Bundle Quality, Safety and Experience Committee 18 September 2018

Agenda attachments

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10.1	Committee Dates 2019/20
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10.2	Minutes from Clinical Board Quality, Safety and Experience sub Committees
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10.3 Agenda for the Private QSE Meeting

00 Private Agenda QSE September.docx

10.4 Items to bring to the attention of the Board or other Committees

Oral

10.5 Review of the meeting

10.6 Date of next meeting: 16th October 2018 Annual Special Meeting

QUALITY SAFETY AND EXPERIENCE COMMITTEE
9am on 18th September 2018
Corporate Meeting Room, HQ, University Hospital of Wales

AGENDA

1. Preliminaries		
1.1	Welcome and Introductions	Oral
1.2	Apologies for Absence	Oral
1.3	Declarations of Interest	Oral
1.4	Minutes of the Committee meeting held on 12th June	*Chair*
1.5	Action Log	*Chair*
1.6	Chair's Action Taken since the last meeting	Oral *Chair*
2. Governance, Leadership and Accountability		
2.1	Patient Story	*CB*
2.2	Medicine Clinical Board Quality, Safety and Experience Assurance Report	*Medicine Clinical Board*
2.3	Community Health Council Report	*No report for September*
2.4	Hot Topics including an update on the WAST SIs	Oral *Executive Nurse Director*
2.5 2.5.1 2.5.2	**Policies for Approval** Interventions Not Normally Undertaken (INNU) Incident, Hazard and Near Miss Reporting Policy and Procedure	*Director of Public Health* *Executive Nurse Director*
2.6	Revised Corporate Risk and Assurance Framework	Oral *Director of Corporate Governance*
2.7	Health and Care Standards	*Executive Nurse Director*
2.8	Putting Things Right Annual Report	*Executive Nurse Director*
2.9	HTA Inspection and Response to Independent Review of Mortuary and Cellular Pathology Services and RCA Into Tissue Traceability	*Chief Operating Officer*
3. Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)		
4. Theme 2: Safe Care		
4.1	Patient Safety Solutions Alerts and Notices	*Executive Nurse Director*
4.2	Cleaning Standards	*Director of Planning*
4.3	Blood Products (Std 2.8)	*Medical Director*
4.4	Nutrition and Hydration (Std 2.5)	*Director of Therapies and Health Sciences*

4.5	Medical Devices, Equipment and Diagnostic Systems (Std 2.9)	*Director of Therapies and Health Sciences*
4.6	Protecting Patients from Pressure Damage	*Executive Nurse Director*
4.7	Child Practice Review	*Executive Nurse Director*
4.8	Ombudsman Public Report	*Executive Nurse Director*
4.9	Safeguarding Annual Report 2018	*Executive Nurse Director*
5. Theme 3: Effective Care		
5.1	Cancer Peer Review – Cancer Pathway	*Medical Director*
5.2	MBRRACE – Perinatal Mortality Surveillance Report	*Medical Director*
5.3	Care of the Deteriorating Patient - Hospital at Night Service (Std 3.1)	*Medical Director*
5.4	Quality Improvement and Research and Innovation (Std 3.3)	*Medical Director*
5.5	NICE Guidance (Std 3.1)	*Medical Director*
6. Theme 4: Dignified Care		
6.1	Carers Annual Report	*Executive Nurse Director*
7. Theme 5: Timely Care		
7.1	Monitoring of Patients on Waiting Lists	*Chief Operating Officer*
8. Theme 6: Individual Care		
8.1	Annual Volunteers Report	*Executive Nurse Director*
9. Theme 7: Staff and Resources		
10 . PART 2: Items to be recorded as Received and Noted for Information by the Committe		
10.1	Committee Dates for 2019/20 • 16th April 2019 • 18th June 2019 • 13th August **or** 17th September 2019 • 15th October 2019 • 17th December 2019 • 18th February 2020 • 14th April 2020	Oral *Chair*

10.2 10.3.1 10.3.2 10.3.3 10.3.4 10.3.5 10.3.6 10.3.7 10.3.8	**Minutes from Clinical Board Quality Safety and Experience Sub Committees – Exceptional Items to be raised by the Assistant Director, Patient Safety and Quality** Clinical Diagnostics and Therapeutics – May, June and July Mental Health – April and July Primary, Community and Intermediate Care - May Specialist Services – April, May, June x 2 and July Medicine – May and June Surgery – May Children and Women – May Dental – June	*Assistant Director, Patient Safety and Quality* *(Chief Operating Officer)*
10.3	Agenda for the Private QSE	*Executive Nurse Director*
10.4	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
10.5	Review of the Meeting	Oral – *Chair*
10.6	Date of next meeting - 9am on Tuesday 16th October 2018 (Special Meeting)	

UNCONFIRMED MINUTES OF THE MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 12 JUNE 2018 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Akmal Hanuk	Independent Member – Community
Dawn Ward	Independent Member – Trade Union
Maria Battle	UHB Chair & Chair of Meeting
Michael Imperato (part)	Independent Member – Legal

In Attendance:

Abigail Harris	Director of Planning
Alex Scott (part)	Patient Safety and QA Manager
Angela Hughes	Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Chris Lewis	Deputy Finance Director
Fiona Salter	Staff Representative
Dr Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance
Rhian Williams	Head of Patient Experience, WG (Observer)
Ruth Walker	Executive Nurse Director
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Steve Curry (part)	Interim Chief Operating Officer
Stuart Egan	Staff Representative

Apologies:

Susan Elsmore	Independent Member, QSE Chair
Prof Gary Baxter	Independent Member - University
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Robert Chadwick	Director of Finance
Dr Sharon Hopkins	Deputy Chief Executive / Director of Public Health

Secretariat: Julia Harper

QSE 18/080 WELCOME AND INTRODUCTIONS

The UHB Chair welcomed everyone to the meeting, and explained that she would Chair the meeting in the absence of the Committee Chair and Vice Chair. Members of the Clinical Board for Clinical Diagnostic and Therapeutics were attending the meeting to deliver the patient story and their quality and safety report.

QSE 18/081 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 18/082 DECLARATIONS OF INTEREST

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

QSE 18/083 MINUTES OF THE COMMITTEE HELD ON 17th APRIL 2018

The Minutes of the last meeting were **RECEIVED** and **APPROVED** subject to a correction to the 5th bullet point on page 12 to read –

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 *from* Llandough.

QSE 18/084 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 18/055 Out of Date Policies –** The overarching Policy had been reviewed and approved by the Board at the end of last year. Policies from other health boards would be studied, but it was not envisaged that the UHB policy would be amended further at this time. **Complete.**

2. **QSE 18/019 Outpatient Follow Ups –** The reasons for DNAs would be provided and an update on the "scraper" used on follow ups would be provided at the next meeting.
   Action – Mr Steve Curry

3. **QSE 18/062 Endoscopy SI and Lessons Learned –** details on timescales for polyp activity would be provided.
   Action – Mr Steve Curry

QSE 18/085 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

The Chair reported that it had not been necessary to take any action in between meetings.

QSE 18/086 PATIENT STORY – CLINICAL DIAGNOSTICS AND THERAPEUTICS

Mrs Sue Bailey, Clinical Board Director of Quality, Safety and Experience read a very sad letter from a family whose baby had died in Bridgend and was transferred to UHW for post mortem. The lack of communication between the

two Health Boards had caused considerable distress and a 12 day delay had meant that they had been unable to properly say goodbye to their daughter.

Mrs Bailey told the Committee that the UHB had failed to let Bridgend know that the post mortem had been completed and this delay had been avoidable. Following honest and open discussions within the Clinical Board, a letter of apology had been sent to the family. Failings were recognised and assurances that lessons had been learned and processes changed were given.

The family generously accepted the apology and thanked the Clinical Board for their honesty.

The Chair advised that it was always best to be honest and open, to offer apologies and assurances that incidents would not recur. It was also noted that the UHB had a policy that covered cultural/religious community concerns.

The learning from this incident would be shared with other Clinical Boards and was part of complaints training and consultant induction. However, it was noted that some individuals remained nervous about personal sanctions if they admitted making a mistake so it was important to provide ongoing reassurance.

The Chair thanked Mrs Bailey for sharing this story.

QSE 18/087 **CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT**

Mrs Sue Bailey and Mr Matt Temby, Director of Operations attended the meeting to present their comprehensive report covering both challenges and successes in the Clinical Board.

The Chair invited comments and questions on the comprehensive report:

- In terms of regulatory compliance, governance arrangements and compliance had been reviewed and escalation and performance had been identified as a theme. In response, a Regulatory Compliance Group had been established and key metrics agreed.
- The change in culture including openness to challenge and engagement was welcomed.
- The new process would provide an “early warning” system.
- Regulators were looking more closely at the quality of services and whether this deteriorated during times of financial squeeze.
- There was a single-handed neuro interventional service with support from Bristol. This was doing well with the shortest ever waiting list but the service needed support to become sustainable.
- The comment of erroneous outcomes from ultrasound equipment was concerning. The difficulty of recruiting to medical physics and clinical

engineering was noted and the UHB was working in conjunction with Velindre. Unfortunately quality assurance was not being properly considered when new equipment was purchased and Clinical Boards were being reminded of their obligations.

- There was a good incident reporting culture in the Clinical Board so Members should not be concerned by the number of incidents recorded. However, it was important to look at incidents that resulted in harm.
- Implementation of GDPR was a significant challenge so it was important to get the basics in place.
- The response rate to complaints was 80%. The largest number of complaints were about communication, however there were small pockets of very good communication and it was important to learn from those areas.
- Storage of medical records had been a challenge for some time. It had been hard to retain staff and there were delays in appointing new staff and this had exacerbated the problem. Vast quantities of records had been stored in Whitchurch Hospital and these had to be transferred to Treforest and Carmarthen. In addition, records had not previously been destroyed if they had not been accessed in 8 years meaning the UHB held some 0.75m records. This was now being addressed. All Clinical Boards needed to recognise they had a role to play. The situation was being monitored at the Information Technology and Governance Sub Committee.
- Record digitalisation was being monitored by the Sub Committee and Miss Battle would discuss this further with the Sub Committee Chair so as not to duplicate discussions.
- **Action – Miss Maria Battle**
- The Medical Engagement Charter had started to make a difference and elements of it would benefit others. However, the greatest impact had been found by the use of a mediator.

ASSURANCE was provided by:

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

The Committee:

- **NOTED** the progress and approach taken by the Clinical Board to date 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 18/088 COMMUNITY HEALTH COUNCIL (CHC) REPORT

The CHC Chief Officer, Mr Stephen Allen, briefly presented 3 reports from the CHC.

1. **Scrutiny Overview**

Mr Allen highlighted themes from CHC visits and feedback: staffing levels on wards, moving patients from ward to ward, parking and the environment. The report also highlighted areas of good practice and the increased satisfaction about the level of cleanliness.

Mr Allen also reported 90% completion of recommendations made by the CHC compared with 75% last year. Where it was stated staff were "unable to take personal responsibility", it was agreed this would be discussed separately with the Executive Nurse Director.
Action – Mr Stephen Allen
However, it was noted that compliance with the Nurse Staffing Act could be monitored on the new boards on every ward and CHC members could ask the ward sister/charge nurse how the risk of gaps were being managed.

2. **"Our Lives on Hold"**

Mr Allen commended the UHB for publishing this national report with its Committee papers. The stories described what it was like to be a patient waiting months and months for treatment. Mr Allen said he would share separately all the UHB patient stories and would welcome a UHB action plan in response to the report's findings.
Action – Mr Stephen Allen and Mr Steve Curry

It was noted that the UHB was seeing a theme emerging from its own systems and this would be raised as a "hot topic" (harm caused whilst waiting) and the UHB's focus was to reduce referral to treatment time.

3. **Sensory Loss Assessment of NHS Organizations Across Cardiff and Vale of Glamorgan**

Whilst there had been significant improvements, the CHC had found there to be a lack of good sensory loss awareness and training for staff. Five key questions had been used for the review and it was noted that whilst some areas had improved since 2016, others had declined. The report was just a snapshot but did include a breakdown by site.

Mr Allen asked the UHB to consider the recommendations and suggested some joint working with Velindre. The CHC looked forward to receiving the UHB's formal response.
Action – Mr Steve Curry

QSE 18/089 HOT TOPICS – SERIOUS INCIDENTS INVOLVING WAST (WALES AMBULANCE SERVICES TRUST)

The Executive Nurse Director, Mrs Ruth Walker gave an oral update. Information on specific cases had been provided to WAST and the outcome of their investigation was awaited.

With regard to waiting lists, it was important to get assurance that patients were monitored whilst waiting to ensure they were not coming to harm. In that regard, each Clinical Board would be asked to provide such assurance and the overall situation would be reported back to Committee.
Action – Mrs Ruth Walker

QSE 18/090 POLICIES FOR APPROVAL

The Committee received two all Wales Policies that required formal approval and adoption within the UHB and one local policy for approval.

1 NHS WALES PRIOR APPROVAL POLICY

ASSURANCE was provided by:

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

The Committee:

- **APPROVED** the UHB's adoption of the All-Wales Prior Approval Policy
- **SUPPORTED** the full publication of the All-Wales Prior Approval Policy in accordance with the UHB Publication Scheme.

2 ALL WALES POINT OF CARE TESTING POLICY. WHAT, WHEN, HOW?

ASSURANCE was provided by:

- The UHB Clinical Lead who was the author of the document.
- The All Wales Policy was mapped to Health and Care Standards 2015 and the current UHB Point of Care Testing Policy was 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:

- **APPROVED** and **ADOPTED** the all Wales Policy on the Management of Point of Care Testing (POCT). What, When and How?
- **APPROVED** the full publication of the Policy in accordance with the UHB Publication Scheme

- **AGREED** that the EHIA approved by the Committee in September 2017 for the UHB POCT Policy could also be applied to the All Wales Policy on the Management of Point of Care Testing.

3 INTRAOPERATIVE CELL SALVAGE POLICY AND PROCEDURE

ASSURANCE was 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:

- **APPROVED** the review of the provision of Intraoperative Cell Salvage Policy and Procedure
- **APPROVED** the full publication of the provision of Intraoperative Cell Salvage Policy and Procedure in accordance with the UHB Publication Scheme.

QSE 18/091 PATIENT EXPERIENCE FRAMEWORK UPDATE

Mrs Angela Hughes, Assistant Director Patient Experience presented good progress against the 3 year framework and reported that evidence was now available from all quadrants.

The use of “happy or not” machines had proved valuable in gaining feedback and were able to pinpoint the time of day and day of the week that feedback was given. In all, over 168,000 responses had been received.

From the feedback it was possible to distinguish carers’ perceptions from those of staff. In addition, bespoke questions were targeted at certain departments and volunteers were being used to improve patient experience.

Work for the coming year included UHB values, access for patients with sensory loss and whole service changes.

The Chair invited comments and questions:

- Carers wanted support that was sustainable, not support that was time limited by additional resources.
- Work had taken place with young carers in schools.
- Staff were raising difficulties with caring duties more frequently with Trade Unions.

- Feedback would be used to inform and influence service change, new pathways and transformation, but a formal mechanism for sharing knowledge was required.
- GPs and community nurses were being encouraged to use the engagement tools.
- CHC offered their support to get feedback and support engagement.
- Links with Cardiff Business School could be exploited to support work in this area.

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 framework.
- **NOTED** the main high level achievements for 2017/2018
- **AGREED** to monitor the implementation of the framework and to receive regular updates.

QSE 18/092 REVISED CORPORATE RISK AND ASSURANCE FRAMEWORK

The Director of Corporate Governance, Mr Peter Welsh gave an oral update on the transition to a new system. This would be presented in detail at the June Board Development Day and go live in the UHB in July. The benefit would be that the new system of controls would be measurable. The Committee **NOTED** the update.

QSE 18/093 ANNUAL QUALITY STATEMENT (AQS)

The Executive Nurse Director, Mrs Ruth Walker introduced Ms Alex Scott, Patient Safety and Quality Assurance Manager who had produced the AQS that contained details of all the work done in the last year. This would be shared with Board and made available at the Annual General Meeting.

Ms Scott gave an overview of performance around the seven themes of the Health and Care Standards and the action that had been taken following learning from patient safety work.

It was noted that work on priority areas had been shared with Clinical Boards and fed into the IMTP process. Clinical Boards would be held to account on these areas and this ensured connectivity.

It was noted that the AQS had been received at Management Executive where it had been highly complimented. The CHC and Members concurred that its presentation was excellent.

Mrs Walker thanked Ms Scott and Mrs Carol Evans for all the work done on the AQS. In addition to some further comments from Internal Audit, the Chair agreed to send some information of her own that she would like included.
Action – Miss Maria Battle and Ms Alex Scott

ASSURANCE was provided by:

- The provision of the draft Annual Quality Statement 2017/18

The Quality, Safety and Experience Committee:

- **APPROVED** the draft Annual Quality Statement for 2017 / 2018; in readiness for endorsement at the public Board meeting in July 2018.

QSE 18/094 CLINICAL AUDIT PLAN 2018/19

The Medical Director, Dr Graham Shortland had nothing to add to the report but advised that there had been a significant improvement in the recording of audit activity including the benefits derived.

ASSURANCE was provided by:

- The development of a local Clinical Audit Plan based on Tier 1,Tier 2 and Tier 3 priorities

The Quality, Safety and Experience Committee **APPROVED** the Clinical Audit Plan.

QSE 18/095 INFECTION PREVENTION AND CONTROL EXCEPTION REPORT

The Executive Nurse Director, Mrs Ruth Walker had nothing to add to the report and reminded Committee that the information on infection outbreaks was included as requested at the last Board meeting.

LIMITED ASSURANCE was provided by:

- Compliance with Welsh Government target for *C.difficile* 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 was required to meet the WG expectations for 2018-2019

The Quality, Safety and Experience Committee:

- **CONSIDERED** the contents of the report.

QSE 18/096 CLEANING STANDARDS

The Planning Director, Mrs Abigail Harris gave an oral update and confirmed that targets had been exceeded in the latest performance report. Good progress was probably linked to the number of ward and bathroom refurbishments that had been completed. Better supervision was required to complete audit and new technology was being trialled for risk areas.

It was agreed that up to date cleaning scores were required outside wards and that risk assessments needed to be carried out and recorded.
Action – Mrs Abigail Harris

QSE 18/097 MEDICINES MANAGEMENT – HEALTH AND CARE STANDARDS 2.6

The Medical Director, Dr Graham Shortland had nothing to add to the report and commented that whilst some progress had been made, the UHB was still "getting there". It was hoped that the UHB would have progressed to level 4 by next year.

ASSURANCE was provided by:

- The annual self-assessment process against the Health and Care standards was led by the multi-disciplinary corporate Medicines Management Group which met on a monthly basis
- Clinical Board Quality, Safety and Experience Sub Committees had the opportunity to contribute and share best practice in terms of medicines quality and safety work

The Quality, Safety and Experience Committee:

- **CONSIDERED** the self assessment rating of *"Getting there"* against the Health and Care Standard 2.6 Medicines Management.

QSE 18/098 POINT OF CARE TESTING (POCT)

The Medical Director, Dr Graham Shortland advised of the significant programme of work that had been put in place and the progress that had been made. However, the system required proper resource and governance and costs needed to be shared via a trading framework that was included in the IMTP.

ASSURANCE was provided by:

- The current governance and reporting structures in place.
- Further initiatives to strengthen the PoCT functionality.
- Training and educational programme.

The Committee:

- **AGREED** the continuation of the current Governance Structure for Point of Care Testing and
- **NOTED** the initiatives for service improvement that were being put in place to further strengthen governance.

QSE 18/099 CANCER PEER RE REVIEW – GYNAECOLOGY

The Medical Director, Dr Graham Shortland told Committee that this was a re-review of gynaecology.

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

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

QSE 18/100 MORTALITY DATA AND MORTALITY REVIEW

The Medical Director, Dr Graham Shortland thanked Dr Tony Turley and Ms Joy Whitlock for their work and reminded Committee that it received an update twice a year. He invited Members to specify any areas of concern that would merit a closer investigation and mentioned that the Chief Executive had already asked for a greater focus on mortality audit. The benefit of this work supporting triangulation was noted.

ASSURANCE was provided by:

- Monitoring of Mortality measures and reviews
- Internal Audit report

The Quality, Safety and Experience Committee:

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

QSE 18/101 HIW ACTIVITY UPDATE

The Executive Nurse Director, Mrs Ruth Walker had nothing to add to the report that contained an overview of the primary and community work. It was noted that more work was being done with Primary Community and

Intermediate Care Clinical Board on action planning but it was a challenge trying to influence the work of independent contractors.

ASSURANCE was 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:

- **NOTED** the ongoing monitoring and performance management systems and outcomes for Primary Care Dentists.

QSE 18/102 OPHTHALMOLOGY SERVICES PRESENTATION

Mr Mike Bond, Director of Operations, Surgery, gave a presentation to the Committee on the current situation with ophthalmology. He set the context of the situation, described the inter-relationships and complexity, the internal and external inputs and the impacts.

The service received 149 formal complaints in 9 months, but treated 258 patients per day. 43% of complaints related to cancellations and 37% were about waiting times.

The next steps involved a single plan and set of priorities based on safety first, capacity, adherence to national pathways and performance that covered AMD, glaucoma and cataract. One of the main challenges was to conform with the national pathway and a step change was required by September.

The Chair reported on a meeting that she and the Chief Executive had attended with AMs recently. Other health boards had managed to reduce their waiting lists considerably through a number of means and she asked Mr Bond to help draft a letter setting out the good news as well as the remaining challenges.

Members were assured that the UHB had a plan with a delivery time and requested an update in late Autumn.
Action – Mr Steve Curry

QSE 18/103 OUT OF HOURS INTERVENTIONAL RADIOLOGY

The Chief Operating Officer, Mr Steve Curry gave a brief oral update to the Committee. The UHB currently had 3 consultants but had never provided a 24 hour service, although demand for treatment out of hours (OOH) was growing and was met on a goodwill basis. There was no OOH service in Wales or much of England. A 24 hour rota to meet demand and growth would

require 8-9 staff and therefore a network solution was being considered along with the centralisation of the vascular service that accounted for 60% of interventional demand. The infrastructure for a networked service was being considered as this would also be needed to support the major trauma centre.

It was agreed that any change to the vascular service would require a process of engagement and consultation.

QSE 18/104 SENSORY LOSS

Mr Keithley Wilkinson, Equalities Manager attended the meeting for this item. In addition to the report, he agreed that the Sensory Loss Group needed to pick up the recommendations made by the CHC earlier in the meeting, and the work being done with the deaf community. Whilst there were pockets of success across the organization, the UHB needed to find more consistent and sustainable success.

It was also important not to favour one group above another and therefore it was important to invest in time and people to look at improving services for people with sight loss. It was also agreed that it would be helpful to find a way of sharing stories (video) of what it was like to be a patient with a sensory loss.

Accessibility to treatment was discussed, covering UHB letters and means of contact as well as parking signage. Whilst there were new national accessible communication standards, not all patients with a sensory loss were flagged on UHB patient management systems. There was, however, a checklist covering issues of sensory loss during ward and department refurbishments.

There were pockets of very good practice in Dental and Pulmonary Unit and this was being shared with champions. It was noted, however, that successes had been achieved on a cost neutral basis and significant improvements would require an increase in resources. It was agreed that the Director of Corporate Governance would look at whether Charitable Funds could be used to support progress.
Action – Mr Peter Welsh

The point was made that training needed to be continuous so that knowledge was not lost when staff left. This would be difficult as it was already clear from PADR and mandatory training rates that staff were having difficulty giving time to training. It was suggested that a particular campaign may bring better results.

It was agreed to receive an update in 6 months' time (December).
Action – Mr Steve Curry

ASSURANCE was 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 Committee **NOTED** the progress made in relation to sensory loss.

QSE 18/106 SINGLE ROOMS, DECANT FACILITIES AND ISOLATION ROOMS AT UHW

The Director of Planning, Mrs Abigail Harris gave a brief oral update to the Committee a year on since her last report. Mrs Harris was pleased to report that it had been possible to create some decant beds and that it had been possible to respond to an infection incident.

The provision of isolation rooms was compliant. It was harder to make single en suite rooms within the current building template but this would be achieved for bone marrow transplant.

In the longer term, major capital development money was required from Welsh Government. In the shorter term, the UHB needed to consider whether any more facilities were required to support the major trauma centre.

The Committee **NOTED** the current position.

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

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

QSE 18/107 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The following Minutes were received and noted.

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**

QSE 18/108 AGENDA FOR THE PRIVATE QSE MEETING

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

QSE 18/109 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

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

QSE 18/110 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 18/111 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 18th September 2018.

ACTION LOG FOLLOWING QSE COMMITTEE JUNE 2018 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 18/087	12.6.18	CD&T QSE Report		Discuss digitalization of medical records with the ITG Sub Committee Chair to ensure no duplication.	M Battle	
QSE 18/088	12.6.18	CHC Reports Scrutiny Overview		"Unable to take personal responsibility" to be discussed with END.	S Allen, CHC	
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
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 deferred to September 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 18/102	12.6.18	Ophthalmology Presentation		Update to come to QSE in Autumn.	S Curry	**QSE December**
QSE 18/104	12.6.18	Sensory Loss		Update in 6 months' time.	S Curry	**December QSE**
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 18/055 & 18/084	17.4.18 12.6.18	Out of Date Policies		Consider simplifying process and review overarching Policy.	P Welsh	The overarching Policy was reviewed and approved by the Board at the end of 2017. It would not be amended at this time. **Complete**
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. CLOSED as new format expected at July 2018 QSE**
QSE 18/090	12.6.18	Approved policies		Advise authors/ publish	J Harper	13th June 2018 **COMPLETE**
QSE 18/019 & 18/084	13.2.18 12.6.18	Management of Outpatient Follow Ups and Endoscopy Surveillance		Investigate reasons for Endoscopy DNAs.	S Curry	Two main reasons for DNAs – appointment not mutually agreed with patient and patient decides not to attend following receipt of patient information (including bowel preparation). Progress made on the first – by changing method of booking (letter based) to a direct booking system either by phone booking or face to face after outpatient appointment. Working on improving DNAs related to the second reason

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
						through the GI Cancer Improvement Group - earlier communication with patient regarding pre-procedure preparation and what can be expected on the day. **CLOSED**
QSE 18/062 & 18/084	17.4.18 12.6.18	Endoscopy SIs and Lessons Learned		Questions to be answered on timescales for polyp activity.	S Curry	Gastroenterology Directorate has improved specialist waiting list management to allow oversight of all categories of patients waiting. There has been a delay in the recently appointed second substantive consultant commencing in post, employed to support the specialist element. In the interim, we are utilising sessions from an English consultant to support the specialist endoscopy service. Formal MDT not yet commenced – timescales dependent on the above consultant's start. In mitigation, the Clinical Director is reviewing patients waiting for specialist procedures and expediting where possible using current operators. **CLOSED**
QSE 18/093	12.6.18	Draft AQS		Provide additional	M Battle	**COMPLETE**

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				comments for inclusion.	A Scott	
QSE 18/104	12.6.18	Sensory Loss		Determine whether charitable funds could be used for some initiatives.	P Welsh	This will be possible providing funds are used to enhance services. Bids Panel already approved such bids. **COMPLETE**
QSE 18/088	12.6.18	Sensory Loss Assessment		Provide CHC with UHB's formal response.	S Curry	Response sent to CHC on 9/8/18 **COMPLETE**
QSE 18/088	12.6.18	Our Lives on Hold		Share UHB patient stories with Health Board. Produce UHB Action Plan in response.	S Allen, CHC S Curry	S Allen confirmed 16/08/18 that patient stories could not be shared at this time. UHB therefore, unable to develop specific action plan. Monitoring of patients on waiting lists/long waits is on QSE agenda for September. **CLOSED**
QSE 18/089	12.6.18	Hot Topics		Report back to QSE on how patients were monitored on waiting lists and whether any harm was being caused.	R Walker	This is an agenda item in September under Chief Operating Officer. **COMPLETE**
QSE 18/096	12.6.18	Cleaning Standards		Ensure up to date cleaning standards are displayed outside wards & risk assessments are carried out & recorded.	A Harris	C4C scores are collated following joint risk assessments and reported monthly. Facilities Teams are fulfilling duty of sharing scores with wards/clinical areas. responsibility for displaying this information lies with the Clinical Board. **Complete**

MEDICINE SERVICES CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting 18th September 2018**

Executive Lead : Executive Nurse Director
Author : Quality and Governance Lead Medicine Clinical Board Tel: 2074 6209
Caring for People, Keeping People Well: This report summarises the quality, safety and experience issues for patients and staff in Medicine Clinical Board. It is aligned to the quality components of the UHB's ten year Shaping our Future and Wellbeing Strategy 2015-2025, focusing on the Clinical Board's governance arrangements and the delivery of safe, effective and dignified care.
Financial impact : Not applicable
Quality, Safety, Patient Experience impact: This report provides assurance on the work of the Medicine Clinical Board on a range of quality, safety and patient experience issues. It is aligned to the NHS Outcomes Framework focusing on the Clinical Board's governance arrangements, the promotion of health and delivery of safe, effective and dignified care. Further, it summarises key areas of improvement for access to services and plans to further improve access.
Health and Care Standard Number: All standards **CRAF Reference Number:** All but this report predominately relates to Objectives 5, 6 & 7.
Equality Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The sustained progress the Clinical Board has made on the range of key quality, safety and patient experiences. The focus on governance arrangements in relation to the promotion of health, the delivery of safe, effective and dignified care. 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 Medicine Clinical Board to date and its planned actions
- **APPROVE** the approach taken by Medicine Clinical Board

SITUATION

This report provides detail of the clinical governance arrangements within Medicine Clinical Board in relation to Quality, Safety and Patient Experience (QSPE). It identifies the achievements, progress and planned actions to maintain the priority of QSPE.

BACKGROUND

The Medicine Clinical Board offers high quality clinical care to people with multiple, complex health needs, minor injuries and serious disease. The services provide for the wider regional and Welsh population e.g. Infectious Diseases, Stroke, Dermatology and Gastroenterology. The Clinical Board also provides secondary care services to the local Cardiff and Vale population.

The Medicine Clinical Board has six clinical Directorates with associated clinical services and sub-specialties.

- Emergency Medicine
- Acute Medicine
- Internal Medicine
- Clinical Gerontology
- Gastroenterology (including Endoscopy and Hepatology)
- Rheumatology and Dermatology

The Clinical Board for 2018/19 has an annual budget just under £105 million, and a current workforce establishment of 1,754 WTE staff which includes 714.18 Registered Nurses, 435.06 Health Care Support Workers, 177.27 Admin and Clerical, and 250.08 Medical and Dental staff. It has an inpatient bed base of 632 beds, three Day Units and several outpatient suites.

Secondary to the diversity and high volume of activity provided across the Clinical Board, it is essential that robust risk management arrangements are in place to reduce the risk to our staff and service users.

The aims of the Medicine Clinical Board in summary are:

- Ensuring that there is a process in place to continually monitor and review the quality and safety risk register, taking action to mitigate risks on an ongoing basis:

- Maintaining an open culture of improving quality, safety and patient experience across all teams and all staff; and

- Promoting a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care.

ASSESSMENT

Governance, Leadership and Accountability

Quality, Safety and Patient Experience (QSPE) is the highest priority for the Clinical Board and it has developed significantly over the last three to four years. The Clinical Board Director leads the agenda and the operational responsibility devolved to the Director of Nursing.

QSPE group meetings are held every month and are well attended by medical, nursing and managerial staff for all Directorates as well as other multi-disciplinary colleagues from corporate areas who all take an active part in the meetings and shape the overall agenda. The Terms of Reference are reviewed annually.

The key improvement identified for 2018/2019 are identified as:

Health and Care Standard	RAG Rating	Key Improvements
2.2 Preventing Pressure and Tissue damage		• Educational workbooks completed for all staff as a means of providing additional staff education in the prevention and treatment of pressure and tissue damage. The correct grading and reporting processes of all healthcare acquired pressure damage • Prompt reporting to Patient Safety and Welsh Government • Implementation of Clinical Board Pressure Damage Working Group and the development of pressure damage information for all clinical areas to ensure consistency. The development of a revised patient care plan incorporating EPUP classification, correct reporting, treatment and documentation • Working in close partnership with the UHB Tissue Viability Task and Finish Group and the implementation of the UHB pressure damage passport, Datix stickers and patient/carer information leaflet • Shared learning from all Grade 3, 4 or unstageable pressure damage at Directorate and Clinical Board QSPE meetings and Nursing Board Forums
2.3 Falls Prevention		• Implementation of the Enhanced Supervision Framework is fully embedded across the Clinical Board as a means of minimizing risk of patient falls based on agreed principles and risk assessments

		• Implementation of Model Wards focusing on nutrition and hydration to prevent deconditioning of patients • Implementation of Johns Campaign focusing on activities, relatives/carers involvement in providing care to prevent deconditioning • The Clinical Board has been fully engaged in campaigns such as 'End PJ paralysis, and Get Up, Get Dressed and Get moving' • Models of care focusing on dementia friendly areas and the use of activities co-ordinators, volunteers and therapies support
2.4 Infection Prevention and Control (IPC) and Decontamination		• The Clinical Board achieved 65% compliance for the uptake of the Flu vaccination for all frontline staff last season. This is a huge achievement for the Clinical Board and remains a key objective for this season • Infection, Prevention and Control remains a key priority for the Clinical Board. Infection, Prevention and Control meetings are well embedded within the Clinical Board at both senior management team and Directorate level
3.1 Safe and Clinically Effective Care		• Standard patient information boards for all wards, this will ensure consistency and that the most relevant and up to date information is used • A clear and sustained process in reviewing the Clinical Boards Risk Register, with the implementation of a Risk Register workshop • Full implementation of recently shared Mortality Level 2 review tool and documentation, and how this can be widely embedded throughout the Clinical Board
5.1 Timely Access		• Sustained and continued compliance with Stroke pathway • Sustained and continued improvement with patient flow from Emergency and Acute footprints and inpatient capacity • All ward areas to be provided with bleeps/voceras as a means of improved communication and patient flow
6.2 Peoples Rights		• Full implementation of 'Read About Me' across the Clinical Board • Engagement and development of the Learning Disabilities Bundle and full implementation with the UHB Learning Disabilities Lead

The Clinical Board Risk Register is a live document and is maintained and updated monthly based on the review of existing components of the register, the completion of new risk assessments and review of Directorate Risk Registers. The Clinical Board Risk Register is presented and reviewed at Board QSPE twice a year and reviewed monthly at Formal Board. Directorate Risk Registers also form part of the monthly performance reviews.

The high risk issues discussed at Formal Clinical Board and Executive Performance reviews and are as follows:

Risk	Mitigation	Current Risk
Issue: Approximately 973 patients with overdue endoscopic surveillance procedures. Several SI's reported due to cancers diagnosed in these patients (expedited procedures). Delays in symptomatic waiting times also resulting in delayed cancer diagnosis and treatment	Risk stratification for patients in place alongside clinical and clerical validation. A business paper has been presented highlighting the Colonoscopy backlog and the required actions and recommendations to reduce this risk	25
Issue: Inability to recruit the required numbers of Registered nurses to fill the vacancy gap posing a clinical and financial risk to the Clinical Board	Robust governance regarding recruitment in place to ensure workforce is appropriate. Nursing establishment reviews undertaken with Executive Nurse Director. Bespoke recruitment events ongoing, Director of Nursing and Head of Finance undertaking focused work with the highest spending clinical areas to identify reasons, scrutinize and reduce overspend	25
Issue: The recruitment for medical staff across Emergency Medicine, Acute Medicine, Internal Medicine Directorates	Medical workforce review undertaken with establishments agreed and understood	25
Risk: The failure to promptly identify and treat patients resulting in harm secondary to patients remaining on ambulances for long periods of time secondary to lack of capacity within the Emergency Department and UHB	All delays escalated via the Emergency Unit Controller. Establishment of Medical Control Hub to promote and escalate timely patient flow. AEC supporting patient flow to alleviate WAST delays. Implementation of set 'huddles' to improve communication and patient flow. Daily analysis of 4 and 12 hour breach performance	25

HEALTH AND CARE STANDARDS

The Medicine Clinical Board QSPE Group meets monthly with the agenda framed around the Health and Care Standards. Below are examples of work being driven through these frameworks.

Staying Healthy

The uptake and compliance of the flu vaccination is a priority for the Clinical Board. For the previous 2017/18 season, the Clinical Board achieved 65% compliance with the uptake of the vaccination for all frontline staff. This has been recognized as an excellent achievement for the Clinical Board, particularly in achieving the expected target for the first time. Going forward into this year's preparation the Clinical Board are looking to further improve the number of Champions available within each clinical area and to provide additional focus for medical colleagues and those staff working unsociable hours.

The Clinical Board is currently prioritising the following public health issues:

Diabetes: Within secondary care, structured patient education is in place for patients with Type 1 Diabetes. This includes 10 DAFNE courses (dose adjustment for normal eating), which are led by Diabetes Specialist Nurses and Dieticians. In addition to this, monthly 3 hour carbohydrate counting courses are also run for this patient group. EXPERT courses are provided for patients with Type 2 Diabetes in Primary Care. The availability and efficiency of Insulin Pump therapy has increased via the education of staff, and the provision of structured education for patients. The Diabetes team have worked with colleagues in the Obstetric service to develop new pathways to manage Gestational Diabetes and women with pre-existing Diabetes. This service has been revolutionised by the use of Telehealth to avoid unnecessary visits to the UHB in the care of pregnant ladies with Gestational Diabetes.

Both the Community Model and e-advice are well embedded, demonstrating improved communication between primary and secondary care. The Community Model is an excellent example of technology supporting partnership working between GP's, Practice Nurses, and secondary care Consultants. Future service development aims to include the Diabetic Specialist Nurses within this model. A successful 'invest to save project' has already demonstrated the benefits of Diabetes Specialist Nurses in Primary Care. In-patient teams are now able to remotely monitor patients with hypoglycemia via Point of Care Testing, although currently there is not enough capacity for this to be fully embedded across all areas within the UHB.

The improvement of pathways for common conditions and reasons for referral: Working through the joint development pathway with General Practitioners, the Clinical Board have seen a reduction in the number of patients attending outpatient clinics to exclude skin cancer as a diagnosis, whilst ensuring the appropriate pathways for earlier detection. Similarly there is a small reduction in the number of patients attending endoscopy for cancer

diagnosis, which ensures appropriate pathways for earlier detection. We are continuing this work by reviewing the referrals to Rheumatology and exploring alternatives to hospital referral including those for follow up.

Older Persons Services: The potential extension of FOPAL services with a view to reduce the number of admissions to University Hospital Llandough is being considered. A new Consultant has been appointed to support the frailty model of care including FOPAL services. The Parkinson's Service Team are embarking on the further development of the application of Parkinson's Kinetograph, which means the patients are monitored remotely via a small device worn by the patient. This allows the electronic review of results in a virtual clinic thus reducing the need for face to face consultation and clinic attendances. The Memory Service continues with the GP led clinics and together with Primary Care colleagues, have submitted a bid to Welsh Government for a portion of the new dementia money that is linked to the Welsh Government Dementia Action Plan. This includes recurring money for the GP memory clinics, as well as some additional posts to start the new locality-based "teams around the individual" that will work alongside Community Resource Teams. Waiting times for Memory Clinic continue to improve with a current waiting time of 6 – 8 weeks.

Cancer: There is a 31 and 62 week target cancer pathway in Dermatology, Gastroenterology and Respiratory within the Clinical Board. Dermatology currently have a 25 day waiting time which is a significant improvement from what was reported as 35 days in July 2017. Gastroenterology continue to have cross specialty issues which impact on the waiting times for cancer patients, this is being performance managed with improvement noted. Respiratory pathway complexities and multi-specialty involvement for urgent suspected cancer referrals provides a challenge for the Clinical Board, which is being performance managed. Improvements in pathways for the current cohort of patients has been noted and performance improvement should be seen over the coming months.

Smoking cessation: The Clinical Board recognises the importance of smoking cessation and continues through 'making every contact count' to assist patients to access smoking cessation programme.

SAFE CARE

Safety Alerts

The Clinical Board has a robust management system in place for Patient Safety Alerts working in conjunction with the Patient Safety Team. An identified member of staff within the Clinical Board is responsible for all alerts received, and is responsible for the dissemination and actions where applicable. These are shared at Directorate and Clinical Board QSPE meetings.

Health and Safety

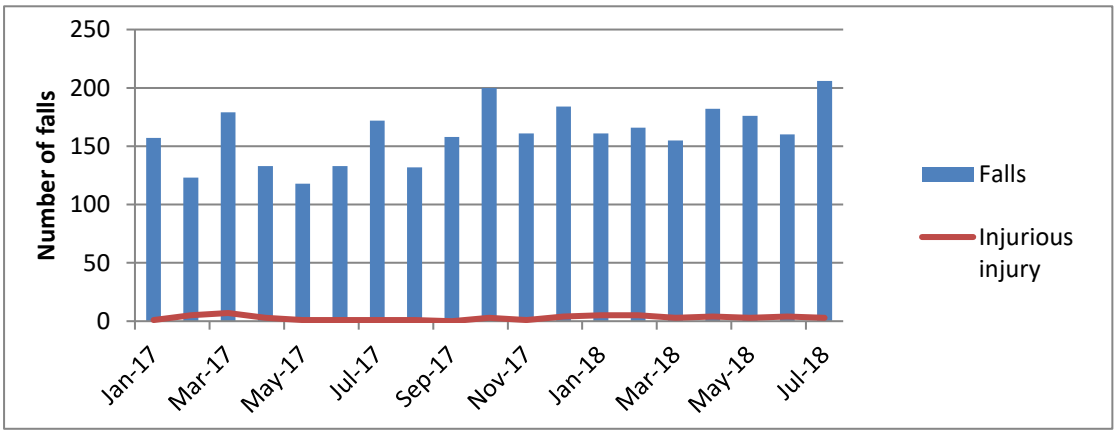
In the period 01.01.2018 to 30.06.2018 the following 8 incidents were reported to the Health and Safety Executive as RIDDOR events:

- 2 manual handling incidents
- 4 violence and aggression incidents
- 1 hit something fixed/stationary
- 1 dirty needle stick involving a patient who was known high risk

6 of these cases have been closed with the remaining 2 cases in progress. Case Management Support has been offered for the four reported cases of violence and aggression towards staff members. Three incidents resulted in members of staff being off duty for more than 7 days which was investigated as per Health and Safety guidelines. Violence and Aggression training is available for all staff members. Of the 8 RIDDORS none were significant injuries. No common themes or areas of concern were noted.

Falls

Every fall within the Clinical Board is reported via E Datix and a proportionate level of investigation undertaken. Falls remain the most reported incident via Datix for the Clinical Board and these are reported at the Board's QSPE to identify any common themes or trends.



The Clinical Board continues to have an active key role in the UHB Falls Focus Group. The Injurious Assessment tool is utilised appropriately for all falls when an injurious injury is sustained, with progression to a full Root Cause Analysis if required. All death related falls are referred to Her Majesty's Coroner. All Injurious Assessments and Root Cause Analysis are shared at Directorate and Clinical Board QSPEs to share learning and good practice. These reports are shared across other Clinical Boards as appropriate to share wider learning, and also with families and carers to ensure transparency and rigor in the investigation process and learning outcomes.

It is evident that there is heightened awareness of falls risk and management across all areas. Wards A4 and B7 have recently been involved in a LIPS project focusing on falls and the provision of simulation training for falls procedures and best practice in line with UHB and NICE 2015 guidelines. This training is being disseminated across all areas within the Clinical Board. In addition, the Clinical Board have been fully engaged with campaigns such as 'End PJ Paralysis and Get Up, Get Dressed and Get Moving' as a means of preventing patient deconditioning, thereby reducing any potential falls risk and subsequent harm. Several wards in conjunction with therapy colleagues have exercise clubs for patients, which have received positive feedback from patients, relatives and staff.

The Enhanced Supervision Framework which supports a patient risk assessment and levels of observation is fully embedded across the Clinical Board and is currently being piloted across two other Clinical Boards. This has provided positive outcomes for patients and the Clinical Board, with the reduction of 1:1 intervention when needed, and improved overall communication with all members of staff in reducing patient risk and harm as a consequence of falls.

Documentation audits are undertaken monthly which include all falls risk assessments and pre and post falls procedures. These are monitored by the Directorate Senior Nurses and actioned accordingly when areas of improvement are required. Intentional Rounding is well embedded across the Clinical Board for all patients.

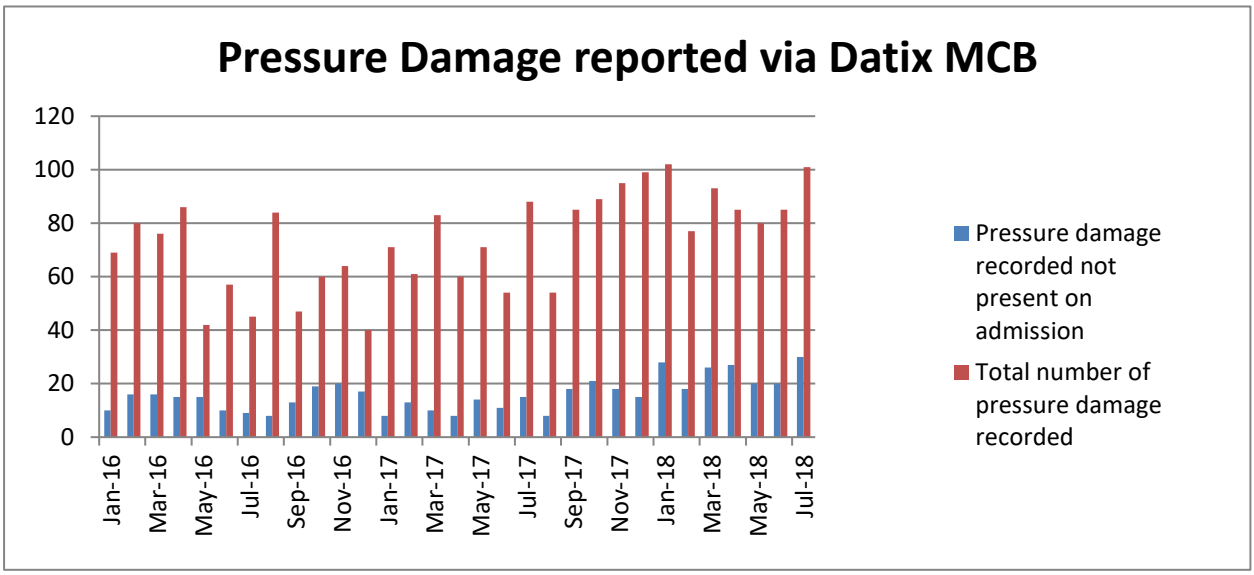
As a Clinical Board, Measles Maps have been widely encouraged and implemented. These maps provide the ability to identify areas within the clinical area where falls are most prevalent and offer the opportunity to mitigate specific risk. The Clinical Board has received very positive feedback from Welsh Government for the utilisation of these, and has been used as an exemplar across Wales.

The Day Hospital at UHL in partnership with Physiotherapy colleagues have completed two series of intergenerational interaction, by inviting children of different age groups to take part in activities, including exercises with patients who attend day hospital. This has proved extremely beneficial for those patients with anxieties around mobilizing and engaging in activities, as a means of preventing deconditioning and improving overall patient confidence.

Pressure and tissue damage reduction and prevention

The Clinical Board continues to improve the disparity between the accuracy of pressure damage reported via E Datix and the Health Care Standards system. To date a significant amount of work has been introduced across the Clinical Board with the use of Datix Stickers as a means of preventing duplication, the implementation of a patient passport, the development of a single educational poster which will be used across the Clinical Board and educational workbooks for all staff to complete. In addition a new patient care plan has been developed and will be implemented following ratification at Clinical Board QSPE in

September. The Clinical Board is fully engaged with the UHB Tissue Viability Task and Finish Group and has been praised for the work undertaken to date.



The Clinical Board is aware of the increase in the number of healthcare acquired pressure damage reported to Welsh Government, which in part is secondary to new reporting guidelines. It is reassuring that from the All Wales Pressure Damage Tool investigations undertaken, the pressure damage reported have been deemed predominately unavoidable.

Serious Incidents

The Clinical Board is currently investigating the following serious incidents:

- 5 healthcare acquired Grade 3 pressure damage
- 6 Injurious Injuries
- 1 Incorrect blood transfusion (Never Event)
- 1 delay in treatment
- 1 medication error
- 1 delay in off-loading from WAST and patient deterioration
- 1 delayed Gastroenterology surveillance patients
- 1 air emboli

The Clinical Board have closed a total of 78 Serious Incidents from January 2018 to August 2018. Welsh Government Closures wherever possible are submitted within the expected timeframe and the Clinical Board consistently achieve the expected number of closures per month. The Clinical Board have identified learning from these incidents, and pleasingly areas of improvement have been noted in relation to Injurious injuries and compliance with NICE 2015 guidelines post falls procedures, along with improvements for healthcare acquired pressure damage.

There are demonstrable improvements in the services provided by Gastroenterology, Hepatology and Endoscopy for surveillance and waiting list patients for Endoscopy and Colonoscopy, however this remains a significant risk for the Clinical Board.

The Gastroenterology service has seen an emerging theme through its incidents in relation to the missed or late diagnosis of cancers, particularly surveillance patients. This factor is contributed to by the high demand of urgent suspected cancer (USC) referrals, urgent and routine waiting lists, alongside those patients on a surveillance list. The following actions are being taken by the Medicine Clinical Board to reduce the risks currently being experienced:

- Stability and strong leadership through current Gastroenterology Directorate Manager, CD and Lead Nurse
- A live action plan which is reviewed at Directorate and Clinical Board level to monitor improvement
- A review of the current administration services both in terms of capacity/demand and capability
- A review of Gastroenterology capacity and demand and the development of a plan to reduce the waiting time
  - Aim to achieve JAG accreditation (2019/20)
  - Risk stratification of current waiting list to ensure high risk patients are brought forward (<3 months)
  - Ensure capacity is fully utilized using new CWM scheduler system
  - Insourcing contract in place for another 13 weeks to accelerate waiting time reduction plans for diagnostic position

The current issues are reflected in the Directorate's and Clinical Boards Risk Register. There is Executive oversight of the service and regular monitoring of the improvement plan.

Safeguarding

From January 2018 to July 2018 there have been 67 Safeguarding referrals made by the Clinical Board. These are noted as:

- 4 emotional – 3 hospital and 1 friend/carer
- 3 financial – 1 patient, 1 family member and 1 unknown
- 5 neglect – 4 hospital and 2 unknown
- 9 physical – 1 family member, 6 hospital, 1 partner and 1 unknown
- 1 neglect and pressure damage - hospital
- 1 neglect and physical - hospital
- 2 physical, neglect and pressure damage – 2 hospital
- 37 pressure damage (in line with EPUP and WG guidance to report all Grade 3 pressure damage and VA1 referrals) 26 hospital and 11 unknown
- 3 sexual – 2 patient and 1 unknown
- 2 physical and emotional – 1 family member and 1 hospital

26 of these cases remain open and are being managed in line with Safeguarding processes to ensure prompt review and timely closure.

Concerns between 1st January 2018 - 31st July 2018

The management of concerns is a key priority for the Clinical Board. The implementation of tracker meetings across all Directorates aligned to a Clinical Board tracker data base allows an overview promoting timeliness of responses and actions undertaken where delays are identified.

All concerns are firstly considered resolvable informally by making contact with the patient/complainant and dealing with the concern promptly. As a result 141 informal concerns were received. For the same period 140 formal concerns were received.

Compliance with the timescale for formal concerns has significantly improved over the year. The current 30 day response rate for the Clinical Board is 64%, with June reporting 80%. This is discussed at all Directorate Performance Reviews and Clinical Board QSPE to help drive the continued improvement that is required. The Clinical Board currently have 2 concerns over 100 days, these are being case managed for closure.

Reasons of formal concerns are below:

Formal

Subject	Number
No subject	1
Access (bed availability)	1
Accident/falls	1
Admissions	2
Appointments	18
Attitude/behavior/assault	6
Cancellation of appointments, admission and surgery	12
Clinical diagnosis and treatment	67
Clinical treatment/assessment	84
Communication issues	11
Communication between staff and patients	16
Concerns handling	1
Confidentiality	1
Deficiency of treatment/facilities	2
Discharge arrangements	8
Discharge issues	1
Environment facilities	2
Infection control	1
Nursing Care	11
Nutrition/hydration	2
Patient care	4

Resources	2
Test results	1
Waiting Times	16

The number of clinical diagnosis, treatment and assessment concerns have in the main been attributed to Emergency and Acute Medicine and Internal Medicine Directorates. Case reviews are undertaken as part of the Directorates QSPE to share any potential learning and themes.

No common themes or trends have been noted within communication between staff and patients and nursing care. The Clinical Board however recognises the importance of learning and sharing information in relation to all concerns received. All 'Appendix S' claims and redress are shared at Clinical Board QSPE meetings.

Some examples of you said we did can be demonstrated via:

- The establishment of Carers Clinics
- Early contact and resolution of all informal concerns
- All Ward Sisters/Managers act in a supervisory role making themselves more visible to patients/relatives/carers and improved communication
- We have recorded with permission, meetings where relatives have outlined their issues and played edited versions back to the staff involved, this has had a very positive impact upon staff as they were able to hear the anxiety and distress caused with real reflection noted

Infection, Prevention and Control

Clostridium difficile

37 cases of *Cl. difficile* were reported for the Clinical Board for July 2017 – July 2018, this is a significant improvement from the same time period the previous year which was reported as 45 cases. The Clinical Board is fully engaged with the expected reduction figures for all healthcare acquired infections and is disappointed that this was not been achieved in relation to *C difficile* for last year, and recognises the challenges ahead in this forthcoming year.

Microbiology and Pharmacy colleagues continue to support ward rounds and the provision of antibiotic stewardship. Shared learning forms part of the QSPE and Clinical Board Infection, Prevention and Control agendas for all healthcare acquired infections and RCA's. RCA's have demonstrated that anti-biotic treatment is predominately prescribed in conjunction with advice from Microbiology, with additional Microbiology support provided to those areas with an increased rate of reported cases. On-going audits with Infection, Prevention and Control and the Senior Nurses continue. There is particular focus on environmental audits and decluttering of clinical areas.

MSSA

28 cases of MSSA Bacteremia were reported for the Clinical Board from July 2017 – July 2018. This is noted to be around the same from the same time

period the previous year which was reported as 27 cases. RCA's have noted that improvements mainly focus on the compliance of PVC stickers.

MRSA

The Clinical Board has disappointingly had 3 cases of MRSA Bacteremia from July 2017 – July 2018 compared to the 5 cases reported for the same period the previous year. The RCA's completed have identified that one case was related to a patient with a known chronic skin condition and MRSA, which could not be treated with topical therapy. The two outstanding RCA's have been escalated for completion to understand any potential learning.

E Coli

Since the requirement to report E Coli in August 2017, the Clinical Board have reported 47 cases of E Coli to July 2018. The RCA investigations have noted that these where attributed to biliary and urinary catheter sources. Recent CAUTI audits undertaken have shown generally positive results with some learning identified around how often catheter bags are being changed. Additional learning has also identified the requirement for early urine samples to be sent when a patient is first admitted to the Health board to support accurate reporting, particularly those patients cared for in Primary Care with long term catheters.

Klebseilla

The Clinical Board commenced reporting the number of Klebseilla cases from July 2018. To date 4 cases have been reported, and recognise that these will in the main be attributed to respiratory patients.

The Sepsis 6 Bundle is fully implemented across the Clinical Board with work ongoing in conjunction with the Practice Development Nurses for the full implementation of Aseptic Non Touch Technique (ANTT).

The Clinical Board is working with the Patient Safety Team to ensure that all areas are compliant with the National Safety Standards for Invasive Procedures (NaTTSIP's). To date Local Standards Procedures have been completed for Endoscopy, Paracentesis and Nurse Led Pleural Tap procedures.

EFFECTIVE CARE

Each Directorate has a Clinical Audit Lead and it is part of the Clinical Board Medical Lead's responsibilities. The Clinical Board has an audit/research plan for 2018. Some of the clinical research/audits are noted as:

Dermatology

- Observational study to investigate surgical site infection in ulcerated skin cancers

Gastroenterology

- Research of new robotic endoscope carried out for the first time this year in the clinical research facility where there is now a purpose built research endoscopy suite
- Fecal microbiota transplantation in Ulcerative Colitis
- Personalised medicine in Crohn's Disease
- Predicting serious drug side effects in Gastroenterology

Medicine

- In August 2018 the first patient in the world was dosed with a new drug for Type 1 Diabetes as part of a new clinical trial led by Professor C Dayan. The Research Facility is providing 24 hour car Monday – Thursday for the first time to support patients taking part in this trial
- Ustekinumab in adolescents with recent onset Type 1 Diabetes
- The health cost of mould and damp in homes of people with Cystic Fibrosis
- Experiences of non-invasive ventilation treatment in older people with hypercapnic respiratory failure
- Experiences of living with Cystic Fibrosis, the impact on children, young people, adults and their families

Clinical Gerontology

- Atherothrobotic risk factors and risk of ischaemic vascular events among patients with intracerebral haemorrhage
- Characterising mild vascular cognitive impairment and vascular dementia

Rheumatology

- Biologics for children with rheumatic diseases
- Toxicity from biologic therapy
- Inflammation and immune regulation in early inflammatory arthritis

In-order to promote effective care and improve patient journey and experience through the UHB, the Clinical Board has well embedded multi-disciplinary 'Board Rounds' and 'Deep Dives'. Using the Safer Patient Flow Bundle, it has been recognised that Board Rounds do not always follow any standard approach. Forming part of the Safer Bundle Implementation Group the Clinical Board aims to review the current Board Round principles, in order to establish effective timely Board Rounds, and establish refreshed standards of board rounding with clear roles and responsibilities, identifying clear outcomes and actions. This will ensure that appropriate delays are escalated, that clear plans are identified for the patient each day, and review of predicted discharge dates ensuring that a clear discharge destination is identified and reviewed as appropriate.

Acute and Emergency Medicine have implemented a patient booklet designed for patients with learning disabilities, cognitive impairment and non-compliant behavior. Patients with these complexities find attending a hospital environment a stressful experience and their clinical examination can often be difficult secondary to fear and anxiety. The booklet is intended to ensure the

early escalation of a patient's clinically deteriorating condition, and provide a standardized approach to documentation. To improve staff compliance and provide greater awareness of the complex needs of this patient group. To provide a recognized pathway that is embedded into practice. To link with the UHB vision and core values, and to be used as a benchmark of best practice within other Health boards across Wales.

Sam Davies Ward in Barry Hospital have been involved in a Digital Health pilot, and have seen extremely positive outcomes for patients with the introduction of digital technology within the ward environment. Supported by intergenerational interaction with a local school, patients were provided with help and support to use electronic devices such as I-pads, searching the patients' interests and hobbies, and help to keep in touch with relatives via tools such as Skye. By using music, dementia friendly apps and reminiscence websites positive outcomes for the patients were noted, including improved engagement and increased brain stimulation, which led to a reduction in medication, and levels of enhanced monitoring required.

Based on Prudent Healthcare Principles 6 Quality domains, East 8 in UHL have adopted a model of care known as CWTCH (Compassionate Ward delivering Therapy, Care Home Planning), to provide an enhanced service and environment of care for its patients. This aims to improve patient, relative/carer experience with an environment focused on activities with the support of activities coordinators, promoting independence, and the prevention of deconditioning.

A LIPS project in UHL aims to improve the experience and service for patients within Mental Health Services for Older People (MHSOP) who become physically unwell. This aims to reduce the number of physically unwell patients transferred to emergency medical wards through the development of a new care pathway by November 2018. This will include additional education for MHSOP ward staff in relation to Sepsis and infection, prevention and control to support staff in competently evaluating patient care needs. In addition to this, the Practice Development Nurse for Clinical Gerontology is in the process of implementing Healthcare Support Worker swaps with MHSOP wards to help support and assist staff in understanding different patient care needs.

Mortality and morbidity reviews are routinely undertaken as part of the Emergency Medicine QSPE meetings in line with the All Wales checklist. Mortality Level 2 reviews are slowly being embedded across all clinical areas and a proportion of them are shared at Directorate QSPE meetings as a means of discussion and shared learning.

DIGNIFIED CARE

Unannounced Quality Checks in Healthcare are routinely undertaken across the Clinical Board noting how patients were treated and received appropriate dignified care. Improvement plans are developed to address any issues that have been identified.

HIW visited Elizabeth Ward in April 2018, and reported evidence of strong and consistent management and leadership, with evidence of positive interaction between staff and patients. Areas identified as needing some improvement included, the safe administration of medicines, out of hour's medical cover, multi-disciplinary involvement of Speech and Language Therapy, the timely involvement of Social Workers to input into discharge planning and improvements to the application of Deprivation of Liberty's Safeguards (DOLS) legislation. These are being addressed with an action plan, and monitored for progress and completion via QSPE meetings.

The Clinical Board in conjunction with Dietetic and housekeeping colleagues implemented a 6 week pilot 'The Model Ward' Nutrition and Hydration within two ward areas East 2 UHL and A4 UHW. Funding has been secured from charitable funds to undertake a 12 month service evaluation across 4 wards. This model ensures that all patients can access and receive the best possible nutrition and hydration outside the rigid confines of set meal times. It has provided a real improvement in patient experience of being in hospital, enabling them to be co-producers of their own nutritional care retaining independence as far as possible. In addition, it has improved clinical outcomes while patients are in hospital and assisted in the transition back to the patient's permanent place of residence by preventing deconditioning.

TIMELY CARE

Following the submission of Serious Incidents to Welsh Government, noting the significant risk associated with this, the Gastroenterology, Hepatology and Endoscopy Directorate and Clinical Board continue to focus on the waiting times for surveillance endoscopy procedures and waiting lists and how they can be managed more effectively. This includes the provision of a live action plan which is reviewed by both the Directorate and Clinical Board to monitor progression. Strategic mapping of demand and capacity, the provision of stability and strong leadership through current Gastroenterology Directorate Manager, CD and Lead Nurse and the review of the current administration services both in terms of capacity/demand and capability. The Directorate and Clinical Board continue to work towards JAG accreditation.

The Clinical Board recognises the importance of the timely closure of Welsh Government Serious Incidents. There are currently 6 Serious Incidents which have breached the expected closure dates, 4 of these are being escalated for closure in September 2018. Significant and sustained progress has been made with the closure of Serious Incidents within the Clinical Board. With the support of the Quality and Governance Lead for the Clinical Board all open Serious Incidents are driven for timely closure with clear actions and learning identified.

The Emergency Unit have introduced a number of new initiatives to improve patient experience and compliance with Welsh Government and UHB 4 and 12 hour key performance indicators. This includes the ability to flex open a second triage room which enables adherence to the 15 minute triage standard. The implementation of 'huddles' at specific times over a 24 hour period, including

an EU Consultant, EU Controller or Nurse in Charge, Patient Access and Site Manager. The Senior Manager on call is also expected to join the 17:00 huddle ahead of the handover going into the evening. The purpose of the huddle is for the team to take a wider view of the department and actively re-allocate resources to ensure waiting times are managed. This has proved to be extremely effective and has improved communication between the team and external stakeholders which has led to ownership and a sense of responsibility to manage the 4 hour performance standard for patients. Daily breach analysis of the 4 hour standard is undertaken, with specialty 4 hour breaches shared with the relevant areas for feedback.

For Stroke a second 90 day transformation project is being led by a dedicated Senior Nurse and Programme Manager. With the support of IM&T a Stroke Dashboard has been developed and is being launched in September to monitor activity including achievement against quality indicators, flow and constraint reasons. The Stroke Nurse Specialists are piloting extended hours which supports timely assessments. Nursing Stroke Champions within the Emergency and Acute footprints, champion all aspects of the four hour component to ensure compliance of the Stroke Care performance indicators. In thrombolysis management, the Code Stroke 1 pathway has been process mapped and a pilot has commenced to further embed elements of the Helsinki Model. This is working well with further reductions noted in the “door to needle” time observed. Cardiff and Vale retained its B rating position over the winter period which was a significant achievement given the pressures normally experienced during this time of the year.

INDIVIDUAL CARE

All areas of the Clinical Board are fully engaged with the Patient Experience Framework, in the participation of National Satisfaction ‘Two minutes of your time’ surveys. These are shared at the Clinical Board QSPE meetings with particular focus on the comments that our patients are making regarding all aspects of care they receive. The themes to be noted include comments on clinical areas sometimes being noisy and cold and suggest where improvements could be made. All staff are generally praised for their care, compassion and dedication to their roles.

The Clinical Board also shares patient stories at Board QSPE each month to share good practice, areas for improvement and learning outcomes for patients in our care.

John’s Campaign was launched in February 2018 in partnership with the Patient Experience Team across four areas within Clinical Gerontology. This aims to improve engagement with carers by utilizing four principles, Priority, Principles, Promises and Please. Carers are identified early, that they have a voice and are communicated with as soon as possible, and are kept informed. Carers are encouraged to continue to be involved and provide support at meal times, when providing personal care and the giving of medicines. All carers are encouraged to respect other patients dignity, to respect any issues on the

ward that might impact on the ward supporting their stay and encouraged to tell staff if they need any help or support. Additional initiatives have been introduced including the use of a toiletries kit for anyone who has had to stay overnight so they would be able to freshen up and remain with their loved ones during difficult times, and the use of a voucher that allows relatives to get a staff discount at the restaurants in UHW and UHL.

Volunteers are also important members of the team within the Clinical Board, providing support to patients. This is reflected in the excellent work that is being undertaken on Wards A7, East 8, Sam Davies and C7.

Staff and Resources

Medicine Clinical Board consists of approximately 1754 WTE staff: as of July 2018 the professional break down as follows:

Staff Group	Establishment WTE
Additional Professional & Technical	3.4
Additional Clinical Services	2.69
Administrative and Clerical	177.27
Estates and Ancillary	0
Healthcare Scientists	4.41
Medical and Dental	250.08
Nursing and Midwifery Registered	714.18
Unqualified Nursing	435.06

The Clinical Board currently has 91% of the agreed establishment in post with 8.76% turnover rate in July 2018. Cumulative sickness at June 2018 was 5.78% compared to a target of 5.16%, this demonstrates a continuous improvement in the work to reduce sickness absence.

As expected the biggest part of the workforce is Registered Nurses and as such requires ongoing recruitment, training and retention to ensure there is a workforce that is fit for purpose to deliver the fundamental and specialist care that patients require. This is noted within the relevant Directorate's and Clinical Boards Risk Registers Nursing vacancies in July 2018 are 107 WTE. The current number of vacancies for all Registered Nurses within the Clinical Board is currently reported as 15%. From August 2017 to July 2018 the position for all Registered Nurses within the Clinical Board sickness is 5.86%.

The Clinical Board is proactively recruiting staff and to keep inpatient vacancies to a minimum in order to provide safe staffing levels. An agreed recruitment plan is in place with the All Wales Staffing Act in place within relevant areas.

As well as recruitment, retention of staff is vital. The Clinical Board recognises the importance of developing capability through continuous improvement and the development of our future leaders across all specialties. Staff development is supported by Practice Educators with education pathways from novice to

expert. The Clinical Board are exploring several innovative ideas to recruit and retain registered nurses.

The clinical Board in patient wards are currently reviewing the All wales Nurse Staffing acuity data for June, to triangulate this information with quality Indicators and professional judgement; to ensure the clinical Board in patient wards have the right number of registered nurses and the right skill mix to ensure the delivery of a high quality and standard of care to our patients.

The importance of staff appraisal cannot be underestimated. The Clinical Board and Directorates are working hard to improve compliance with PADR and pay progression. The current compliance is as follows:

Emergency Medicine	71 %
Acute Medicine	77%
Internal Medicine	68%
Clinical Gerontology	65%
Gastroenterology, Hepatology and Endoscopy	30%
Rheumatology & Dermatology	38%
Clinical Board Total	**62 %**

The Clinical Board has long recognised the importance of listening to and engaging with staff and are developing a service improvement and engagement plan. The engagement of staff in the development of the Board is inherent to its values. Issues in relation to staff concerns have to be addressed robustly and sustainably and the Clinical Board is committed to that.

The Clinical Board is fully supportive and engaged with the UHB's values and behaviours and has strategies in place to manage staff who fail to meet the standard expected.

The Clinical Board strives to recognise and celebrate success, therefore Celebration Events and Recognition Schemes are held twice a year. There are many excellent examples of innovative practice making real improvements in the quality and safety of the care we provide to our patients. In this year's Staff Recognition Awards, the Adult Cystic Fibrosis Centre multi-disciplinary team were winners of The Research and Development Award. Practice Development Nurse Ian Dovaston was runner up for The Education and Development Award. Emergency Department Consultant Stephen Mullen was the winner of The Leadership Award. Ward A4 were runners up for The Welsh Language Award. Haydn Cantor was the winner for The Volunteer of the Year Award for all of his dedication in supporting patients on the Regional Stroke Unit. Parkinson's Specialist Nurses Tracy William and Sandra Mahon were runners up for The Patient Experience Award.

The Medicine Clinical Board are proud that several of their employees have been recognised as exemplars and leaders. Dr Hamaraj Shetty has recently been awarded the first Welsh Stroke Specialist Award. Dr Shetty is described by his colleagues as passionate, dedicated and a champion for Stroke services. Parkinson's Specialist Nurses Tracy William and Sandra Mahon have recently

received a UK Parkinson's Excellence Award for their Parkinson's Dementia Clinic which was recognized as driving standards and encouraging other professionals to continually push the boundaries of high quality care creating better services for patients with Parkinson's. Janet Lewis Endocrinology Nurse Specialist was announced as the winner of the 'Society for Endocrinology Endocrine Nurse Award' 2018. Marking the 70th anniversary of the NHS, Clinical Board Nurse Director Rebecca Aylward was asked to share her experience of nursing, and shared that 'I am still that student nurse and staff nurse inside, because I haven't lost those values that are important – patient care'.

With staff leading the way the Medicine Clinical Board continues to maintain and drive the key quality improvements required to ensure optimum patient experience and staff development.

APPROVAL OF INTERVENTIONS NOT NORMALLY UNDERTAKEN POLICY AND INTERVENTION LIST
Name of Meeting Quality, Safety and Experience Committee **Date of Meeting** 18th September 2018

Executive Lead : Executive Director of Public Health
Author : Consultant in Public Health Tel: 029 21832125
Caring for People, Keeping People Well: The updated INNU policy and intervention list supports the avoiding harm, waste and variation component of our Shaping Our Future Wellbeing Strategy.
Financial impact :
Quality, Safety, Patient Experience impact: Potential positive impact on quality, safety and patient experience as treatments with limited clinical or cost effectiveness and/ or safety concerns are minimised.
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: YES

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The policy has been fully reviewed and the intervention list has been comprehensively updated with Clinical Boards. A full Equality Health Impact Assessment (EHIA) has been completed.
- All Clinical Boards had previously reviewed Interventions Not Normally Undertaken activity relating to their areas of service provision.
- The monthly activity list of a subset of procedures provided to Clinical Boards has been reviewed and focuses on high volume and high cost interventions.

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Interventions Not Normally Undertaken Policy and Intervention List and
- **APPROVE** the full publication of the revised INNU policy and List in accordance with the UHB Publication Scheme

SITUATION

To support prudent healthcare and the implementation of our *Shaping Our Future Wellbeing Strategy*, Cardiff and Vale University Health Board (UHB) has a list of health service interventions which are not normally undertaken by the UHB, or which will be undertaken only within specified criteria. The first

UHB Interventions Not Normally Undertaken (INNU) policy and intervention list was published in May 2010 (v01) and was subsequently updated in 2014 (v02). The INNU policy, intervention list and Equality Health Impact Assessments (EHIA) have been revised again during 2018.

BACKGROUND

Interventions Not Normally Undertaken are not routinely available because:

- There is currently insufficient evidence of clinical and /or cost effectiveness *or*
- The intervention is considered to be of relatively low priority for NHS resources.

The interventions included in the UHB INNU intervention list have been agreed with Clinical Boards. The UHB Business Intelligence Team produce a monthly INNU monitoring report to Clinical Boards on a core set of INNU interventions.

ASSESSMENT

As part of the NHS Wales National Improvement Programme Public Health Directors' Action Plan for 2017/18, all Health Boards reviewed their INNU activity and costs. Clinical Boards in the UHB reviewed INNUs relating to their service areas to ensure that activity and costs were acceptable.

A preliminary review of the INNU list (v02) has been undertaken to ensure the background clinical evidence is up to date. Amendments have been made as necessary, for example where NICE guidance has been updated. Subsequent work has been undertaken with Clinical Boards to confirm clinicians are content with the statements and/or to seek advice where amendments were needed. The amendments to the INNU list are listed in Appendix A.

Consultation has taken place to ensure that the policy meets the needs of our stakeholders and the Health Board. The consultation undertaken specific to this document has been as follows:

- The INNU policy, intervention list and EHIAs were added to the Policy Consultation pages on the intranet
- The documents were shared with Cardiff and Vale UHB Clinical Boards
- The documents were shared with Cardiff and Vale Community Health Council
- The documents were shared with a wide range of additional stakeholders facilitated by Glamorgan Voluntary Services and Cardiff Third Sector Council

The primary source for dissemination of the INNU policy and intervention list 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.

Appendix A

AMENDMENTS TO THE INTERVENTIONS NOT NORMALLY UNDERTAKEN (INNU) LIST 2018
CARDIFF AND VALE UNIVERSITY HEALTH BOARD

Where NICE guidance has changed and the criteria for use was in line with NICE guidance, Clinical Boards were asked to confirm that usage in line with the updated NICE guidance remains appropriate and has been approved by the Clinical Board. OCPS codes have been updated to version 4.8.

	Children and Women Obstetrics and Gynaecology	Responses coordinated by Rachel Burton Mr Nigel Davies confirmed the INNU statements reflect practice (4/4/18) Further correspondence following update of NICE guidance relevant to heavy menstrual bleeding interventions
1	Elective Caesarean Section (CS)	Change to evidence reference: NICE CG13 replaced by NICE CG132 No change to statement Following statement removed from evidence column "Initial review through UHB Clinical Effectiveness Group (CEG) March 2001 & subsequently April 2014. Awaiting reviewed intervention policy statement" Removal of OCPS codes R18.- R17.- elective caesarean section, R18.- other caesarean delivery
2	Sterilisation – Reversal of (male and female)	Duplicate entry removed Public Health Wales Observatory evidence summary hyperlink refreshed Following statement removed from evidence column (time expired) "Latest review: UHB Clinical Effectiveness Group November 2010"
3/4	Heavy Menstrual Bleeding - Dilation and curettage (D&C)/ Hysteroscopy Hysterectomy	Removal of following statements from evidence columns "Dilation and curettage is one of the five surgical procedures that the Department of Health monitors as indicators of excess surgical activity" "Hysterectomy is one of the five surgical procedures that the Department of Health monitors as indicators of excess surgical activity" Evidence updated from NICE CG44 to NICE CG88. Confirmation of revised wording for statement being sought from clinical board (6/6/18) Hysterectomy – statement amended. The following bullet points were removed from the clinical circumstances when hysterectomy can be offered: • There is a wish for amenorrhoea • The woman (who has been fully informed) requests it • The woman no longer wishes to retain her uterus and fertility.

		The statement now reads: "Can be used when other treatment options have failed, are contraindicated or are declined by the woman. Request for exemption required in all other cases."
	CAMHS	
	Melatonin for delayed sleep phase disorder	See under medicine/ respiratory (44)
	Clinical Diagnostic and Therapeutics	Responses coordinated and confirmation from Sue Bailey 10/04/18
5 6	Open MRI scans Complementary Therapies	Public Health Wales Observatory evidence summaries hyperlinks refreshed
	Low Back Pain	See under surgery/ orthopaedics (22,23)
	Mirror therapy	See under medicine/ stroke services (45)
	Dental	Confirmation from Hayley Dixon (21/3/18)
7	Dental Implants	RCS reference and hyperlink added
8	Apicectomy	Hyperlink refreshed
9	Orthodontic treatments of essentially cosmetic nature	Health Evidence Bulletin Wales Oral Health reference and hyperlink removed as longer active and no replacement found Amendment to OCPS codes: Orthodontic treatments of essentially cosmetic nature F16.- replaced by F15.- F14.- remains as before (F14.-orthodontic operations, F15.- other orthodontic operations, F16.- other operations on tooth)
10	Wisdom teeth - Removal of asymptomatic	Reference and hyperlink to London Health Observatory removed as link broken. No replacement found.
	Surgery	Responses coordinated by Mike Bond Specifically requested confirmation that statements permitting use in line with NICE guidance were still appropriate after changes to NICE references listed Ophthalmology: Mr Sanjiv Banerjee (9/4/18) and Mr Chris Blyth (11/4/18) Orthopaedics: Mr Simon White (16/4/18) Vascular: Mike Bond after discussion with Mr Ian Williams (2/5/18) During the consultation, the absence of nasal surgery for snoring from the intervention list was highlighted. This intervention is on the national Do Not Do list and these interventions are not currently undertaken. For clarity nasal surgery for snoring has been added to the INNU list.
	Ophthalmology	
11	Corneal implants for the correction of refractive error in the absence of other ocular pathology e.g.keratoconus.	*NICE do not do recommendation* added to evidence column Update of OCPS codes
12	Scleral expansion surgery for presbyopia	*NICE do not do recommendation* added to evidence column
13	Laser therapy for short sight	No changes

14	Photodynamic Therapy (PDT) for late Age-related Macular Degeneration (AMD) (wet active)	Evidence reference updated NICE TA68 replaced by NG82 Statement updated in line with NG82.
	Cardiac/ vascular	
15	Percutaneous laser revascularisation for refractory angina pectoris	*NICE do not do recommendation* added to evidence column
16	Transmyocardial laser revascularisation (TMLR) for refractory angina pectoris	*NICE do not do recommendation* added to evidence column
	Orthopaedics	
17	Therapeutic use of ultrasound in hip and knee osteoarthritis	Public Health Wales Observatory updated evidence summary - hyperlink refreshed
18	Ganglia – Surgical Removal	Public Health Wales Observatory updated evidence summary - hyperlink refreshed Amendment to OCPS codes: Ganglia – Surgical Removal T60.- added to existing T59.- (T59.-excision of ganglion, T60.- re-excision of ganglion)
19	Autologous Chondrocyte implantation for knee/ ankle problems caused by damaged articular cartilage	Evidence reference updated NICE TA89 replaced by TA477 Statement changed in line with TA477 Amendment to OCPS codes: Autologus Chrondrocyte implantation for knee/ ankle problems caused by damaged articular cartilage Y71.4 replaced by W71.4 (Y71.4= late operations noc- failed minimal access approach converted to open. W71.4 other open operations on intra-articular structure- open autologous chondrocyte implantation into articular car[sic]
20	Electrical & electromagnetic field treatments bone non-union	Public Health Wales Observatory updated evidence summary - hyperlink refreshed
21	Abrasion arthroplasty	Public Health Wales Observatory updated evidence summary - hyperlink refreshed
22	Low Back Pain (Non-specific) – Plain X-rays of lumbar spine & MRI scans	Evidence link updated. NICE CG88 replaced by NG59
23	Low Back Pain (Non-specific) – Management	Evidence link updated: NICE CG88 replaced by NG59. "do not offer" list updated in line with NG59. "General" changed to "Management" in heading. IDET changed to Percutaneous electrothermal treatment of the intervertebral disc annulus (in line with title of NICE guidance and reference added -NICE IPG544. NICE IPG545 added to PIRFT line. SSRIs excluded (pharmacological intervention).
24 25	Spinal Injections for spinal surgery/ pain medicine	No changes
26	Hallux valgus (bunion)	Public Health Wales Evidence based information updated with evidence summary and refreshed hyperlink Amendment to OCPS codes: Hallux valgus (bunion). Codes W15.1 and W15.2 added.
27	Hip Resurfacing Techniques apart from in-line with published NICE guidance	Evidence links updated: NICE IP203 and TA44 replaced by TA304

28	Endoscopic Lumbar Decompression and Laser Disc Decompression	Evidence link updated: NICE IP027 replaced by IPG570
29	Laser Lumbar Micro-Discectomy	Evidence link updated: NICE IP027 replaced by IPG570
30	Hip Arthroscopy & Debridement	Evidence link updated: NICE IPG213 replaced by IPG408
31	Hip Prostheses	Evidence link updated: NICE TA02 and IP112 replaced by TA304 Statement added in evidence column: NICE TA304: Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.
	ENT	
32	Tonsillectomy – children & adults	Reference and hyperlink to RCPCH guidelines for management of acute and recurring sore throat and indications for tonsillectomy removed as hyperlink broken and guidelines not found elsewhere. Public Health Wales Observatory evidence summary hyperlink added Removal of following statement from evidence column "Tonsillectomy is one of the five surgical procedures that the Department of Health monitors as indicators of excess surgical activity"
33	Soft palate implants for obstructive sleep apnoea	*NICE Do not do recommendation* added to evidence column
33 b	Nasal surgery for snoring	Added to interventionlist. National 'Do not do'. Nasal surgery for snoring: No routine exemption critieria. Requests for exemption required in all cases
34	Grommets – Drainage of middle year in otitis media with effusion (OME)	Removal of following statement from evidence column "Insertion of grommets is one of the five surgical procedures that the Department of Health monitors as indicators of excess surgical activity"
	Vascular	
35	Variscose Veins – asymptomatic & mild / moderate cases	Reference to London Health Observatory and hyperlink removed No longer active. Following statement removed from evidence column "Reviewed at UHB Clinical Effectiveness Group on 11th April 2014. Awaiting revised intervention policy statement".
	Gynaecology	
36	Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain	No changes
	Gastroenterology	
37	Capsule Endoscopy / Pillcam	No changes

38	Cholecystectomy (for asymptomatic gall stones)	Updated evidence summary. Hyperlink refreshed
39	Haemorrhoidectomy	Updated evidence summary. Hyperlink refreshed
	Neurosurgery	
40	Subthalamic nucleotomy for Parkinson's disease	No changes
	Specialist services	Interventions sent to Paula Goode, Dale-Charlotte Moore. 26/3/18, 10/4/18) Baclofen also followed up with Jennifer Thomas (2/5/18) Confirmation re Baclofen received from Dr Jennifer Thomas (3/5/18)- WHSSC commissioned therefore Baclofen taken out of C&V INNU list
	Spinal injections	See under surgical (25) – no changes
	Baclofen	Removed from INNU list – see comment above
	Medicine	Sent to Geraldine Johnston (26/03/18, 10/04/18) Medicines issues highlighted to Dr Graham Shortland and Darrell Baker. Fibromyalgia statement – amendment agreed by Fiona Jenkins, Mel Wilkey, Dr Sharon Jones (16/04/18)
	Gastroenterology	
41	PH/Manometry Impedance Studies	Public Health Wales Observatory evidence summary hyperlink added 'in adults' added to statement for clarity as NICE NG1 recommends clinicians to "consider performing an oesophageal pH study (or combined oesophageal pH and impedance monitoring if available) in infants, children and young people with certain symptoms or conditions. Following statement removed "Evidence yet to be formally released"
	Urology	
42	Treated for Erectile Dysfunction (ED)	Hyperlink removed as no longer active. No replacement found. Link to Cardiff and Vale formulary and Erectile Dysfunction Care Pathway added
	Rheumatology	
43	Fibromyalgia in adults: Inpatient pain management / specialised fibromyalgia programmes	Update evidence summary. Hyperlink refreshed New heading/ statement clarifying those fibromyalgia treatments not available. Previous heading read Fibromyalgia in adults and the statement "No routine exemption criteria. Requests for exemption required in all cases."
	Respiratory	
44	Melatonin for delayed sleep phase disorder	Previous statement read "No routine exemption criteria. Request for exemption required in all cases". Statement amended to clarify use in children should be specialist initiated and in line with C&V shared care protocol CV54 Currently no exemption criteria for adults however this is under review via the medicines management formulary process.

		Statement added, “Use in adults under review (07/18). Please refer to Cardiff and Value formulary for updated guidance. Updated evidence summary. Hyperlink refreshed
	Stroke services	
45	Mirror therapy	Public Health Wales Observatory evidence summary hyperlink added Statement removed from evidence column “Evidence yet to be formally released.”
	Mental health	Responses coordinated and confirmed by Jayne Tottle (30/4/18)- Specifically requested confirmation that statement permitting use in line with NICE guidance was still appropriate after changes to NICE references listed
46	Computer Based Cognitive Behavioural Therapy	NICE clinical guidelines added to evidence / reference column; CG90, CG91, CG159
47	Electroconvulsive Therapy (ECT)	NICE CG90 added to evidence / reference column

Reference Number: UHB 009 **Version Number:** 3	**Date of Next Review:** *To be included when document approved* *xx/20xx* **Previous Trust/LHB Reference Number:** UHB 009

Interventions Not Normally Undertaken (INNU) Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will identify, monitor and review a list of health service interventions which are not normally undertaken by the UHB, or which will be undertaken only within specified criteria.

Interventions Not Normally Undertaken (INNUs) are not routinely available because:

- There is currently insufficient evidence of clinical and /or cost effectiveness *or*
- The intervention is considered to be of relatively low priority for NHS resources

They are either not normally available on the NHS in Wales, or are available only within specified criteria. The list of INNUs can be found in the supporting document *List of Interventions Not Normally Undertaken by Cardiff and Vale University Health Board.*

The Individual Patient Funding Request (IPFR) process can be used to apply for an intervention included in the INNU list in clinically exceptional circumstances.

Pharmaceutical treatments are generally excluded from the list, as there is a process for looking at these through the Cardiff and Vale UHB Corporate Medicines Management Group. Details of medicines that can be routinely prescribed along with the associated indications and criteria are detailed in the Cardiff and Vale Formulary.

Policy Commitment

- The list of Interventions Not Normally Undertaken by the UHB is a live document which will be updated as new evidence becomes available or as prioritisation decisions are made within the UHB.
- The UHB lead or designated lead in conjunction with the appropriate Clinical Board(s) and the Head of Outcomes Based Commissioning, will agree whether an addition/deletion/amendment to the INNU list is required.
- Proposed changes will be taken to Health System Management Board (HSMB) for approval prior to updating the INNU list.
- The INNU list part 2, for services commissioned by the Welsh Health Specialised Services Committee (WHSSC) will be updated by WHSSC.
- The current INNU list will be published on the Cardiff and Vale UHB IPFR internet page.
- The UHB Business Intelligence Team will provide a monthly INNU monitoring report on a core set of INNU interventions to Deputy Director of Public Health, Head of Outcomes Commissioning, IPFR co-ordinator and the Director of Operations,

Surgery Clinical Board.

- Overarching INNU activity will be monitored through the UHB Board Performance Report.

Supporting Procedures and Written Control Documents

This Policy is to be used in conjunction with the supporting documents listed below:

- List of Interventions Not Normally Undertaken by Cardiff and Vale University Health Board
- NHS Wales Policy: Making Decisions on Individual Patient Funding Requests Policy
- The All Wales Prioritisation Framework
- Welsh Health Specialised Services Committee (WHSSC) Specialised services commissioning policies and service specifications
- Cardiff and Vale UHB Formulary
- Public Health Wales Evidence summaries to support INNU

Documents are publicly available as follows:

The INNU list and IPFR policy (when approved):
www.cardiffandvaleuhb.wales.nhs.uk/individual-patient-funding-requests

The All Wales Prioritisation Framework:
http://www2.nphs.wales.nhs.uk:8080/HealthTopicLeads.nsf/85c50756737f79ac80256f2700534ea3/c997185d64441b3980257bb80049f48d/$FILE/Prioritisation%20Framework_Final%2021-12-11.pdf

WHSSC Specialised services commissioning policies and service specifications:
www.whssc.wales.nhs.uk/policies-and-procedures-1

Cardiff and Vale UHB Formulary:
http://cardiffandvaleuhb.inform.wales.nhs.uk/

Public Health Wales Evidence summaries to support INNU:
http://nww.publichealthwalesobservatory.wales.nhs.uk/favicon.ico

Scope

This policy applies to all of our staff in all locations including those with honorary contracts, and to those that deliver care to Cardiff and Vale UHB patients.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) been completed. The results highlight that whilst certain interventions

	relate in particular to certain protected characteristics (age, disability, pregnancy, race, sex) due to higher prevalence of related conditions or illness in particular sub groups of the population, no negative impact on protected characteristics was identified and in some aspects the impact on protected characteristics was positive. Key actions have been identified and incorporated within supporting procedures.

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Health Systems Management Board
Accountable Executive or Clinical Board Director	Executive Director of Public Health

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	Cardiff and Vale Board	May 2010	Not applicable
2	Quality, Safety and Experience Committee 23/09/2014	Sept 2014	Additional information provided to strengthen Equality Impact Assessment
3	Quality, Safety and Experience Committee 18/09/18	TBC	Updated and reformatted UHB009v02 in line with the revised policy template. Changes to the interventions included in the INNU list are documented alongside the INNU list.

Equality & Health Impact Assessment for

Interventions Not Normally Undertaken (INNU) policy

Note- Embedded documents are available on request

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Not applicable
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Public Health Executive Director: Dr Sharon Hopkins Anne Hinchliffe, Consultant in Public Health. Tel: 029 2183 2125 Anne.hinchliffe@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The purpose of the INNU policy is to outline the UHB process for identifying, monitoring and reviewing a list of health service interventions which are not normally undertaken by the UHB, or are only undertaken within specified criteria. An intervention is placed on the INNU list if the clinical and/or cost effectiveness evidence for the intervention is weak, or as a result of service prioritisation. The INNU policy is in line with the UHB's Principles for Change described in *Shaping Our Future Wellbeing Strategy 2015-2025,* in particular avoiding harm, waste and variation by: • Adopting evidence based practice, standardising as appropriate

		• Fully using the limited resources available, living within the total • Minimising avoidable harm • Achieving outcomes through minimum appropriate intervention
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 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].	In 2015 there were estimated to be 357,160 people living in Cardiff, and 127,592 living in the Vale of Glamorgan. The population age structure of the Vale of Glamorgan is very similar to the Wales average. The Cardiff population is relatively young compared with the rest of Wales, with the proportion of infants (0-4 years) and young working age population (20-39 years) significantly higher than the Wales average. There are several universities in Cardiff and the student population exceeds 40,000. There are an estimated 15,000 people living with some degree of sight loss, and 33,000 people have moderate or severe hearing impairment in Cardiff and the Vale of Glamorgan. There are 2000 people registered with learning disability in Cardiff and the Vale of Glamorgan and over 30,000 classified themselves in 'bad' or 'very bad' health. Population data from the *Census 2011* https://www.nomisweb.co.uk/ Cardiff and Vale identified: • Marital status: Single (incl. divorced and widowed) 56%, Married 40%, Civil partnership 0.2%, Separated 3.5%* • Religion: Christian 53%, Muslim 5.2%, Hindu 1.1%, Buddhist 0.4%, Sikh 0.3%, Jewish 0.2%, other religion 0.4%; Non-religion 32% • Ethnicity: White 88%, Asian 6.8%, Mixed 2.5%, Black/African/Caribbean/British Black 1.7%, Arab 1.0%,Other ethnic

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		group 0.5% • 50,580 carers were recorded in Cardiff and Vale of Glamorgan • The number of men and women is similar, with women slightly outnumbering men (50.8% Cardiff, 51.4% Vale of Glamorgan) • There are 36,735 fluent Welsh speakers in Cardiff and 13,189 in the Vale of Glamorgan, equating to approximately 10% of the population *Data on disability and marital status were collected from the Household reference person. Data on sexual orientation and gender reassignment was not collected in the Census 2011. A survey undertaken for the Cardiff and Vale Population needs assessment (see below) reported 86.7% respondents specified their sexual orientation as heterosexual, 3% gay man, 2.6% bisexual, 1.7% gay woman/lesbian, 0.6% other. There are no official estimates however UK research carried out in 2009 estimated 0.6%-1.0% of the population over 15 year old identify as transgender, which would equate to between 2,300 and 3,900 in Cardiff and Vale of Glamorgan. In 2016 there were 105,800 women aged 16-44 resident in Cardiff and Vale and there were 5676 maternities. Births by mothers' usual area of residence in the UK - Office for National Statistics The *Cardiff and the Vale of Glamorgan Population needs assessment* was prepared following the introduction of the Social Services and Well-being (Wales) Act 2014. The Act placed a duty on Local Authorities and Local Health Boards to prepare and publish an assessment of the care and support needs of the population, including carers who need support.

		Information for the assessment was drawn from a number of sources including public surveys tailored to the audience; focus group interviews with local residents; a survey of local professionals and organisations providing care or support, including the third sector; and service and population data. The assessment report presented findings for the following population themes: • Children and young people • Health and physical disabilities • Learning disability and autism • Adult mental health and cognitive impairment • Adult carers • Sensory loss and impairment • Violence against women, domestic abuse and sexual violence • Asylum seekers and refugees • Offenders • Veterans • Substance misuse Suggested areas for action from the Population Needs Assessment that are pertinent to the INNU policy and EHIA include: Recognising the diversity within age groups (e.g. children and young people, older people) and tailoring services to meet individual needs; increasing engagement with people in decisions about them; increased clarity on referral pathways and criteria and support for professionals in decision making; recognising people with complex needs and requiring additional support. Recommendations from the Cardiff and Vale Dementia Health Needs Assessment (2017) identified the importance of treating people with

		kindness and compassion and the importance of avoiding unwarranted inequalities in access to services. http://www.cvihsc.co.uk/wp-content/uploads/2017/02/DHNA-Cardiff-and-Vale-Final.pdf An assessment of the future health and social care needs of older people in Cardiff and Vale of Glamorgan (2011) recognised the following as having increasing impact on people's health as they got older; reduced mobility, visual impairment, increased risk of falls, urinary incontinence, diabetes, stroke, mental health problems and dementia. http://www.valeofglamorgan.gov.uk/Documents/Living/Social%20Care/Adult%20Services/Older%20Peoples%20Needs%20Assessment_%20First%20Report%20June%202011%20(2).pdf *Health inequalities impact on people and communities* Health inequalities are differences in life expectancy and healthy life expectancy between people or groups due to social, geographical, biological or other factors. Some differences, such as ethnicity, may be fixed. Others are caused by social or geographical factors. The association between social inequalities and health inequity is well documented, the latter being defined as "an unnecessary, avoidable, unfair and unjust difference between the health or healthcare of one person and that of another. There is an enduring association between socioeconomic position and health, both over time and across major causes of death. The difference in life expectancy between those living in the most and least deprived communities in Cardiff and Vale is 10.3 years for men and 9.2 years for women. To explore the potential impact of the INNU policy on individuals with one or

		more protected characteristics searches were undertaken on 5 March 2018 using the search engine Google. The searches listed below provided little evidence that implementing an INNU policy would have a negative impact on individuals with protected characteristics. However, the impact is inextricably linked to the interventions included in the INNU list. Age + interventions not normally undertaken policy - Google Search Disability + interventions not normally undertaken policy - Google Search Gender reassignment + interventions not normally undertaken policy - Google Search Marriage or civil partnership + interventions not normally undertaken policy - Google Search Pregnancy or breastfeeding + interventions not normally undertaken policy - Google Search Race + interventions not normally undertaken policy - Google Search Religion or belief + interventions not normally undertaken policy - Google Search Sex + interventions not normally undertaken policy - Google Search Sexual orientation + interventions not normally undertaken policy - Google Search To further explore the potential impact of this policy EHIA has been undertaken focusing on each of the interventions in the INNU list. A number of interventions in the INNU list are permitted only in accordance with NICE guidance. Processes within NICE require equality issues to be considered in the scoping and production phases and NICE publishes an equality impact assessment alongside its guidance. A national list of elective activity by INNU by area of residence for 2015/16 captured by Health Board was produced in September 2017 by the Financial Information Strategy team in the Welsh Health Collaborative. Activity data is

		not provided by protected characteristic. As the focus of this policy is on clinical needs and capacity of any patient to benefit, it is not deemed beneficial to request further data analysis in this regard. The following sources provided evidence for the interventions included in the INNU list. Public Health Wales Observatory evidence summaries. http://nww.publichealthwalesobservatory.wales.nhs.uk/favicon.ico Relevant technology appraisals and clinical guidelines published by the National Institute for Health and Care Excellence www.nice.org.uk/
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Patients, staff and stakeholders will have clear and transparent information about those health service interventions not normally undertaken by the UHB or undertaken only within specified criteria. The population served by Cardiff and Vale UHB will benefit through the efficient use of limited healthcare resources and minimising of avoidable harm.

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	Certain of the interventions in the INNU list are applicable in particular to younger or older people because of the higher prevalence of a related condition or illness in that age group. Where this is the case it is clearly stated in the EHIA undertaken on the INNU list. For each intervention it is stated whether there is: • No provision because the intervention is not clinically and cost	Patients are assessed individually based on their clinical need and potential to benefit from treatment. The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases.	The IPFR route is highlighted throughout the INNU list.

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
	effective • Provision only within certain criteria		
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	Some of the interventions in the INNU list are particularly pertinent to people with disabilities and wherever this has been identified actions are in place to ensure that there is no negative impact because of disability. In some instances a positive impact was identified, for example, good practice in dental services for people with learning disabilities. For patients with a learning disability or sensory loss	Patients are assessed individually based on their clinical need and potential to benefit from treatment. The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases.	The IPFR route is highlighted throughout the INNU list.

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
	appropriate measures need to be put in place to ensure effective communication. Reasonable adjustments UHW d		
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	Some interventions in the INNU list may be particularly applicable to men or women due to anatomical differences (e.g. hysterectomy; management of erectile dysfunction) or variation in prevalence of some conditions by gender (e.g. hallux valgus). Gender reassignment	Patients are assessed individually based on their clinical need and potential to benefit from treatment. The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases.	The IPFR route is highlighted throughout the INNU list.

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
procedures. Sometimes referred to as Trans or Transgender	interventions are commissioned by Welsh Health Specialised Services Committee and the INNU list includes a hyperlink to the WHSSC policy webpage. The INNU policy states that some interventions are not available due to lack of clinical and/or cost effectiveness; or as a result of service prioritisation. No evidence was identified to suggest that people would be disproportionately affected by the INNU policy on the basis of gender or gender reassignment.		

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
6.4 People who are married or who have a civil partner.	The general health needs of married people or people in a civil partnership are the same as others within the population. The policy does not have a direct impact on people because of their being married or in a civil partnership. Any health needs would be covered by who they are in terms of other characteristics, such as gender or sexual orientation in terms of civil partnership	None identified	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	The INNU list includes one intervention that specifically relates to pregnancy- elective caesarean section. Criteria for when the procedure may	Patients are assessed individually based on their clinical need and potential to benefit from treatment.	The IPFR route is highlighted throughout the INNU list.

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
having a baby whether or not they are on maternity leave.	be undertaken, which apply to all women were developed in partnership with clinical leads. The INNU policy states that some interventions are not available due to lack of clinical and/or cost effectiveness; or as a result of service prioritisation. No information was identified to suggest that pregnant women, those who had recently given birth or are breast feeding would be negatively impacted by the INNU policy.	The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases.	

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
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	At the time of the 2011 Census 15% of people living in Cardiff and 6% in the Vale were non-UK born. Cardiff has the highest ethnic minority population of the local authorities in Wales and Asian is the most represented ethnic minority group. The INNU policy states that some interventions are not available due to lack of clinical and/or cost effectiveness; or because of service prioritisation. Certain of the interventions in the INNU list may be	Patients are assessed individually based on their clinical need and potential to benefit from treatment. The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases.	The IPFR route is highlighted throughout the INNU list.

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
	particularly applicable to ethnic minority groups due to higher prevalence of related conditions or illnesses in particular populations (e.g. cholecystectomy). Where this is the case it is stated in the EHIA accompanying the INNU list. The INNU policy supports the efficient use of limited resources by not routinely making treatments which are considered to have low clinical and/ cost effectiveness or are considered low priority. No evidence of negative impact has been identified because		

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
	of a person's race.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No evidence has been found of specific impacts from the INNU policy on people because of their religion, belief or non-belief.	None identified	N/A
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	No evidence has been found of specific impacts from the INNU policy on people based on whether they are heterosexual, lesbian or gay, or bisexual.	None identified	N/A
6.9 People who communicate using the Welsh language in terms of correspondence,	No evidence has been found of specific impacts from the INNU policy on people who	The INNU policy states that some interventions are not available due to lack of	The IPFR route is highlighted throughout the INNU list.

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
information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	wish to communicate using the Welsh language. Under the Cardiff and Vale University Health Board Welsh Language Scheme, patients and service users whose first language is Welsh should be given the choice to receive a Welsh language service. This may include discussing treatment options, gaining consent and providing patient information.	clinical and/or cost effectiveness; or as a result of service prioritisation. The Individual Patient Funding Request (IPFR) route is available for clinically exceptional cases. Patient Information Leaflets for IPFR are available in Welsh and English. e-learning Welsh Language Awareness training for all NHS Wales staff is being developed.	IPFR patient information leaflets in Welsh and English are available on the Cardiff and Vale internet site

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No evidence has been found of specific impacts from the INNU policy on people because of their income. The INNU policy advocates clinical and cost effectiveness, taking into consideration prioritisation decisions, to determine those interventions not normally undertaken.	None identified	N/A
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	No evidence has been found of specific impacts from the INNU policy on people because of where they live. The INNU policy applies to the resident population of	None identified	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
	Cardiff and Vale UHB.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	The needs of other groups including carers, prisoners, refugees/asylum seekers, and people who are homeless were considered. No impacts were identified.	None identified	N/A

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No specific impacts from the INNU policy on people's ability to access services have been identified. The INNU policy is explicit about those interventions that should not be undertaken routinely or only under certain circumstances. This supports consistency in the management of patients between clinicians, in relation to the interventions included on the INNU list.	None	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	No specific impacts from the INNU policy on people's ability to improve / maintain healthy lifestyles have been identified. The interventions included in the INNU list are treatment		The introduction of *Making Every Contact Count (MECC)* by Cardiff and Vale UHB has supported health and social care staff to maximise their interactions and when appropriate to offer healthy lifestyle advice and signposting

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
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	rather than preventative interventions.		to support services. The *Optimising Outcomes Policy (OOP),* offers patients who require surgery additional support to lose weight or quit smoking which will improve their chances of successful surgery. A proportionate universalism approach to the delivery of preventative services is supported by the Public Health team as part of a strategy to reduce health inequalities.
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,	No specific impacts from the INNU policy on income and employment status have been identified.	None	

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
job security, working conditions Well-being Goal – A prosperous Wales			
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	No specific impacts from the INNU policy on people's use of the physical environment have been identified.	None	

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	No specific impacts from the INNU policy on people in terms of social and community influences on health have been identified.	None	
7.6 People in terms of macro-economic,	No specific impacts from the INNU policy on macro-	None	

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
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	economic, environmental and sustainability factors have been identified.		

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	The INNU policy outlines the UHB process for identifying, monitoring and reviewing a list of health service interventions which are not normally undertaken by the UHB, or are only undertaken within specified criteria. The INNU list makes explicit the interventions not normally undertaken, and for those interventions where the intervention may be offered to patients meeting certain criteria, what the criteria are. The policy supports the *Shaping Our Future Wellbeing Strategy 2015-2025*. Interventions are placed on the INNU list if the clinical and/or cost effectiveness evidence for the intervention is weak, or as a result of service prioritisation. The policy supports the avoidance of harm, waste and variation within the UHB and making best use of the limited sources available. The Individual Patient Funding Request (IPFR) route is available in clinically exceptional cases.

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?	No further actions are required.	FK	N/A	N/A
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?	No.			

	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	Consultation responses to be considered and any necessary amendments made to the policy and/ list Policy to be submitted to Health Systems Management Board (HSMB) and subsequently to Quality, Safety and Experience Committee for approval. Policy, list and EHIA to be published on Cardiff and Vale UHB internet and intranet sites Adherence to the policy will be monitored via monthly Business Intelligence Support (BIS) reports and clinical board audit processes. The 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.	AH AH FK BI team Exec DPH	End July 2018 August 2018 TBC Every month Add month & year	There were no comments that required amendments to the documentation. Policy & list approved by HSMB On 02/08/18. Clinical Boards have responsibility for activity undertaken within their Clinical Board.

LIST OF INTERVENTIONS NOT NORMALLY UNDERTAKEN BY CARDIFF AND VALE UNIVERSITY HEALTH BOARD

Executive Lead:	Executive Director of Public Health, Cardiff and Vale University Health Board
Approval Route:	Cardiff and Vale UHB Board 11 May 2010 (v01) Clinical Effectiveness Group (18th January 2016) Quality, Safety and Experience Committee (18th September 2018)
Date Published:	12 May 2010 (v01) 2 June 2016 (v02) + minor amendment 24 October 2016 TBC …..2018 (v03)
Area for Circulation:	Public Document
Linked Documents:	**Please note -** 'Embedded documents are available on request'

Please read the following documents alongside this list:

- *Cardiff and Vale UHB Policy on Interventions not Normally Undertaken*
- *All Wales Policy on Making Decisions on Individual Patient Funding Requests*
- *All Wales Prioritisation Framework*

- *All Wales Procedure for Requests for Healthcare in the European Economic Area*
- *Cardiff and Vale UHB Guide to Individual Patient Commissioning*

Version control	Review date	Reviewed by	Completed action	Ratified by	Date ratified	New review date
v02	October 2015 19/09/12 & July & Nov 2015 24/02/12 & July 2015	PCIC and CD & T Clinical Boards Clinical Effectiveness Group & Surgery Clinical Board review National Orthopaedic Innovation & Delivery Board & Surgery Clinical Board review	New policy statements prepared on: • Open MRI scans • Spinal injections for spinal surgery • Spinal injections for pain medicine • Hallux valgus	Clinical Effectiveness Group	18/01/16	List of Interventions Not Normally Undertaken is subject to continuous review.
V02 + minor amendments		Request from Dental Clinical Board for slight amendment to criteria & inclusion of updated evidence.	Slight change to wording of criteria for Dental implants.	Chair's action (Dr Sharon Hopkins).	24/10/16	
V03	August 2018	Consultant in Public Health and Clinical boards	Review of OCPS codes, intervention statements and updating of evidence for of all interventions in the INNU list			

			Addition of nasal surgery for snoring intervention.			

PART 1: LIST OF INTERVENTIONS NOT NORMALLY UNDERTAKEN BY THE CARDIFF AND VALE UNIVERSITY HEALTH BOARD

Clinical Board	Office of Population Censuses & Surveys (OPCS) code	Intervention	Criteria for Use without an Individual Patient Funding Request	Clinical Evidence Base
Children and Women Obstetrics and Gynaecology	R17.1 R17.2 R17.8 R17.9	Elective Caesarean Section (CS)	Can be undertaken when patients meet one or more of the following: • HIV (only if recommended by a HIV consultant) • Both HIV and Hepatitis C (as above, there is no evidence that CS should be performed for Hepatitis C alone) • Primary genital herpes in the third trimester (active genital herpes at the onset of labour) • Grade 3 and 4 placenta previa • Previous upper segment caesarean section / type unknown • Previous significant uterine perforation/surgery breaching cavity • A term singleton breech (if external cephalic version is contraindicated, failed or declined) • A twin pregnancy regardless of chorionicity with breech or smaller first twin • A monochorionic twin pregnancy after appropriate discussion about the risks of acute TTTS • A previous caesarean section if VBAC (Vaginal Birth after Caesarean) has been declined or is felt to be inappropriate • A previous traumatic vaginal delivery if VBAC has been fully explored but declined • A fetus at high risk of fetal distress in labour e.g. known severe placental insufficiency • A woman with tocophobia who has requested caesarean section, providing that her concerns have been fully	NICE Clinical Guideline 132 Caesarean Section: https://www.nice.org.uk/guidance/cg132

			explored and documented AND support and counselling has been made available AND the patient has attended the Birth Choices Clinic (she should have been offered a referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her fears in a supportive manner. If, after providing such support, a vaginal birth is still not an acceptable option, an elective c-section can be supported). An IPFR is required for all other circumstances.	
Children and Women Obstetrics and Gynaecology	Q37.- Q29.- N18.1	Sterilisation – Reversal of (male and female)	Can be used: If death of an existing child has occurred • If remarried after death of spouse • If loss of unborn child when vasectomy has taken place during the pregnancy. Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary Reversal of sterilisation (male and female): http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-reversal-of-sterilisati Royal College of obstetricians and Gynaecologists. FRSH Clinical Guidance Male and female sterilisation. September2014: https://www.fsrh.org/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/ The evidence suggests that reversal of sterilisation for both females and males appear to be effective methods of restoring fertility. Those seeking sterilisation should be fully advised and counselled in accordance with Royal College of Obstetricians and Gynaecologists guidelines that

				the procedure is intended to be permanent.
Children and Women Obstetrics and Gynaecology	Q10.3 Q18.-	Heavy Menstrual Bleeding - Dilation and curettage (D&C)/ Hysteroscopy	D&C should NOT be used as a therapeutic treatment or as a diagnostic tool for heavy menstrual bleeding so will not receive prior approval for these conditions. Hysteroscopy can be used when it is carried out: • As an investigation for structural and histological abnormalities where ultrasound has been used as the first line diagnostic tool and where the outcomes are inconclusive • When undertaking endometrial ablation Request for exemption required in all other cases. **Statement being reviewed in light of NICE guideline 88 (published March 2018) which replaces CG44**	NICE Guideline 88 Heavy menstrual bleeding: Assessment and management: https://www.nice.org.uk/guidance/ng88
Children and Women Obstetrics and Gynaecology	Q07.- Q08.-	Heavy Menstrual Bleeding - Hysterectomy	Can be used when other treatment options have failed, are contraindicated or are declined by the woman Request for exemption required in all other cases.	NICE Guideline 88 Heavy menstrual bleeding: Assessment and management: https://www.nice.org.uk/guidance/ng88
Clinical Diagnostic and Therapeutics Radiology	No code	Open MRI scans	Conventional MRI scanning is provided locally by Cardiff and Vale UHB. It is expected that all patients requiring an MRI scan would use this service. Open MRI scanning will usually only be used when patients meet one or both of the following two criteria: **Category 1 – Claustrophobia** In the first instance, the Radiology department can meet with a patient that has concerns regarding claustrophobia	Public Health Wales Observatory Evidence Summary. Open Magnetic Resonance Imaging: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-open-magnetic-resonance A process is in place both for

			and MRI scanning - a member of staff can describe the process to the patient and show them the scanner. If these fears cannot be alleviated by the Radiology Department, there is an option for sedation. *If suitable,* the patient will be referred to their General Practitioner for a prescription of a sedative which can be used during the scan. In most cases this is sufficient to enable an MRI scan to be performed. The patient must have had a failed attempt at conventional (closed) MRI with oral sedation, where appropriate, prior to acceptance for Open MRI. If the conventional option is not suitable (after review) and the referring clinician still feels that an Open MRI scan is needed, then the patient could be considered for an Open MRI scan. **Category 2 - Patient Size** The size of a patient and the restriction of the MRI scanner tunnel will vary depending on the patients and the circumstances. Some patients may be large but would still be suitable for a conventional closed MRI. In the first instance, the patient should be invited to attend the radiology department and be formally assessed by MRI radiographer for suitability. The patient can be talked through the procedure, and shown the scanner. The Radiographer will examine the evidence presented, and make judgement on whether to proceed with the MRI scan. If the closed MRI is not suitable (after review) and the referring clinician still feels that an MRI scan is needed, then the patient could be considered for an Open MRI. It should be noted that MRI may not be the imaging modality of choice for patients in this category and referral to a Specialist may be preferable. Request for exemption required in all other cases.	primary and secondary care referrals for open MRI.
Clinical Diagnostic	X61.-	Complementary	Can be used as treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary	Public Health Wales Observatory Evidence

and Therapeutics Therapies		Therapies	approach to symptom control by a hospital based pain management team) and as such will be used as part of an existing contract. The LHB will not support referral outside of the NHS for these services. Request for exemption required in all other cases.	Summary. Complementary Medicine and Alternative Therapies: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-complementary-medicine- The evidence suggests that there are large numbers of complementary and alternative therapies that have not been subject to the trials used to establish the effectiveness of conventional clinical treatments. The evidence base is developing and up to date evidence on complementary therapies and alternative treatments can be obtained from the Cochrane library and specialist evidence of NHS Library.
Dental	F11.5 F11.6	Dental Implants	Can be used for patients who need post cancer reconstruction, hypodontia, major trauma with bone loss, or on the advice of NHS specialists as outlined in the Dental Hospital Referral Criteria for Restorative Dentistry: Dental hospital referral guidelines.PDF . Request for exemption required in all other cases.	Public Health Wales Evidence-Based Information: http://www2.nphs.wales.nhs.uk:8080/healthservicegdtdocs.nsf/PublicPage?OpenPage Royal College of Surgeons Guidelines for selecting appropriate patients to receive treatment with dental implants: Priorities for the NHS (2012): https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/implant-guidelines-20121009_final.pdf?la=en

				The evidence suggests that dental implants have been shown to be a successful treatment. However, dental implant treatment should only be provided by appropriately trained dentists in accordance with General Dental guidance
Dental	F12.1	Apicectomy	Can be used for: • Presence of periradicular disease, with or without symptoms in a root filled tooth, where non surgical root canal re-treatment cannot be undertaken or has failed, or where conventional re-treatment may be detrimental to the retention of the tooth • Presence of periradicular disease in a tooth where iatrogenic or developmental anomalies prevent non surgical root canal treatment being undertaken • Where biopsy of periradicular tissue is needed • Where visualisation of the periradicular tissues and tooth root is required when perforation, root crack or fracture is suspected • Where procedures are required that need either tooth sectioning or root amputation • Where it may not be expedient to undertake prolonged non-surgical root canal re-treatment because of patient considerations. Request for exemption required in all other case	Public Health Evidence-Based Summary. Apicectomy: http://www2.nphs.wales.nhs.uk:8080/healthservicegdtdocs.nsf/PublicPage?OpenPage Royal College of Surgeons of England. Guidelines for surgical endodontics 2012: https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/surgical_endodontics_2012.pdf?la=en The evidence suggests that the success rate of apical surgery on molar teeth is low.
Dental	F14.- F15.-	Orthodontic treatments of essentially cosmetic nature	Priority will be based on those with high Index of Orthodontic Treatment Need Scores - 5, 4 and 3 where a significant aesthetic component can be demonstrated and those with other major conditions e.g. cancers, craniofacial deformity. Request for exemption required in all other cases.	Evidence based on expert opinion suggests that orthodontic treatment should be directed at those individuals in which the greatest benefit can be achieved.

Dental	F09.3	Wisdom teeth - Removal of asymptomatic	Can be used in cases where there is evidence of pathology. Request for exemption required in all other cases	NICE Technology Appraisal 1 Guidance on the extraction of wisdom teeth: http://guidance.nice.org.uk/TA1 Impacted wisdom teeth free from disease should not be operated on.
Surgery Ophthalmology	C44.8 C46.4 C46.8 + Y02.1	Corneal implants for the correction of refractive error in the absence of other ocular pathology e.g.keratoconus.	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 225 Corneal implants for the correction of refractive error: http://guidance.nice.org.uk/IPG225/guidance/pdf/English NICE Do not do recommendation Current evidence on the efficacy of corneal implants for the correction of refractive error shows limited and unpredictable benefit. In addition, there are concerns about the safety of the procedure for patients with refractive error that can be corrected by other means, such as spectacles, contact lenses, or laser refractive surgery.
Surgery Ophthalmology	C55.4	Scleral expansion surgery for presbyopia	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 70 Scleral expansion surgery for presbyopia: http://guidance.nice.org.uk/IPG70 NICE Do not do recommendation Current evidence on the safety and efficacy of scleral expansion

				surgery for presbyopia is very limited. There is no evidence of efficacy in the majority of patients. There are also concerns about potential risks of the procedure.
Surgery Ophthalmology	C44 + C45	Laser therapy for short sight	Can be used if the patient has a biometry error following cataract surgery. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 164 Photorefractive (laser) surgery for the correction of refractive errors: https://www.nice.org.uk/guidance/ipg164 Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious for use in appropriately selected patients. However, the safety and effectiveness of this procedure should be considered against the alternative methods of correction: spectacles and contact lenses.
Surgery Ophthalmology	C88.2	Photodynamic Therapy (PDT) for late Age-related Macular Degeneration (AMD) (wet active)	Only to be offered as an adjunct to anti-VEGF as second-line treatment for late AMD (wet active) in the context of a randomised controlled trial. Request for exemption required in all other cases.	NICE Guideline 82 Age-related macular degeneration: https://www.nice.org.uk/guidance/ng82/resources/agerelated-macular-degeneration-pdf-1837691334853 NICE Do not do recommendations: Do not offer photodynamic therapy alone for late AMD (wet active). Do not offer photodynamic therapy as an adjunct to anti-

				VEGF as first-line treatment for late AMD (wet active).
Surgery Cardiac/vascular	K23.4 + Y08.5	Percutaneous laser revascularisation for refractory angina pectoris	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 302 Percutaneous laser revascularisation for refractory angina pectoris : http://www.nice.org.uk/nicemedia/pdf/IPG302Guidance.pdf NICE Do not do recommendation Current evidence on percutaneous laser revascularisation (PLR) for refractory angina pectoris shows no efficacy and suggests that the procedure may pose unacceptable safety risks.
Surgery Cardiac	K23.4 + Y08.5	Transmyocardial laser revascularisation (TMLR) for refractory angina pectoris	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 301 Transmyocardial laser revascularisation for refractory angina pectoris: http://www.nice.org.uk/nicemedia/pdf/IPG301FullGuidance.pdf NICE Do not do recommendation Current evidence on TMLR for refractory angina pectoris shows no efficacy, based on objective measurements of myocardial function and survival. Current evidence on safety suggests that the procedure may pose unacceptable risks.
Surgery	U13.2 + Z84.3	Therapeutic use of ultrasound in hip and	No routine exemption criteria. Request for exemption required in all cases.	Public Health Wales Observatory Evidence Summary. Therapeutic use of ultrasound in hip and knee

Orthopaedics	+ Z84.6	knee osteoarthritis		osteoarthritis: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-therapeutic-use-of-ultr
Surgery Orthopaedics	T59.- T60.-	Ganglia – Surgical Removal	Can be used if the ganglion is very painful and restricts work and hobbies (subject to specialist surgical assessment and advice). Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary. Ganglia surgical removal: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-ganglia-surgical-remova The evidence suggests that there is a high rate of spontaneous resolution for ganglia and that reassurance should be the first therapeutic intervention for most patients and all children
Surgery Orthopaedics	W71.4 W85.3	Autologous Chondrocyte implantation for knee/ ankle problems caused by damaged articular cartilage	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 477: Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee: https://www.nice.org.uk/guidance/ta477 TA477: Autologous chondrocyte implantation (ACI) is recommended as an option for treating symptomatic articular cartilage defects of the knee, only if: • the person has not had previous surgery to repair articular cartilage defects • there is minimal osteoarthritic damage to the knee (as

				assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis) • the defect is over 2 cm^2
Surgery Orthopaedics	NO CODE	Electrical & electromagnetic field treatments bone non-union	No routine exemption criteria. Request for exemption required in all cases.	Public Health Wales Observatory Evidence summary. Electrical and electronic field treatments in non-union of bones: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-electrical-and-electron
Surgery Orthopaedics	NO CODE	Abrasion arthroplasty	No routine exemption criteria. Request for exemption required in all cases.	Public Health Wales Observatory Evidence summary. Abrasion arthroplasty for knees: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-abrasion-arthroplasty-f
Surgery Orthopaedics **Clinical Diagnostic and Therapeutics** Radiology	U21.1 + Z66.5	Low Back Pain (Non-specific) – Plain X-rays of lumbar spine & MRI scans	MRI scans can be used in the context of a referral for an opinion on spinal fusion or if one of the following diagnoses are suspected: • Spinal malignancy • Infection • Fracture • Cauda Equina Syndrome • Ankylosing Spondylitis or another Inflammatory Disorder. Request for exemption required in all other cases.	NICE Guideline 59 Low back pain and sciatica in over 16s: assessment and management: https://www.nice.org.uk/guidance/NG59
Surgery Orthopaedics / anaesthetics **Clinical**	M45.59 (ICD10 code)	Low Back Pain (Non-specific) - Management	Do not offer the following for the management of low back pain with or without sciatica: • Belts or corsets • Foot orthotics • Rocker sole shoes	NICE Guideline 59 Low back pain and sciatica in over 16s: assessment and management: https://www.nice.org.uk/guidance/NG59

Diagnostic and Therapeutics Therapies			• Traction • Acupuncture • Ultrasound • Percutaneous electrical nerve stimulation (PENS) • Transcutaneous electrical nerve stimulation(TENS) • Interferential therapy The following referrals should NOT be offered for the early management of persistent non-specific low back pain: • Radiofrequency facet joint denervation • Percutaneous electrothermal treatment of the intervertebral disc annulus • Percutaneous intradiscal radiofrequency treatment (PIRFT)	NICE IPG 544 Percutaneous electrothermal treatment of the intervertebral disc annulus for low back pain and sciatica https://www.nice.org.uk/guidance/ipg544 NICE IPG 545 Percutaneous intradiscal radiofrequency treatment of the intervertebral disc nucleus for low back pain https://www.nice.org.uk/guidance/ipg545
Surgery Orthopaedics **Specialist Services** Neurosurgery	A52.1 A52.2 A52.8 A52.9 A54.9 A57.7 V54.4	Spinal Injections for Spinal Surgery	Before the use of spinal injections is considered, all patients must have been treated using conservative management techniques, as described in the UHB back pain pathway, and failed to achieve sufficient pain control. Spinal injections serve both a therapeutic and diagnostic role. The specific indications for which each of the three types of spinal injection may routinely be used are: 1. Lumbar and sacral epidural injections (A52.1, A52.2, A52.8) should only be used for therapeutic reasons where the diagnosis of spinal stenosis has been made and for post spinal stabilisation radicular pain where a nerve block might be difficult due to anatomical reasons. 2. Facet joint and sacro-iliac injections (V54.4) should be used for diagnostic purposes only. This may need to be repeated to ascertain consistency. 3. Spinal Nerve root blocks (A577) may be used for radicular pain. Injections should not be used more than twice in the same individual for the same episode of pain. If pain persists beyond this and no significant surgical target has been identified, the patient may require referral to the Pain	Clinical evidence base:  130102 SpinalInjections_spina

			Team to be assessed for management of chronic pain. Request for exemption required for the use of spinal injections in all other circumstances.	
Surgery Anaesthetics: Pain Medicine	A52.1 A52.2 A52.8 A52.9 A54.9 A57.7 V54.4 W90.3	Spinal Injections for Pain Medicine	Before the use of spinal injections is considered, all patients must have been treated using appropriate conservative management techniques, as described in the UHB back pain pathway, and failed to achieve sufficient pain control. The specific indications for which each of the three types of spinal injection may routinely be used are: 1. Lumbar and sacral epidural injections (A52.1. A52.2, A52.8) may be used for the following therapeutic reasons: a. Where the diagnosis of spinal stenosis has been made. b. For post spinal stabilisation radicular pain, where a nerve block might be difficult due to anatomical reasons. c. In patients with leg pain, either before or after back surgery, presenting with stenotic or radicular leg pain. 2. Facet joint and sacro-iliac injections (V54.4, W90.3) may be used for diagnostic and therapeutic purposes in patients suffering from chronic low back pain for greater than one year, as detailed below. a. Diagnostic facet joint injections may be used in order to identify patients that benefit from therapeutic Radiofrequency ablation of nerve to the facet joint in specific facet joint related back pain identified as such. b. Therapeutic facet and sacroiliac injections may be used in patients with specific facet or sacroiliac related back pain and/or referred leg pain 3. Spinal Nerve root blocks (A57.7) may be used for radicular pain. Repeat spinal nerve root block may be required if pain persists and no significant surgical	Clinical evidence base:  131115_SpinalInjecti ons_INNU_pain_medi In the pain clinic, spinal injections serve both a therapeutic and diagnostic role. All spinal injections will be performed following a thorough bio psychosocial assessment and discussion with a consultant in pain medicine. They will always be performed as a part of a comprehensive pain management plan with the intention of improving patients' physical functioning and enabling participation in rehabilitative physiotherapy and/ or psychotherapy as appropriate within individualised pain management plans. The goal of spinal injections will be facilitation of pain management via reduction of the intensity of physical symptoms in order to promote patient engagement with self management strategies in the long term.

			target has been identified. Repeated therapeutic injections may be required in patients unable to tolerate oral medications, the independent elderly intolerant of analgesics, patients with drug dependence issues, young patients trying to avoid medication related side effects in order to retain their job, care for a family or continue study, and patients with concomitant worsening mental illness due to chronic pain uncontrolled despite optimal medical management. Spinal injections should not be used more than twice in the same individual for the same episode of pain. Such repeated injections should only be carried out if the patient reports ongoing pain relief (measured at first follow up) of greater than 50%, with improved physical functioning as demonstrated utilising suitable standardised outcome measures, 3 months or more post procedure. Request for exemption is required for the use of spinal injections in all other circumstances.	
Surgery Orthopaedics	W15.1 W15.2 W15.3 W15.6 W15.8 W16.4 W57.1 W59.3 W71.2 W79.1 W79.2	Hallux valgus (bunion): Surgical correction	Only patients identified with the following criteria should be listed for treatment: • Osteoarthritis affecting the 1st metatarsal phalangeal joint • Impending or actual skin compromise • Evidence of transfer metatarsalgia with mechanical changes requiring intervention e.g. claw toe	Public Health Wales Observatory Evidence Summary. Surgery for Hallux valgus (Bunion): http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-surgery-for-hallux-valg

Surgery Orthopaedics	W58.1 + Z84.3	Hip Resurfacing Techniques apart from in-line with published NICE guidance	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 304 Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip: https://www.nice.org.uk/guidance/ta304 Do not use prostheses for total hip replacement and resurfacing arthroplasty as treatment options for people with end-stage arthritis of the hip if the prostheses have rates (or projected rates) of revision of more than 5% more at 10 years.
Surgery Orthopaedics	V25.- + Y08.- Y76.3	Endoscopic Lumbar Decompression and Laser Disc Decompression	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica: https://www.nice.org.uk/guidance/ipg570

Surgery Orthopaedics	V33.7 + Y08.-	Laser Lumbar Micro-Discectomy	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica: https://www.nice.org.uk/guidance/ipg570
Surgery Orthopaedics	W86.8	Hip Arthroscopy & Debridement	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 408 Arthroscopic femoro–acetabular surgery for hip impingement syndrome: https://www.nice.org.uk/guidance/ipg408
Surgery Orthopaedics	W37.- W38.- W39.- W93.- W94.- W95.-	Hip Prostheses	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 304 Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip: https://www.nice.org.uk/guidance/ta304 NICE TA304: Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.

Surgery ENT	F34.-	Tonsillectomy – children & adults	Can be used if patients meet ALL of the following criteria prior to referral: • Sore throat is due to tonsillitis • Five or more episodes of sore throat per year • Symptoms for at least one year • Episodes of sore throat are disabling and prevent normal function Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary. Tonsillectomy (adult and children): http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-tonsillectomy-adult-and A six-month period of watchful waiting is recommended prior to tonsillectomy to establish firmly the patterns of symptoms and allow the patient to consider fully the implications of the operation. Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur.

Surgery ENT	F32.8	Soft-palate implants for obstructive sleep apnoea	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 241 Soft-palate implants for obstructive sleep apnoea: http://www.nice.org.uk/nicemedia/pdf/IPG241Guidance.pdf NICE Do not do recommendation Current evidence on soft-palate implants for obstructive sleep apnoea raises no major safety concerns, but there is inadequate evidence that the procedure is efficacious in the treatment of this potentially serious condition for which other treatments exist.
Surgery ENT		Nasal surgery for snoring	No routine exemption criteria. Request for exemption required in all cases.	Included on National Do Not Do list
Surgery ENT	D15.1	Grommets - Drainage of middle ear in otitis media with effusion (OME)	Can be used where there has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist or GP with special interest in ENT AND the child is placed on a waiting list for the procedure at the end of this period; AND otitis media with effusion persists after three months AND the child (who must be over three years of age) suffers from at least one of the following: • At least 3-5 recurrences of acute otitis media in a year • Evidence of delay in speech development • Educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency	NICE Clinical Guideline 60 Otitis media with effusion in under 12s surgery: http://www.nice.org.uk/nicemedia/pdf/CG60fullguideline.pdf

			loss) • A significant second disability such as Down's syndrome. Request for exemption required in all other cases.	
Surgery Vascular	L84.- L85.- L86.- L87.- L88.-	Varicose Veins – asymptomatic & mild/moderate cases	Can be used in the following circumstances: • ulcers/history of ulcers secondary to superficial venous disease • liposclerosis • varicose eczema • history of phlebitis. Request for exemption required in all other cases.	NICE Referral Advice https://pathways.nice.org.uk/pathways/varicose-veins-in-the-legs Evidence from recent population surveys indicates very little relationship between symptoms and varicose veins – substantial numbers of patients without varicose veins have similar symptoms Most varicose veins require no treatment. The most common complaint about varicose veins is their appearance. When bleeding or ulceration occurs referral may be appropriate and of that number some may benefit from surgical intervention.

Surgery Gynaecology	A79.8 + Y08.-	Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 234 Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain: http://guidance.nice.org.uk/IPG234 The evidence on laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain suggests that it is not efficacious and therefore should not be used.
Surgery Gastroenterology	G80.2	Capsule Endoscopy/ Pillcam	Can be used for disease of the small bowel for: • Overt or transfusion dependant bleeding from GI tract, when source not identified on OGD/ Colonoscopy • Crohns Disease in whom strictures are not suspected • Hereditary GI polyposis syndromes Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 101: Wireless capsule endoscopy for investigation of the small bowel: http://guidance.nice.org.uk/IPG101
Surgery Gastroenterology	J18.1 J18.2 J18.3 J18.4 J18.5 J18.8 J18.9	Cholecystectomy (for asymptomatic gall stones)	Can be used in patients who are at increased risk of developing gallbladder carcinoma or gallstone complications. Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary. Cholecystectomy for asymptomatic gallstones: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-cholecystectomy-for-asy There is insufficient evidence of clinical effectiveness of cholecystectomy (for asymptomatic gallstones).
Surgery Gastroenterology	H51.-	Haemorrhoidectomy	Can be used in cases of: • Recurrent haemorrhoids • Persistent bleeding • Failed conservative treatment	Public Health Wales Observatory Evidence Summary. Haemorrhoidectomy: http://nww.publichealthwalesobs

			Request for exemption required in all other cases.	ervatory.wales.nhs.uk/evidence-summary-haemorrhoidectomy No routine exemption criteria. Request for exemption required in all cases. The evidence suggests that first and second degree haemorrhoids are classically treated with some form of non-surgical ablative/ fixative intervention, third degree treated with rubber band ligation or haemorrhoidectomy, and fourth degree with haemorrhoidectomy.
Surgery Neurosurgery	No code	Subthalamic nucleotomy for Parkinson's disease	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 65 Subthalamotomy for Parkinson's disease: https://www.nice.org.uk/guidance/ipg65
Medicine Gastroenterology	No code	PH/Manometry Impedance Studies	No routine exemption criteria for adults. Request for exemption required in all adult cases.	Public Health Wales Evidence Summary. Oesophageal manometry and 24 hour pH monitoring: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-oesophageal-manometry-a
Medicine Urology	N29.1	Treatment for Erectile Dysfunction (ED)	Can be used in accordance with the agreed service specification of: a. Assessment by specialist ED providers for men with ED referred by GPs. b. Treatment (drug or mechanical device) for ED in line with WHC (1999) 06 i.e. for men suffering from ED who fall	Cardiff and Vale Formulary and Erectile Dysfunction Care Pathway http://cardiffandvaleuhb.inform.wales.nhs.uk/favicon.ico

			into the eligible groups for NHS prescriptions from GPs. c. Treatment (drug or mechanical device) by specialist ED providers for men categorised as suffering with ED and severe distress who do not fall into 1(b). Request for exemption required in all other cases.	

Medicine Rheumatology	M79.09 (ICD10 code)	Fibromyalgia in adults: In patient pain management/ specialised fibromyalgia programmes	There is no cure for fibromyalgia syndrome and treatment is aimed at alleviation of symptoms. There are no agreed criteria for referral to inpatient pain management or specialised fibromyalgia programmes without an IPFR.	Public Health Wales Observatory Evidence Summary. Fibromyalgia in adults: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-fibromyalgia-in-adults-
Medicine Respiratory **Children & Women** CAMHS	No code	Melatonin for delayed sleep phase disorder	No routine exemption criteria for use in adults. Request for exemption required in all adult cases. Use in children and adolescents should be specialist initiated and in line with Shared Care Protocol CV54 **Use in adults under review (07/18). Please refer to Cardiff and Vale formulary for updated guidance** **http://cardiffandvaleuhb.inform.wales.nhs.uk/favicon.ico**	Public Health Wales Evidence Summary. Melatonin for delayed sleep disorder: http://www2.nphs.wales.nhs.uk:8080/healthservicegdtdocs.nsf/PublicPage?OpenPage Shared care protocol CV54: Melatonin for children and adolescents (up to and including 18 years) with significant sleep onset difficulties https://www.wmic.wales.nhs.uk/cv54-melatonin/
Medicine Stroke services **Clinical Diagnostic and Therapeutics** General rehabilitation	No code	Mirror therapy	No routine exemption criteria. Request for exemption required in all cases.	Public Health Wales Observatory Evidence Summary. Mirror therapy: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-mirror-therapy-innu-

Mental health	X66.-	Computer Based Cognitive Behavioural Therapy	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 97 Computerised cognitive behaviour therapy for depression and anxiety: www.nice.org.uk/guidance/ta97 NICE Clinical Guideline 90 Depression in adults: recognition and management: www.nice.org.uk/guidance/cg90 NICE Clinical Guideline 91 Depression in adults with a chronic physical health proble: recognition and management: www.nice.org.uk/guidance/cg91 NICE Clinical Guideline 159 Social anxiety disorder: recognition, assessment and treatment www.nice.org.uk/guidance/cg159
Mental health	A83.8 A83.9	Electroconvulsive Therapy (ECT)	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 59 Guidance on the use of electroconvulsive therapy: www.nice.org.uk/Guidance/TA59 NICE Clinical Guideline 90 Depression in adults: recognition and management: www.nice.org.uk/guidance/cg90

Please refer to the Cardiff and Vale Prescribing Formulary for a list of medicines and their indications approved for use within Cardiff and Vale UHB. The formulary can be found at:

http://cardiffandvaleuhb.inform.wales.nhs.uk

Technology appraisal decisions produced by the National Institute of Health and Care Excellence (NICE) and medicines appraisal decisions from All Wales Medicines Strategy Group can be found at:

https://www.nice.org.uk/guidance/published?type=ta
http://www.awmsg.org/awmsgonline/app/report;jsessionid=4f4bcc7791af5daa9bfd99212284?execution=e1s1

PART 2: SERVICES COMMISSIONED BY WELSH HEALTH SPECIALISED SERVICES (WHSSC)

LIST OF SPECIALISED SERVICES COMMISSIONING POLICIES AND SERVICE SPECIFICATIONS

The policies are available to view on the WHSSC website[1]
www.whssc.wales.nhs.uk/policies-and-procedures-1

Conditions and procedures of the head and neck

Auditory brain stem implants (CP36)

Bevacizumab (Avastin) Use in Patients with Relapsed Glioma (CP65)

Cochlear Implants (CP35)

Deep Brain Stimulation (CP28)

Facial Surgery Procedures (CP43)

Pipeline Embolisation Devices for Intracranial Aneurysms (CP101)

Stereotactic Radiosurgery (CP22)

Vagal Nerve Stimulation (CP23)

Conditions and procedures of the thorax

Breast Surgery Procedures (CP69)

Cardiac Resynchronisation Therapy in the Management of Advanced Heart Failure (CP12)

Genetic Testing for Inherited Cardiac Conditions (CP57)

Stereotactic Ablative Body Radiotherapy (SABR) for the management of surgically inoperable Non-Small Cell Lung Cancer in Adults (CP76)

Thoracic Surgery (CP144a)

Transcatheter Aortic Valve Implantation (TAVI) for Severe Symptomatic Aortic Stenosis (SSAS) (CP58)

Conditions and procedures of the abdomen and lower back

Abdominoplasty/ aprenectomy following significant weight loss (PP45)

Bariatric Surgery (CP29)

Diaphragmatic/Phrenic Nerve Stimulation (CP13)

Hepatobiliary Cancer Surgery (CP73)

Hyperthermic Intraperitoneal Chemotherapy (HIPEC) and Cytoreductive Surgery for treatment of Pseudomyxoma Peritonei (CP02)

Selective dorsal rhizotomy (CP53)

Transarterial Chembolisation (TACE) Drug-eluting Doxyrubicin (DEBOX) for the Management of Unresectable, Metastatic Liver Disease (CP68)

[1] Website accessed 28 March 2018

Gender and reproductive conditions and procedures

Circumcision (CP34)

Enhanced Image Guided Brachytherapy (IGBT) Service for the Treatment of Gynaecological Malignancies (CP75)

Low Dose Brachytherapy in the Treatment of Localised Prostate Cancer (CP01)

Pre-implantation Genetic Diagnosis (PGD) (CP37)

Gender Identity (Adult) Services (CP21)

Specialist Fertility Services (CP38)

Conditions and treatments not specific to one body area

Positron Emission Tomography (PET) (CP50)

68-gallium DOTATE scanning for the Management of Neuroendocrine Tumours (NETs) (CP66)

Alternative and augmentative communication (AAC) aspect of the electronic assistive technology (EAT) service, Wales (CP93a)

Body Contouring (CP44)

Blood and marrow transplantation (CP79)

Cancer services for Children Specialised Service (CP86)

Eculizumab for Atypical Haemolytic Syndrome (aHUS) (CP98)

Extracorporeal Photophoresis (ECP) for the Treatment of Chronic Graft versus Host Disease in Adults (CP91)

Extracorporeal Photophoresis (ECP) for the Treatment of Cutaneous T-cell Lymphoma (CP92)

Fetal Medicine (Specialist) (CP97)

Home Administered Parenteral Nutrition (HPN) (CP24)

Hyperbaric Oxygen Therapy (CP07)

Immunology (CP78)

Integrated Specialist Rehabilitation (CP48)

Live Donor Expenses (CP30)

Lymphovenous Anastomosis (LVA) Microsurgery for Primary and Secondary Lymphoedema (CP87a, CP87b)

New Health Technologies (including Clinical Trials) (CP18)

Peptide Receptor Radionuclide Therapy (PPRT) for the Treatment of Neuroendocrine Tumours (NETs) (CP67)

Posture and Mobility (All Wales) CP59

Prosthetic and Amputee Rehabilitation Services (CP89)

Proton Beam Therapy (PBT) for Adults with Cancer (CP147)

Proton Beam Therapy (PBT) for Children, Teenagers and Young Adults with Cancer (CP148)

Temporary Dialysis Away From Base (DAFB) (Holiday Dialysis) (CP33)

Benign Skin Conditions (CP42)

Hirsuitism (hair depilation) (PP51)

War Veterans - Enhanced Prosthetic Provision (CP49)

Genetic conditions and treatments

Ataluren for treating Duchenne Muscular Dystrophy with a nonsense mutation in the dystrophin gene (CP118)

Drug Treatment for Lysosomal Storage Disorders (CP55)

Elosulfase alfa (Vimizim) for the Management of MPS Type IVA (CP100)

Genetic testing for inherited Cardiac conditions (CP57)

Genetic services (CP99)

Inhaled Therapy for Patients 6 years and older with Cystic Fibrosis (CP74)

Inherited Bleeding Disorders including Haemophilia Management (CP05, CP77)

Ivacaftor (Kalydeco) for G551D Cystic Fibrosis (CP46)

Mental health conditions and treatments

Child and Adolescent Mental Health Services (Tier 4) (CP19)

Tier 4 Specialised Eating Disorder Services (CP20)

LIST OF INTERVENTIONS NOT NORMALLY UNDERTAKEN BY CARDIFF AND VALE UHB: EHIA ASSESSMENT

The Equality Impact Assessment (EqIA) undertaken on 09/05/14 on the INNU list v02 was used as a baseline from which to update the Equality Health Impact Assessment (EHIA) for the INNU list v03 (2018). Web links have also been updated from the v02 EqIA where necessary.

This EHIA on the draft INNU list v03 was undertaken on 24/05/18 by:

Dr Sian Griffiths	Consultant in Public Health Medicine, Cardiff and Vale LPHT
Anne Hinchliffe	Consultant in Public Health, Cardiff and Vale LPHT
Susan Toner	Principal Health Promotion Specialist, Cardiff and Vale LPHT
Keithley Wilkinson	Equality Manager, Cardiff and Vale UHB

Under the general duties of the Equality Act 2010, public bodies are required to have due regard to:

- Eliminating unlawful discrimination
- Advancing equality of opportunity
- And fostering good relations

in relation to the following protected characteristics:-

- Age
- Gender reassignment
- Sex
- Race- including ethnic or national origin, colour or nationality
- Disability
- Pregnancy and maternity
- Sexual orientation
- Religion/ belief- including lack of belief
- Marriage and civil partnership

We also have to consider carers, Welsh language issues and the 1998 Human Rights Act.

Since the INNU list was last updated, the Health Board has replaced EqIA with EHIA and the group therefore also considered the potential impact of interventions on:-

- People being able to access the service offered
- People being able to improve/ maintain healthy lifestyles
- People in terms of their income and employment status
- People in terms of their use of the physical environment
- People in terms of social and community influences on their health
- People in terms of macro-economic, environmental and sustainability factors

The following questions were used to guide the assessment:

1. Are there any equality groups, including carers and Welsh Language speakers, for whom positive or negative impacts of the INNU policy statement can be specifically identified (i.e. differential impact)?

2. Is the policy directly or indirectly discriminatory under the equalities legislation? If the policy is indirectly discriminatory can it be justified under the relevant legislation?

3. Does the INNU policy statement perpetuate health inequities in any way?

4. For each INNU policy statement, is any monitoring/evaluation required to further assess the impact of any changes on equality target groups, and if so, what?

5. For any negative effects of the INNU policy statement, are there any mitigating actions we can undertake to lessen impact?

EHIAs require analysing impacts on the basis of the above protected characteristics. We have been gathering evidence to inform our assessment of the potential impact for the INNU list v03 (2018) on patients, families and carers, staff, and other stakeholders.

Looking at a range of national research evidence and engagement with key stakeholders has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage.

While socio-economic status is not a protected characteristic under the Equality Act 2010, there is a strong correlation between the protected characteristics and low socio-economic status, demonstrated by the findings of numerous research studies.

The report Transport and Social Exclusion: Making the Connections (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by

socio-economic factors but which relate directly to people with different protected characteristics.

The following general key points from the assessment, which apply to all of the interventions in this policy statement list, should be noted:

- The assessment of evidence of clinical effectiveness of an intervention (the extent to which specific clinical interventions achieve what they are intended to achieve) and the capacity for a patient to experience measurable health benefit from an intervention are at the heart of this policy. Assessing evidence of clinical effectiveness is a routine part of this policy process
- A co-produced approach between clinician and patient, with clear communication and informed consent, is key to this policy
- A patient and their clinician can request a 'policy exemption' through the Individual Patient Funding Request (IPFR) process, and can apply for one of these interventions and services in clinically exceptional circumstances
- There should be ongoing review of interventions during the period that the policy exists. If discrimination is identified, mitigating actions should be undertaken to ensure equity

We recognised that consideration of the needs of protected groups helps us to develop and deliver cost-effective services and person-centred care, ensuring that people are treated fairly and equitably.

Note – Embedded documents are available on request

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
1	**Children and Women** Obstetrics and Gynaecology	Elective Caesarean Section (CS)	Can be undertaken when patients meet one or more of the following: • HIV (only if recommended by a HIV consultant) • Both HIV and Hepatitis C (as above, there is no evidence that CS should be performed for Hepatitis C alone) • Primary genital herpes in the third trimester (active genital herpes at the onset of labour) • Grade 3 and 4 placenta previa • Previous upper segment caesarean section / type unknown • Previous significant uterine perforation/surgery breaching cavity • A term singleton breech (if external cephalic version is contraindicated, failed or declined) • A twin pregnancy regardless of chorionicity with breech or smaller first twin • A monochorionic twin pregnancy after appropriate discussion about the risks of acute TTTS	NICE Clinical Guideline 132 Caesarean Section: https://www.nice.org.uk/guidance/cg132	The two protected characteristics where this policy statement was thought to be particularly pertinent with regard to a potential fear of vaginal childbirth were mental health and learning disabilities. It was noted that tocophobia, meaning intense anxiety or fear of pregnancy and childbirth, is included in the criteria for use of the intervention. Guidance is available for nurses and midwives on clinical considerations for pregnant women who have undergone Female Genital Mutilation (FGM): https://www.rcn.org.uk/professional-development/publications/pub-005447 It highlights that Caesarean section is not indicated just because a woman has had FGM performed. FGM is prevalent in some minority ethnic communities: Female genital mutilation: legislation, policy and guidance | NSPCC Cardiff and Vale University Health

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			• A previous caesarean section if VBAC (Vaginal Birth after Caesarean) has been declined or is felt to be inappropriate • A previous traumatic vaginal delivery if VBAC has been fully explored but declined • A fetus at high risk of fetal distress in labour e.g. known severe placental insufficiency • A woman with tocophobia who has requested caesarean section, providing that her concerns have been fully explored and documented AND support and counselling has been made available AND the patient has attended the Birth Choices Clinic (she should have been offered a referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her fears in a supportive manner. If, after providing such support, a vaginal birth is still not an acceptable option, an elective C-section can be supported). An IPFR is required for all other		Board has launched Wales's first Women's Wellbeing Clinic for those affected by FGM. The service will seek to ensure that all females impacted by the physical and psychological trauma of the FGM practice are empowered to access culturally sensitive and individualised care management, support and advice Cardiff & Vale University Health Board - CVUHB | Women's wellbeing clinic opens for those affected by FGM It was also noted that Cardiff and Vale UHB patients have access to the Wales Interpretation and Translation Service and this service is very well used within the Health Board. There is therefore no evidence that this policy statement would have a negative impact on protected characteristics and in the case of mental health and learning disability, the statement has a positive impact.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			circumstances.		
2	**Children and Women** Obstetrics and Gynaecology	Sterilisation – Reversal of (male and female)	Can be used: If death of an existing child has occurred • If remarried after death of spouse • If loss of unborn child when vasectomy has taken place during the pregnancy. Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary Reversal of sterilisation (male and female): http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-reversal-of-sterilisati Royal College of obstetricians and Gynaecologists. FRSH Clinical Guidance Male and female sterilisation. September2014: https://www.fsrh.org/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/ The evidence suggests that reversal of sterilisation for both females and males appear to be effective methods of restoring fertility. Those seeking sterilisation should be fully advised and counselled in accordance with Royal College of Obstetricians	It was noted that this policy statement follows Royal College guidelines. No known mechanism was identified as to why people with protected characteristics would be disproportionately affected by this policy statement. Therefore no evidence of negative impact was identified based on protected characteristics.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				and Gynaecologists guidelines that the procedure is intended to be permanent.	
3	**Children and Women** Obstetrics and Gynaecology	Heavy Menstrual Bleeding - Dilation and curettage (D&C)/ Hysteroscopy	D&C should NOT be used as a therapeutic treatment or as a diagnostic tool for heavy menstrual bleeding so will not receive prior approval for these conditions. Hysteroscopy can be used when it is carried out: • As an investigation for structural and histological abnormalities where ultrasound has been used as the first line diagnostic tool and where the outcomes are inconclusive • When undertaking endometrial ablation Request for exemption required in all other cases. **This statement is currently being reviewed in light of NICE guideline 88 (published March 2018) which replaced CG44.**	NICE Guideline 88 Heavy menstrual bleeding: Assessment and management: https://www.nice.org.uk/guidance/ng88	https://www.nice.org.uk/guidance/ng88/documents/equality-impact-assessment-2 In NICE's Quality Impact Assessment for NG88 they noted the following potential equality issues which were identified during the scoping process. • Women who have difficulties communicating in English • Women with learning difficulties • Women from minority ethnic groups (women from some minority ethnic groups may find it difficult to talk about heavy menstrual bleeding (HMB) with health professionals • Women from disadvantaged socio-economic groups. "The committee noted that these groups might need special consideration in terms of information provision and communication however

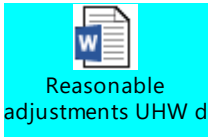
	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
					they agreed that this is not specific to HMB and is covered by the NICE guidance on patient experience in adult NHS services…" (CG138)
4	**Children and Women** Obstetrics and Gynaecology	Heavy Menstrual Bleeding - Hysterectomy	Can be used when: • Other treatment options have failed, are contraindicated or are declined by the woman • There is a wish for amenorrhoea • The woman (who has been fully informed) requests it • The woman no longer wishes to retain her uterus and fertility Request for exemption required in all other cases. **This statement is currently being reviewed in light of NICE guideline 88 (published March 2018) which replaced CG44.**	NICE Guideline 88 Heavy menstrual bleeding: Assessment and management: https://www.nice.org.uk/guidance/ng88	https://www.nice.org.uk/guidance/ng88/documents/equality-impact-assessment-2 The criteria for this intervention within this policy statement would apply to the female population with this clinical need as a whole, Therefore no evidence of negative impact was identified based on protected characteristics.
5	**Clinical Diagnostic and Therapeutics**	Open MRI scans	Conventional MRI scanning is provided locally by Cardiff and Vale UHB. It is expected that all patients requiring an MRI scan would use this service. Open MRI scanning will usually only be used	Public Health Wales Observatory Evidence Summary. Open Magnetic Resonance Imaging: http://nww.publichealthwalesobservatory.wales.nhs.uk/	It was noted that the criteria within this policy statement relate to generic issues which would apply to the whole population. The policy statement has a positive

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
	Radiology		when patients meet one or both of the following two criteria: **Category 1 – Claustrophobia** In the first instance, the Radiology department can meet with a patient that has concerns regarding claustrophobia and MRI scanning - a member of staff can describe the process to the patient and show them the scanner. If these fears cannot be alleviated by the Radiology Department, there is an option for sedation. *If suitable,* the patient will be referred to their General Practitioner for a prescription of a sedative which can be used during the scan. In most cases this is sufficient to enable an MRI scan to be performed. The patient must have had a failed attempt at conventional (closed) MRI with oral sedation, where appropriate, prior to acceptance for Open MRI. If the conventional option is not suitable (after review) and the referring clinician still feels that an	evidence-summary-open-magnetic-resonance A process is in place both for primary and secondary care referrals for open MRI.	impact in that it gives consideration to patient size.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			Open MRI scan is needed, then the patient could be considered for an Open MRI scan. **Category 2 - Patient Size** The size of a patient and the restriction of the MRI scanner tunnel will vary depending on the patients and the circumstances. Some patients may be large but would still be suitable for a conventional closed MRI. In the first instance, the patient should be invited to attend the radiology department and be formally assessed by MRI radiographer for suitability. The patient can be talked through the procedure, and shown the scanner. The Radiographer will examine the evidence presented, and make judgement on whether to proceed with the MRI scan. If the closed MRI is not suitable (after review) and the referring clinician still feels that an MRI scan is needed, then the patient could be considered for an Open MRI. It should be noted that MRI may not be the imaging modality		

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			of choice for patients in this category and referral to a Specialist may be preferable. Request for exemption required in all other cases.		
6	**Clinical Diagnostic and Therapeutics** Therapies	Complementary Therapies	Can be used as treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team) and as such will be used as part of an existing contract. The LHB will not support referral outside of the NHS for these services. Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary. Complementary Medicine and Alternative Therapies: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-complementary-medicine- The evidence suggests that there are large numbers of complementary and alternative therapies that have not been subject to the trials used to establish the effectiveness of conventional clinical treatments. The evidence base is developing and up to date evidence on complementary therapies and alternative treatments can be obtained from the Cochrane library and	It was noted that the criteria within this policy statement apply to the whole population. No known mechanism was identified as to why people with protected characteristics would be disproportionately affected by this policy statement. Therefore no evidence of negative impact was identified based on protected characteristics.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				specialist evidence of NHS Library.	
7	**Dental**	Dental Implants	Can be used for patients who need post cancer reconstruction, hypodontia, major trauma with bone loss, or on the advice of NHS specialists as outlined in the Dental Hospital Referral Criteria for Restorative Dentistry: Dental hospital referral guidelines.PDF . Request for exemption required in all other cases.	Public Health Wales Evidence-Based Information: http://www2.nphs.wales.nhs.uk:8080/healthservicegdtdocs.nsf/PublicPage?OpenPage Royal College of Surgeons Guidelines for selecting appropriate patients to receive treatment with dental implants: Priorities for the NHS (2012): https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/implant-guidelines-20121009_final.pdf?la=en The evidence suggests that dental implants have been shown to be a successful treatment. However, dental implant treatment should only be provided by appropriately trained dentists in accordance with	It was noted that the criteria within this policy statement apply to the whole population. It was noted that people who drink alcohol and smoke heavily are at greater risk of oral cancer. This intervention is available for those patients who need post cancer reconstruction. No evidence of negative impact was identified based on protected characteristics and there may be a positive impact for those groups where smoking and drinking prevalence is higher.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				General Dental guidance	
8	**Dental**	Apicectomy	Can be used for: • Presence of periradicular disease, with or without symptoms in a root filled tooth, where non surgical root canal re-treatment cannot be undertaken or has failed, or where conventional re-treatment may be detrimental to the retention of the tooth • Presence of periradicular disease in a tooth where iatrogenic or developmental anomalies prevent non surgical root canal treatment being undertaken • Where biopsy of periradicular tissue is needed • Where visualisation of the periradicular tissues and tooth root is required when perforation, root crack or fracture is suspected • Where procedures are required that need either tooth sectioning or root amputation • Where it may not be expedient to undertake prolonged non-surgical root canal re-treatment	Public Health Evidence-Based Summary. Apicectomy: http://www2.nphs.wales.nhs.uk:8080/healthservicegdtdocs.nsf/PublicPage?OpenPage Royal College of Surgeons of England. Guidelines for surgical endodontics 2012: https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/surgical_endodontics_2012.pdf?la=en The evidence suggests that the success rate of apical surgery on molar teeth is low.	It was noted that the criteria within this policy statement apply to the whole population. No known mechanism was identified as to why people with protected characteristics would be disproportionately affected by this policy statement. Therefore no evidence of negative impact was identified based on protected characteristics. It was also noted that UHB dental services have good practice in place in preparing patients with learning disabilities for dental procedures. Such practice has a positive impact on the protected characteristic of learning disability.  The Dental Clinical Board at Cardiff and Vale University Health Board has demonstrated its commitment to

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			because of patient considerations. Request for exemption required in all other case		driving forward the Sensory Loss Agenda by gaining the Action on Hearing Loss Louder than Words Accreditation Charter Mark. The University Dental Hospital is the only NHS Hospital in the UK to have this accreditation. Cardiff & Vale University Health Board - CVUHB | Dental Hospital gains Louder than Words charter mark
9	**Dental**	Orthodontic treatments of essentially cosmetic nature	Priority will be based on those with high Index of Orthodontic Treatment Need (IOTN) Scores - 5, 4 and 3 where a significant aesthetic component can be demonstrated and those with other major conditions e.g. cancers, craniofacial deformity. Request for exemption required in all other cases.	Evidence based on expert opinion suggests that orthodontic treatment should be directed at those individuals in which the greatest benefit can be achieved.	It was noted that the criteria within this policy statement apply to the whole population, although the IOTN tool is used for patients under 18 years of age. No known mechanism was identified as to why people with protected characteristics would be disproportionately affected by this policy statement. Therefore no evidence of negative impact was identified based on protected characteristics. It was also noted that UHB dental services have good practice in place in preparing patients with learning disabilities for dental procedures.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
					Such practice has a positive impact on the protected characteristic of learning disability.
10	**Dental**	Wisdom teeth - Removal of asymptomatic	Can be used in cases where there is evidence of pathology. Request for exemption required in all other cases	NICE Technology Appraisal 1 Guidance on the extraction of wisdom teeth: http://guidance.nice.org.uk/TA1 Impacted wisdom teeth free from disease should not be operated on.	It was noted that the criteria within this policy statement apply to the whole population. All patients with clinical need can access this intervention according to the criteria outlined in the advice. In this instance there appears to be no evidence of negative impact identified based on protected characteristics. It was also noted that UHB dental services have good practice in place in preparing patients with learning disabilities for dental procedures. Such practice has a positive impact on the protected characteristic of learning disability.
11	**Surgery** Ophthalmology	Corneal implants for the correction of refractive error in the absence	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 225 Corneal implants for the correction of refractive error:	It was noted that this policy statement is in line with evidence of clinical effectiveness and reflects safety concerns. The statement affects the

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
		of other ocular pathology e.g.keratoconus.		http://guidance.nice.org.uk/IPG225/guidance/pdf/English NICE Do not do recommendation Current evidence on the efficacy of corneal implants for the correction of refractive error shows limited and unpredictable benefit. In addition, there are concerns about the safety of the procedure for patients with refractive error that can be corrected by other means, such as spectacles, contact lenses, or laser refractive surgery.	whole population.
12	**Surgery** Ophthalmology	Scleral expansion surgery for presbyopia	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 70 Scleral expansion surgery for presbyopia: http://guidance.nice.org.uk/IPG70 NICE Do not do recommendation Current evidence on the	It was noted that this policy statement is in line with evidence of clinical effectiveness and reflects safety concerns. The statement affects the whole population.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				safety and efficacy of scleral expansion surgery for presbyopia is very limited. There is no evidence of efficacy in the majority of patients. There are also concerns about potential risks of the procedure.	
13	**Surgery** Ophthalmology	Laser therapy for short sight	Can be used if the patient has a biometry error following cataract surgery. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 164 Photorefractive (laser) surgery for the correction of refractive errors: https://www.nice.org.uk/guidance/ipg164 Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious for use in appropriately selected patients. However, the safety and effectiveness of this procedure should be considered against the alternative methods of correction: spectacles and	It was noted that this policy statement follows NICE interventional procedures guidance. No known mechanism was identified as to why people with protected characteristics would be disproportionately affected by this policy statement. Therefore no evidence of negative impact was identified based on protected characteristics.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				contact lenses.	
14	**Surgery** Ophthalmology	Photodynamic Therapy (PDT) for late Age-related Macular Degeneration (AMD) (wet active)	Only to be offered as an adjunct to anti-VEGF as second-line treatment for late AMD (wet active) in the context of a randomised controlled trial. Request for exemption required in all other cases.	NICE Guideline 82 Age-related macular degeneration: https://www.nice.org.uk/guidance/ng82/resources/agerelated-macular-degeneration-pdf-1837691334853 NICE Do not do recommendations: Do not offer photodynamic therapy alone for late AMD (wet active). Do not offer photodynamic therapy as an adjunct to anti-VEGF as first-line treatment for late AMD (wet active).	The prevalence of Age-related Macular Degeneration increases with age and is higher in women than in men due to longer life expectancy of women. https://www.macularsociety.org/sites/default/files/resource/Macular%20Society%20Guide%20to%20AMD%20accessible%20pdf%20MS002%20JUN17.pdf In its EIA NICE noted that macular degeneration disproportionately affects older people. When producing the scope for the guideline the following points were noted; specific consideration to be given to people with other co-morbidities that affect visual function, impaired cognitive function, impaired mobility, multi-sensory loss and low socioeconomic status, do not speak English, are housebound or in residential care. https://www.nice.org.uk/guidance/ng82/documents/equality-impact-assessment-2 https://www.nice.org.uk/guidance/ng82/documents/equality-impact-

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
					assessment-4 It was noted that the place of photodynamic therapy (Verteporfin®) has changed following the introduction of anti-VEGF agents and the updated NICE guideline reflects this change. The responsibilities of those running clinical trials to avoid discrimination were also noted.
15	**Surgery** Cardiac/vascular	Percutaneous laser revascularisation for refractory angina pectoris	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 302 Percutaneous laser revascularisation for refractory angina pectoris : http://www.nice.org.uk/nicemedia/pdf/IPG302Guidance.pdf NICE Do not do recommendation Current evidence on percutaneous laser revascularisation (PLR) for refractory angina pectoris shows no efficacy and suggests that the procedure may pose unacceptable safety risks.	It was noted that this policy statement is in line with evidence of clinical effectiveness and reflects safety concerns. The statement affects the whole population.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
16	**Surgery** Cardiac	Transmyocardial laser revascularisation (TMLR) for refractory angina pectoris	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 301 Transmyocardial laser revascularisation for refractory angina pectoris: http://www.nice.org.uk/nicemedia/pdf/IPG301FullGuidance.pdf NICE Do not do recommendation Current evidence on TMLR for refractory angina pectoris shows no efficacy, based on objective measurements of myocardial function and survival. Current evidence on safety suggests that the procedure may pose unacceptable risks.	It was noted that this policy statement is in line with evidence of clinical effectiveness and reflects safety concerns. The statement affects the whole population.
17	**Surgery** Orthopaedics	Therapeutic use of ultrasound in hip and knee osteoarthritis	No routine exemption criteria. Request for exemption required in all cases.	Public Health Wales Observatory Evidence Summary. Therapeutic use of ultrasound in hip and knee osteoarthritis: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-	It was noted that this policy statement is in line with evidence of clinical effectiveness. The IPFR route is available for exceptional cases. No known mechanism was identified as to why people with protected characteristics would be

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				therapeutic-use-of-ultr	disproportionately affected by this policy statement. Therefore no evidence of negative impact was identified based on protected characteristics.
18	**Surgery** Orthopaedics	Ganglia – Surgical Removal	Can be used if the ganglion is very painful and restricts work and hobbies (subject to specialist surgical assessment and advice). Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary. Ganglia surgical removal: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-ganglia-surgical-remova The evidence suggests that there is a high rate of spontaneous resolution for ganglia and that reassurance should be the first therapeutic intervention for most patients and all children	Ganglion cysts affect anyone but are commonly seen in women and in the second to fourth decades of life: https://www.cambridgeshireandpeterboroughccg.nhs.uk/EasysiteWeb/getresource.axd?AssetID=9649&type=Full&servicetype=Attachment [1] It was noted that this policy statement is in line with evidence of clinical effectiveness. The IPFR route is available for exceptional cases.
19	**Surgery** Orthopaedics	Autologous Chondrocyte implantation for knee/ ankle problems caused by damaged articular	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 477: Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee: Autologous chondrocyte	Cartilage damage in the knee occurs most often in young adults. Osteochondral damage (a tear or fracture in the cartilage) of the knee and ankle occurs more commonly in adolescents. It was noted that this policy statement

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
		cartilage		implantation for treating symptomatic articular cartilage defects of the knee | Guidance and guidelines | NICE TA477: Autologous chondrocyte implantation (ACI) is recommended as an option for treating symptomatic articular cartilage defects of the knee, only if: • the person has not had previous surgery to repair articular cartilage defects • there is minimal osteoarthritic damage to the knee (as assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis) • the defect is over 2cm^2 • the procedure is done at	is in line with evidence of clinical effectiveness. The IPFR route is available for exceptional cases.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				a tertiary referral centre	
20	**Surgery** Orthopaedics	Electrical & electromagnetic field treatments bone non-union	No routine exemption criteria. Request for exemption required in all cases.	Public Health Wales Observatory Evidence summary. Electrical and electronic field treatments in non-union of bones: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-electrical-and-electron	Bone non-union occurs when the bone lacks adequate stability and/or blood flow. The likelihood of bone non-union is increased with tobacco or nicotine use, older age, and diabetes. It is estimated that around one-sixth of diabetics are from ethnic minority communities. The authors of a Cochrane review (2011) reported that the available evidence for this intervention is inconclusive and insufficient to inform current practice. No further evidence was identified in the Public Health Wales Observatory Evidence Summary (2018) It was noted that this policy statement is in line with evidence of clinical effectiveness. The IPFR route is available for exceptional cases.
21	**Surgery** Orthopaedics	Abrasion arthroplasty	No routine exemption criteria. Request for exemption required in all cases.	Public Health Wales Observatory Evidence summary. Abrasion arthroplasty for knees: http://nww.publichealthwalesobservatory.wales.nhs.uk/	It was noted that this policy statement is in line with evidence of clinical effectiveness. The IPFR route is available for exceptional cases. No known mechanism was identified

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				evidence-summary-abrasion-arthroplasty-f	as to why people with protected characteristics would be disproportionately affected by this policy statement. Therefore no evidence of negative impact was identified based on protected characteristics.
22	**Surgery** Orthopaedics **Clinical Diagnostic and Therapeutics** Radiology	Low Back Pain (Non-specific) – Plain X-rays of lumbar spine & MRI scans	MRI scans can be used in the context of a referral for an opinion on spinal fusion or if one of the following diagnoses are suspected: • Spinal malignancy • Infection • Fracture • Cauda Equina Syndrome • Ankylosing Spondylitis or another Inflammatory Disorder. Request for exemption required in all other cases.	NICE Guideline 59 Low back pain and sciatica in over 16s: assessment and management: https://www.nice.org.uk/guidance/NG59	Low back pain is a common condition affecting around one-third of the UK adult population each year. Men and women are equally affected and prevalence increases with age peaking between 40-60 years. https://www.kch.nhs.uk/Doc/gpe%20-%20007.1%20-%20management%20of%20back%20pain.pdf It was noted that this policy statement is in line with NICE guidance All patients with clinical need can access this intervention according to the criteria outlined. Therefore no evidence of negative impact was identified based on protected characteristics.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
23	**Surgery** Orthopaedics / anaesthetics **Clinical Diagnostic and Therapeutics** Therapies	Low Back Pain (Non-specific) - Management	Do not offer the following for the management of low back pain with or without sciatica: • Belts or corsets • Foot orthotics • Rocker sole shoes • Traction • Acupuncture • Ultrasound • Percutaneous electrical nerve stimulation (PENS) • Transcutaneous electrical nerve stimulation(TENS) • Interferential therapy The following referrals should NOT be offered for the early management of persistent non-specific low back pain: • Radiofrequency facet joint denervation • Percutaneous electrothermal treatment of the intervertebral disc annulus • Percutaneous intradiscal radiofrequency treatment (PIRFT)	NICE Guideline 59 Low back pain and sciatica in over 16s: assessment and management: https://www.nice.org.uk/guidance/NG59 NICE IPG 544 Percutaneous electrothermal treatment of the intervertebral disc annulus for low back pain and sciatica https://www.nice.org.uk/guidance/ipg544 NICE IPG 545 Percutaneous intradiscal radiofrequency treatment of the intervertebral disc nucleus for low back pain https://www.nice.org.uk/guidance/ipg545	Low back pain is a common condition affecting around one-third of the UK adult population each year. Men and women are equally affected and prevalence increases with age peaking between 40-60 years. https://www.kch.nhs.uk/Doc/gpe%20-%20007.1%20-%20management%20of%20back%20pain.pdf All patients with clinical need can access this intervention according to the criteria outlined. Therefore no evidence of negative impact was identified based on protected characteristics. In its EIA of the draft guideline the NICE Committee considered all groups of patients including those with cognitive or learning disabilities and people for whom English was not a first language and recommendations included consideration for tailoring interventions where appropriate. NICE noted that chronicity is increased in lower socio economic groups, but agreed these groups would not be discriminated against by

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
					any recommendations as all would be available on the NHS. NICE also recognised that advancing age may increase the likelihood of low back pain associated with degenerative changes. Consideration was made when undertaking the review for interventions labelled as 'return to work' interventions to ensure that the review did not discriminate against those that did not work. The Committee also reviewed whether any special consideration was required for pregnant women and decided that pregnant women would not be disadvantaged by the recommendations. https://www.nice.org.uk/guidance/ng59/documents/equality-impact-assessment-2 https://www.nice.org.uk/guidance/ng59/documents/equality-impact-assessment

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
24	**Surgery** Orthopaedics **Specialist Services** Neurosurgery	Spinal Injections for Spinal Surgery	Before the use of spinal injections is considered, all patients must have been treated using conservative management techniques, as described in the UHB back pain pathway, and failed to achieve sufficient pain control. Spinal injections serve both a therapeutic and diagnostic role. The specific indications for which each of the three types of spinal injection may routinely be used are: 1. Lumbar and sacral epidural injections (A52.1, A52.2, A52.8) should only be used for therapeutic reasons where the diagnosis of spinal stenosis has been made and for post spinal stabilisation radicular pain where a nerve block might be difficult due to anatomical reasons. 2. Facet joint and sacro-iliac injections (V54.4) should be used for diagnostic purposes	Clinical evidence base: 130102 SpinalInjections_spina	All patients with clinical need can access this intervention according to the criteria outlined. In this instance there appears to be no evidence of negative impact identified based on protected characteristics.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			only. This may need to be repeated to ascertain consistency. 3. Spinal Nerve root blocks (A577) may be used for radicular pain. Injections should not be used more than twice in the same individual for the same episode of pain. If pain persists beyond this and no significant surgical target has been identified, the patient may require referral to the Pain Team to be assessed for management of chronic pain. Request for exemption required for the use of spinal injections in all other circumstances.		
25	**Surgery** Anaesthetics: Pain Medicine	Spinal Injections for Pain Medicine	Before the use of spinal injections is considered, all patients must have been treated using appropriate conservative management techniques, as described in the UHB back pain pathway, and failed to achieve sufficient pain control. The specific indications for which each of the three types of spinal injection may routinely be used	Clinical evidence base:  131115_SpinalInjections_INNU_pain_medi In the pain clinic, spinal injections serve both a therapeutic and diagnostic	The following statement from the C&V UHB INNU policy statement 'Spinal injections for pain medicines' was noted for its positive impact in recognising the additional need for this intervention for some groups of patients. "Repeated therapeutic injections may be required in patients unable to tolerate oral medications, the

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			are: 1. Lumbar and sacral epidural injections (A52.1. A52.2, A52.8) may be used for the following therapeutic reasons: a. Where the diagnosis of spinal stenosis has been made. b. For post spinal stabilisation radicular pain, where a nerve block might be difficult due to anatomical reasons. c. In patients with leg pain, either before or after back surgery, presenting with stenotic or radicular leg pain. 2. Facet joint and sacro-iliac injections (V54.4, W90.3) may be used for diagnostic and therapeutic purposes in patients suffering from chronic low back pain for greater than one year, as detailed below. a. Diagnostic facet joint injections may be used in order to identify patients that benefit from	role. All spinal injections will be performed following a thorough bio psychosocial assessment and discussion with a consultant in pain medicine. They will always be performed as a part of a comprehensive pain management plan with the intention of improving patients' physical functioning and enabling participation in rehabilitative physiotherapy and/ or psychotherapy as appropriate within individualised pain management plans. The goal of spinal injections will be facilitation of pain management via reduction of the intensity of physical symptoms in order to promote patient engagement with self management strategies in the long term.	independent elderly intolerant of analgesics, patients with drug dependence issues, young patients trying to avoid medication related side effects in order to retain their job, care for a family members or continue study, patients with concomitant worsening mental illness due to chronic pain uncontrolled despite optimal medical management.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			therapeutic Radiofrequency ablation of nerve to the facet joint in specific facet joint related back pain identified as such. b. Therapeutic facet and sacroiliac injections may be used in patients with specific facet or sacroiliac related back pain and/or referred leg pain 3. Spinal Nerve root blocks (A57.7) may be used for radicular pain. Repeat spinal nerve root block may be required if pain persists and no significant surgical target has been identified. Repeated therapeutic injections may be required in patients unable to tolerate oral medications, the independent elderly intolerant of analgesics, patients with drug dependence issues, young patients trying to avoid medication related side effects in order to retain their job, care for a family or continue study, and patients with		

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			concomitant worsening mental illness due to chronic pain uncontrolled despite optimal medical management. Spinal injections should not be used more than twice in the same individual for the same episode of pain. Such repeated injections should only be carried out if the patient reports ongoing pain relief (measured at first follow up) of greater than 50%, with improved physical functioning as demonstrated utilising suitable standardised outcome measures, 3 months or more post procedure. Request for exemption is required for the use of spinal injections in all other circumstances.		

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
26	**Surgery** Orthopaedics	Hallux valgus (bunion): Surgical correction	Only patients identified with the following criteria should be listed for treatment: • Osteoarthritis affecting the 1st metatarsal phalangeal joint • Impending or actual skin compromise • Evidence of transfer metatarsalgia with mechanical changes requiring intervention e.g. claw toe	Public Health Wales Observatory Evidence Summary. Surgery for Hallux valgus (Bunion): http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-surgery-for-hallux-valg	Hallux valgus is more common in older people and more prevalent in women. Consideration was given to individuals employed in a role requiring them to wear protective footwear who may be unable to do so because of hallux valgus. All patients with clinical need can access this intervention according to the criteria outlined. In this instance there appears to be no evidence of negative impact identified based on protected characteristics.
27	**Surgery** Orthopaedics	Hip Resurfacing Techniques apart from in-line with published NICE guidance	Can be used in line with NICE guidance. Request for exemption required in all other cases	NICE Technology Appraisal 304 Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip: https://www.nice.org.uk/guidance/ta304 Do not use prostheses for total hip replacement and resurfacing arthroplasty as treatment options for people with end-stage arthritis of the hip if the prostheses have rates (or projected	It was noted that this policy statement is in line with NICE technology appraisal 304. All patients with clinical need can access this intervention according to the criteria outlined in the guidance. However, as indicated earlier, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage. While socio-economic status is not a protected

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				rates) of revision of more than 5% more at 10 years.	characteristic under the Equality Act 2010, there is a strong correlation between the protected characteristics and low socio-economic status, demonstrated by the findings of numerous research studies. In this instance there appears to be no evidence of negative impact identified based on protected characteristics
28	**Surgery** Orthopaedics	Endoscopic Lumbar Decompression and Laser Disc Decompression	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica: https://www.nice.org.uk/guidance/ipg570	It was noted that this policy statement is in line with NICE interventional procedures guidance. All patients with clinical need can access this intervention according to the criteria outlined in the guidance. Therefore no evidence of negative impact was identified based on protected characteristics.
29	**Surgery** Orthopaedics	Laser Lumbar Micro-Discectomy	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica: https://www.nice.org.uk/guidance/ipg570	It was noted that this policy statement is in line with NICE interventional procedures guidance. All patients with clinical need can access this intervention according to the criteria outlined in the guidance. Therefore no evidence of negative impact was identified based on

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
					protected characteristics.
30	**Surgery** Orthopaedics	Hip Arthroscopy & Debridement	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 408 Arthroscopic femoro–acetabular surgery for hip impingement syndrome: https://www.nice.org.uk/guidance/ipg408	It was noted that this policy statement is in line with NICE interventional procedures guidance. All patients with clinical need can access this intervention according to the criteria outlined in the guidance. Therefore no evidence of negative impact was identified based on protected characteristics.
31	**Surgery** Orthopaedics	Hip Prostheses	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 304 Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip: https://www.nice.org.uk/guidance/ta304 NICE TA304: Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision	It was noted that this policy statement is in line with NICE technology appraisal 304. All patients with clinical need can access this intervention according to the criteria outlined in the guidance. Therefore no evidence of negative impact was identified based on protected characteristics. NICE TA304 supports improved outcomes for all patients.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				of 5% or less at 10 years.	
32	**Surgery** ENT	Tonsillectomy – children & adults	Can be used if patients meet ALL of the following criteria prior to referral: • Sore throat is due to tonsillitis • Five or more episodes of sore throat per year • Symptoms for at least one year • Episodes of sore throat are disabling and prevent normal function Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary. Tonsillectomy (adult and children): http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-tonsillectomy-adult-and A six-month period of watchful waiting is recommended prior to tonsillectomy to establish firmly the patterns of symptoms and allow the patient to consider fully the implications of the operation. Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur.	Tonsillitis is more common in children but attacks in adults can be as frequent and more severe in adults: It was noted that communication around frequency and disablement from this condition may not be easy for patients with learning disability. The panel noted again the need for good communication between clinicians and patients, in respect of all interventions and that where barriers to communication were identified, mitigating action may be required.
33	**Surgery**	Soft-palate implants for obstructive	No routine exemption criteria. Request for exemption required in	NICE Interventional Procedures Guidance 241 Soft-palate implants for	It was noted that this policy statement is in line with NICE interventional procedures guidance and applies to

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
	ENT	sleep apnoea	all cases.	obstructive sleep apnoea: http://www.nice.org.uk/nicemedia/pdf/IPG241Guidance.pdf NICE Do not do recommendation Current evidence on soft-palate implants for obstructive sleep apnoea raises no major safety concerns, but there is inadequate evidence that the procedure is efficacious in the treatment of this potentially serious condition for which other treatments exist.	the whole population.
34	**Surgery** ENT	Grommets - Drainage of middle ear in otitis media with effusion (OME)	Can be undertaken where there has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist or GP with special interest in ENT AND the child is placed on a waiting list for the procedure at the end of this period; AND otitis media with effusion persists after three months	NICE Clinical Guideline 60 Otitis media with effusion in under 12s surgery: http://www.nice.org.uk/nicemedia/pdf/CG60fullguideline.pdf	It was noted that this policy statement is in line with NICE clinical guideline 60. All patients with clinical need can access this intervention according to the criteria outlined in the advice. In this instance there appears to be no evidence of negative impact identified based on protected characteristics. The IPFR route is available for

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			AND the child (who must be over three years of age) suffers from at least one of the following: • At least 3-5 recurrences of acute otitis media in a year • Evidence of delay in speech development • Educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss) • A significant second disability such as Down's syndrome. Request for exemption required in all other cases.		exceptional cases.
35	**Surgery** Vascular	Varicose Veins – asymptomatic & mild/moderate cases	Can be used in the following circumstances: • ulcers/history of ulcers secondary to superficial venous disease • liposclerosis • varicose eczema • history of phlebitis. Request for exemption required in all other cases.	NICE Referral Advice https://pathways.nice.org.uk/pathways/varicose-veins-in-the-legs Evidence from recent population surveys indicates very little relationship between symptoms and varicose veins – substantial numbers of patients without varicose	It was noted that this policy statement is in line with NICE referral advice. All patients with clinical need can access this intervention according to the criteria outlined in the advice. In this instance there appears to be no evidence of negative impact identified based on protected characteristics.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				veins have similar symptoms Most varicose veins require no treatment. The most common complaint about varicose veins is their appearance. When bleeding or ulceration occurs referral may be appropriate and of that number some may benefit from surgical intervention.	
36	**Surgery** Gynaecology	Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 234 Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain: http://guidance.nice.org.uk/IPG234 The evidence on laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain suggests that it is not efficacious and therefore should not be used.	Prevalence of endometriosis in the UK, one of the main causes of chronic pelvic pain, is estimated at around 3 – 10% of women aged 15 – 45 years. It was noted that this policy statement is in line with NICE interventional procedures guidance and is based on lack of clinical effectiveness for this intervention. The statement applies to the whole female population and there is no evidence of negative impact identified based on protected characteristics.
37	**Surgery** Gastroenter	Capsule Endoscopy/	Can be used for disease of the small bowel for:	NICE Interventional Procedures Guidance 101:	It was noted that this policy statement is in line with NICE interventional

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
	ology	Pillcam	• Overt or transfusion dependant bleeding from GI tract, when source not identified on gastroscopy (OGD)/ colonoscopy • Crohns disease in whom strictures are not suspected • Hereditary GI polyposis syndromes Request for exemption required in all other cases.	Wireless capsule endoscopy for investigation of the small bowel: http://guidance.nice.org.uk/IPG101	procedures guidance. All patients with clinical need can access this intervention according to the criteria outlined in the guidance. No evidence of negative impact was identified based on protected characteristics. The IPFR route is available for exceptional cases.
38	**Surgery** Gastroenterology	Cholecystectomy (for asymptomatic gall stones)	Can be used in patients who are at increased risk of developing gallbladder carcinoma or gallstone complications. Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary. Cholecystectomy for asymptomatic gallstones: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-cholecystectomy-for-asy There is insufficient evidence of clinical effectiveness of cholecystectomy (for asymptomatic gallstones).	It is estimated that around one-sixth of diabetics are from ethnic minority communities. Although patients with diabetes mellitus may have an increased risk of complications, the magnitude of the risk does not warrant prophylactic cholecystectomy. It was noted that this policy statement is in line with evidence of clinical effectiveness and all patients with clinical need can access this intervention according to the criteria outlined. We are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
					groups also face social and or economic disadvantage. While socio-economic status is not a protected characteristic under the Equality Act 2010, there is a strong correlation between the protected characteristics and low socio-economic status, demonstrated by the findings of numerous research studies. All patients with clinical need can access this intervention according to the criteria outlined in the guidance.
39	**Surgery** Gastroenterology	Haemorrhoidectomy	Can be used in cases of: • Recurrent haemorrhoids • Persistent bleeding • Failed conservative treatment Request for exemption required in all other cases.	Public Health Wales Observatory Evidence Summary. Haemorrhoidectomy: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-haemorrhoidectomy The evidence suggests that first and second degree haemorrhoids are classically treated with some form of non-surgical ablative/ fixative intervention, third degree treated with rubber band ligation or haemorrhoidectomy, and	It was noted that this policy statement is in line with evidence of clinical effectiveness. All patients with clinical need can access this intervention according to the criteria outlined in the guidance. Therefore no evidence of negative impact was identified based on protected characteristics. All patients with clinical need can access this intervention according to the criteria outlined in the guidance. However, as indicated earlier, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				fourth degree with haemorrhoidectomy.	groups also face social and or economic disadvantage. While socio-economic status is not a protected characteristic under the Equality Act 2010, there is a strong correlation between the protected characteristics and low socio-economic status, demonstrated by the findings of numerous research studies. In this instance there appears to be no evidence of negative impact identified based on protected characteristics.
40	**Surgery** Neurosurgery	Subthalamic nucleotomy for Parkinson's disease	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 65 Subthalamotomy for Parkinson's disease: https://www.nice.org.uk/guidance/ipg65	Parkinson's disease affects around 0.5% of people aged 65 to 74 years and 1 – 2% of people aged 75 years and older (NICE IPG65). It was noted that this policy statement is in line with NICE interventional procedures guidance. NICE IPG65 states "Current evidence on the safety and efficacy of subthalamotomy for Parkinson's disease does not appear adequate to support the use of this procedure without special arrangements for consent and for audit and research." The responsibilities of those running clinical trials to avoid discrimination

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
					was also noted.
41	**Medicine** Gastroenterology	PH/Manometry Impedance Studies	No routine exemption criteria in adults. Request for exemption required in all adult cases.	Public Health Wales Evidence Summary. Oesophageal manometry and 24 hour pH monitoring: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-oesophageal-manometry-a	High-resolution manometry (HM) and impedence-pH/ manometry monitoring are research tools used in clinical investigation of the oesophagus. Oesophageal manometry is a test that measures the pressure in the stomach and gullet. The IPFR route is available for exceptional cases.
42	**Medicine** Urology	Treatment for Erectile Dysfunction (ED)	Can be used in accordance with the agreed service specification of: a. Assessment by specialist ED providers for men with ED referred by GPs. b. Treatment (drug or mechanical device) for ED in line with WHC (1999) 06 i.e. for men suffering from ED who fall into the eligible groups for NHS prescriptions from GPs. c. Treatment (drug or mechanical device) by specialist ED providers for men categorised as suffering with ED and severe distress who do not fall into 1(b).	Cardiff and Vale Erectile Dysfunction Care Pathway http://documents.inform.wales.nhs.uk/Cardiffandvaleuhb/Erectile%20Dysfunction%20Pathway_0.pdf	Erectile dysfunction is a common disorder in men, with European and American studies citing prevalence between 19 and 52%. It is more common in older men but also occurs in young men. https://www.nice.org.uk/advice/esnm45/chapter/full-evidence-summary AWMSG *All Wales Guidance on Prescribing for Erectile Dysfunction* (2012) cited Cardiff and Vale UHB as an example of good practice for the way it addressed this issue. All patients with clinical need can access this intervention according to

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
			Request for exemption required in all other cases.		the criteria outlined in the guidance. Therefore no evidence of negative impact was identified based on protected characteristics.
43	**Medicine** Rheumatology	Fibromyalgia: Inpatient pain management / specialised fibromyalgia programmes	There is no cure for fibromyalgia syndrome and treatment is aimed at alleviation of symptoms. There are no agreed criteria for referral to inpatient pain management or specialised fibromyalgia programmes without an IPFR.	Public Health Wales Observatory Evidence Summary. Fibromyalgia in adults: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-fibromyalgia-in-adults-	Fibromyalgia is a long-term (chronic) condition that causes widespread pain in the muscles, tendons and ligaments. It is relatively common, and more women than men are affected by the condition: https://www.cdc.gov/arthritis/basics/fibromyalgia.htm Rheumatology, physiotherapy and out-patient pain management services are available for patients with Fibromyalgia, (Cardiff and Vale ME/CFS and Fibromyalgia Action plan 2015-18). It was noted that this policy statement is in line with evidence of clinical effectiveness. There appears to be no evidence to suggest that people with protected characteristics would be disproportionately affected in terms of this intervention.

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
					The IPFR route is available for exceptional cases.
44	**Medicine** Respiratory **Children & Women** CAMHS	Melatonin for delayed sleep phase disorder	No routine exemption criteria for use in adults. Request for exemption required in all adult cases. Use in children and adolescents should be specialist initiated and in line with Shared Care Protocol CV54	Public Health Wales Evidence Summary. Melatonin for delayed sleep disorder: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/PublicPage?OpenPage Shared care protocol CV54: Melatonin for children and adolescents (up to and including 18 years) with significant sleep onset difficulties https://www.wmic.wales.nhs.uk/cv54-melatonin/	It was noted that this policy statement is in line with evidence of clinical effectiveness. Shared Care Protocol CV54 supports the used of melatonin where sleep disturbance is so severe that it is causing significant family disturbance. This was noted and considered to confer a positive benefit in regard to social influences on health. The IPFR route is available for exceptional cases.
45	**Medicine** Stroke services **Clinical Diagnostic and Therapeutics** General	Mirror therapy	No routine exemption criteria. Request for exemption required in all cases.	Public Health Wales Observatory Evidence Summary. Mirror therapy: http://nww.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-mirror-therapy-innu-	Mirror therapy is an alternative treatment approach to support a patient regain motor function, or to reduce pain, in an upper limb after a stroke. A recent Cochrane review concludes that 'no clear conclusion could be drawn if mirror therapy replaced other interventions for improving motor

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
	rehabilitation				function of the arm', although, 'mirror therapy could be applied as an additional intervention in the rehabilitation of patients after stroke'. It was noted that this policy statement is in line with evidence of clinical effectiveness. The IPFR route is available for exceptional cases.
46	**Mental health**	Computer Based Cognitive Behavioural Therapy	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 97 Computerised cognitive behaviour therapy for depression and anxiety: www.nice.org.uk/guidance/ta97 NICE Clinical Guideline 90 Depression in adults: recognition and management: www.nice.org.uk/guidance/cg90 NICE Clinical Guideline 91 Depression in adults with a chronic physical health problem: recognition and management:	It was noted that this policy statement is in line with NICE guidance All patients with clinical need can access this intervention according to the criteria outlined by NICE. It was noted that IT literacy skills are lower in some groups within the population, including individuals in manual jobs and some older people. However, it was also noted that the NICE guidance CG90 recommends CCBT as an option and alternatives are given. The intervention chosen should be guided by the patient's preference. There appears to be no evidence to

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
				www.nice.org.uk/guidance/cg91 NICE Clinical Guideline 159 Social anxiety disorder: recognition, assessment and treatment www.nice.org.uk/guidance/cg159	suggest that people with protected characteristics would be disproportionately affected in terms of this intervention.
47	**Mental health**	Electroconvulsive Therapy (ECT)	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 59 Guidance on the use of electroconvulsive therapy: www.nice.org.uk/Guidance/TA59 NICE Clinical Guideline 90 Depression in adults: recognition and management: www.nice.org.uk/guidance/cg90	It was noted that this policy statement is in line with NICE guidance which states that ECT is recommended only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with: • Catatonia • A prolonged or severe manic episode All patients with clinical need can access this intervention according to the criteria outlined by NICE. Therefore no evidence of negative impact was identified based on protected characteristics. The following statement from NICE

	Clinical Board	Intervention	Criteria	Clinical Evidence Base	EHIA comment
					CG90 was noted. "The risks associated with ECT may be enhanced during pregnancy, in older people, and in children and young people, and therefore clinicians should exercise particular caution when considering ECT treatment in these groups."

APPROVAL OF INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY AND PROCEDURE
Name of Meeting Quality, Safety and Experience Committee **Date of Meeting** 18/09/2018

Executive Lead : Executive Director of Nursing
Author : Head of Patient Safety and Quality; telephone 02920 74 6387
Caring for People, Keeping People Well : The report underpins the Sustainability, Values and Culture elements of the Health Board's Strategy.
Financial impact : The incident reporting system is managed within existing resources of the Health Board. Failure to manage incidents can have significant adverse outcomes, including financial impact.
Quality, Safety, Patient Experience impact : It is a vital component of the Health Board's governance structures to ensure a rigorous method of incident reporting, investigation and management.
Health and Care Standard Number 2.1; 3.1
CRAF Reference Number 8.2
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The former Policy has been in existence for a number of years within the UHB.
- It was updated in 2017 by the Head of Health and Safety.
- It has been necessary to provide a further update to the elements of the Policy that relate to patient safety due to updated procedures in the patient safety community being adopted into practice.
- Furthermore, a decision was made to separate the Policy from the Procedure with additional links to the intranet in order to direct staff to the most up to date sources of information and support.
- Existing procedures are in place to monitor incidents reported via the electronic incident reporting system.

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Incident, Hazard and Near Miss Reporting Policy and Incident, Hazard and Near Miss Reporting Procedure
- **APPROVE** the full publication of Policy and Procedure in accordance with the UHB Publication Scheme

SITUATION
The Health Board has a legal obligation to provide a mechanism and structure for reporting, investigating and management of adverse incidents and near misses.

This requirement is mandated within both a Health and Safety and Patient Safety remit.

BACKGROUND
A Policy has been in existence within the UHB for a number of years. The Policy was updated in 2017 by the Head of Health and Safety.

There have been developments since then within the patient safety community necessitating that the Policy be updated.

Furthermore, a decision was made to separate the Policy from the Procedure. The intranet has been developed with links provided throughout the Procedure where appropriate, to direct staff to the most up to date sources of information and support.

The current electronic incident reporting system has been in use within the Health Board since 2015 and is well embedded into practice with increasing numbers of incidents reported as staff familiarity with the system continues to grow. The Health Board appreciates the valuable contribution of staff to the safety culture within the organisation by continuing to report adverse incidents and near misses. This is an important aspect of the organisation being a learning one, in order to improve services for patients and staff.

ASSESSMENT
Wide consultation has taken place to ensure that the Policy and Procedure meets the needs of our stakeholders and the Health Board. The consultation undertaken specific to this document was as follows:-

- The documents were added to the Policy Consultation pages on the intranet between 7th August and 4th September 2018;
- Comments were invited via individual e-mails from the Head of Clinical Engineering; Assistant Director of Therapies; Senior Manager Performance and Compliance and Head of Health and Safety.

Where appropriate comments were taken on board and incorporated within the draft document.

Arrangements for compliance with the document will be monitored by the Health and Safety Committee and Quality, Safety and Experience Committee.

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

Reference Number: UHB 138 **Version Number:** 3	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:**

INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we are committed to the health, safety and welfare of its staff, patients, visitors and all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of untoward incidents.

We consider that it is essential that all incidents, near misses and hazards are reported so that appropriate action can be taken to try to prevent their reoccurrence, improve the environment, patient experience and services where appropriate action can be taken to reduce risk of recurrence.

The Policy defines Incidents, Hazards and Near misses:-

- **Incident**

An *Adverse Incident* is defined as "any unplanned event that resulted in, or had the potential to result in, an injury or the ill health of any person, or the loss of, or damage to, property"

A patient safety incident is defined as "any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care". (National Patient Safety Agency, 2011).

- **Hazard**

A hazard is a source of potential harm or damage or a situation with potential for harm or damage.

- **Near Miss**

A *near miss* is an occurrence, which but for the luck or skilful management would in all probability have become an incident.

- **Serious Incident**

A serious incident is defined as an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following:

- unexpected or avoidable death or severe harm of one or more patients, staff of members of the public;

- a Never Event – all Never Events are defined as Serious Incidents although not all Never Events necessarily result in severe harm or death;
- a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- allegations or incidents, of physical abuse and sexual assault or abuse; and/or
- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

We encourage an open and just culture. The aim of reporting and investigating incidents, near misses and hazards is not to blame but rather learn from the event and to minimise risk of reoccurrence.

Policy Commitment

To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive sound governance-framework.

To promote a culture in which incidents are reported and investigated appropriately and to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff and patient safety and well-being.

To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting

Supporting Procedures and Written Control Documents

- Incident, Hazard and Near Miss Reporting Procedure
- Health and Safety Policy
- Policy for Reporting Research Related Events
- Being Open Policy
- Records Management Policy
- Risk Management Policy

Other supporting documents are:

- Procedure on Reporting Research Related Adverse Events
- Risk Assessment and Risk Register Procedure
- Investigation Procedure

Scope

This policy applies to all staff employed by the UHB, including those with honorary contracts. It also applies to students and locum/agency staff working within UHB

facilities/under contract to the UHB.

This Policy also applies to contractors who have a statutory responsibility to report accidents that have occurred on UHB sites.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact
Policy Approved by	Health and Safety Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Operational Health and Safety Group Clinical Board Health and Safety Groups and Patient Quality and Safety Groups
Accountable Executive or Clinical Board Director	Director of Corporate Governance Executive Director of Nursing

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	18/09/2012	26/09/2012	Trust Incident Reporting and Investigation Procedure reviewed and updated. Replaces previous Trust document reference no: 108
1.1	09/04/2013	14/06/2013	New Appendix 9 added – Internal Management of HM Coroner Rule 43 Reports by Patient Safety Team
2	18/07/2017		To reflect changes as a result of the introduction of E Datix and to simplify by segregating the policy from the procedure
3			Definitions of patient safety incidents updated. Fair culture updated to reflect just culture in line with recent guidance. Policy and procedure separated into two documents.

Equality & Health Impact Assessment for

INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Incident, Hazard and Near Miss Reporting Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive Services – Director of Corporate Governance Author- Head of Health and Safety – 43751
3.	Objectives of strategy/ policy/ plan/ procedure/ service	• To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive framework. • To promote a culture in which incidents are reported and investigated appropriately and to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff safety and patient well-being. • To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting
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 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].	
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	All Staff and Patients

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

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	The incident reporting database details age of victim, which allows for subsequent analysis.		
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	No Impact		

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	The incident reporting database details gender of victims, which allows for subsequent analysis.		
6.4 People who are married or who have a civil partner.	No Impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No Impact		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The incident reporting database records incidents which are related to racial aspects.		
6.7 People with a religion or belief or with no religion or belief.	As above		

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 term 'religion' includes a religious or philosophical belief			
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The incident reporting database covers homophobic and sexual related incidents.		
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	The database includes a racial aspect, which has included Welsh.		

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			
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	No Impact		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No Impact		
6.12 Consider any other groups and risk factors relevant to this strategy,	Incident reporting is available to all staff, through all UHB electronic outlets i.e.		

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
policy, plan, procedure and/or service	computers.		

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities			

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	The incident reporting database allows for analysis of events with a clear aim to improve patient care and staff working conditions.		

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 healthier 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	No Impact		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green	The incident reporting database collects data in relation to environmental events, which allows for analysis and appropriate resolution.		

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
spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer	No Impact		

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
pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	No Impact		

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	Positively supports equality issues, through facilitating reporting of related events and requires managers to progress actions, towards resolution.

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?	To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we are committed to the health, safety and welfare of its staff, patients, visitors and all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of untoward incidents.			

	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?	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	N/A			

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

INCIDENT, HAZARD AND NEAR MISS REPORTING PROCEDURE

Introduction and Aim

Cardiff and Vale University Health Board (UHB) is committed to the health, safety and welfare of its staff, patients, visitors, all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of untoward incidents.

It considers that it is essential that all incidents, near misses and hazards are reported so that appropriate action can be taken with the aim of preventing their reoccurrence, improving staff and patient safety and experience and improving services and the environment where appropriate.

It is the policy of the UHB to ensure that staff feel comfortable to report incidents, hazards and near misses. Therefore, the UHB encourages an open and just culture. The aim of reporting and investigating incidents, near misses and hazards is not to blame but rather to learn from the event and to minimise risk of reoccurrence.

A key aim is to encourage staff to report incidents and for managers to treat staff involved in incidents in a consistent, constructive and fair way. The emphasis is on the "how" and “why” rather than the "who".

However, the UHB will act on information to protect the safety of other staff, patients and visitors where appropriate. Disciplinary action may result from incidents such as those relating to criminal activity, malicious activity and patient care or treatment contrary to the relevant professional code of conduct.

Objectives

- To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive framework.
- To promote a culture in which incidents are reported and investigated appropriately and proportionately to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff and patient safety and well-being.

- To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting.

Scope

This procedure applies to all of our staff in all locations, including those with honorary contracts.

Equality Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has been completed. The assessment found that there was no adverse impact to the equality groups mentioned.
Documents to read alongside this Procedure	• Incident, Hazard and Near Miss Reporting Policy • Health and Safety Policy • Policy for Reporting Research Related Adverse Events • Being Open Policy • Records Management Policy • Risk Management Policy • Welsh Government Putting Things Right Guidance November 2013 (which includes Serious Incident Reporting) • Never Events April 2018 • UHB Serious Incident process which includes Never Event processes • Just Culture guide from NHS Improvement • All Wales Root Cause Analysis (RCA) toolkit • NHS England Serious Incident Framework • Statement Writing guidance • Inquest Policy (under development) RIDDOR Guidance September 2016 • Risk Assessment and Risk Register Procedure • Process for Undertaking an RCA
Approved by	*Health and Safety Committee* *Quality, Safety and Experience Committee*
Accountable Executive or Clinical Board Director	*Director of Corporate Governance* *Executive Nurse Director*
Author(s)	*Head of Health and Safety* *Assistant Director of Patient Safety and Quality* *Head of Patient Safety and Quality*

Disclaimer

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

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
	Date of Committee or Group Approval	*TBA*	A new document was created to separate the policy and procedures into two different components.

1. DEFINITIONS

1.1 An *Adverse Incident* is defined as “any unplanned event that resulted in, or had the potential to result in, an injury or the ill health of any person, or the loss of, or damage to, property”.

1.2 A patient safety incident is defined as “any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care”. (National Patient Safety Agency, 2011).

1.3 A hazard is a source of potential harm or damage or a situation with potential for harm or damage.

1.4 A near miss is an occurrence, which but for the luck or skilful management would in all probability have become an incident.

1.5 A Serious Incident is defined as an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following:

- unexpected or avoidable death or severe harm of one or more patients, staff of members of the public;
- a Never Event – all Never Events are defined as Serious Incidents although not all Never Events necessarily result in severe harm or death;
- a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- allegations or incidents, of physical abuse and sexual assault or abuse; and/or
- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

More information relating to Welsh Government Serious Incident reporting can be found in the Welsh Government Putting Things Right document "Guidance on dealing with concerns about the NHS from 1 April 2011" (2013) click here.

1.6 *RIDDOR* is the recognised abbreviation for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

These Regulations specify the accidents, ill health and dangerous occurrences that must be reported to the Health and Safety Executive by the Health and Safety Department. This includes:

- An *over 7-day injury* – an accident that results in an employee being away from work or unable to perform their normal duties for more than seven consecutive days as the result of their injury, not including the day of the incident.
- A *Specified Injury arising out of or in connection with work,* generally more serious injuries for example a fracture or serious burns.
- A *Dangerous Occurrence* is a certain specified near miss event, which may not result in a reportable injury, but have the potential to cause significant harm. A needlestick injury from a known high risk source is reportable as a Dangerous Occurrence.
- A *Reportable Disease* – a disease that may arise from an individual's occupation. They are specified in Schedule 3 of RIDDOR. Such diseases have to be diagnosed by a doctor and the person's job has to involve a specified work activity.
- Should a member of staff advise that they are absent from work, for over 7 days, due to an injury sustained at work, the Manager must ensure that the relevant Health and Safety Advisor is advised

of this at the earliest opportunity. This action should be taken even if it is some time after the incident and the information comes to light as part of the sickness review process.

Further information can be found can be found on the Health, Safety and Environment Unit RIDDOR intranet page here:

2. ROLES AND RESPONSIBILITIES

2.1 The **Chief Executive** is ultimately responsible for ensuring compliance with the Health and Safety at Work etc Act 1974 and associated legislation including NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011, and that the Incident, Hazard and Near Miss Reporting Policy and these associated procedures are implemented effectively within Cardiff and Vale University Health Board.

2.2 The **Executive Nurse Director** is the lead Executive with responsibility for clinical governance/patient safety and quality. The Executive Medical Director and Executive Director of Therapies and Health Sciences also have responsibilities in relation to these matters within their professional groups.

2.3 The **Executive Director of Governance** has Board level responsibility for health and safety which includes Health and Safety risks and incident management.

2.4 The **Assistant Director of Patient Safety and Quality** supports the development of arrangements for incident reporting and is responsible for providing assurance to the Executive Directors that appropriate systems and processes are in place for incident reporting, management and monitoring. The post holder will also ensure that the appropriate level of support is provided to the Clinical/Service Boards to enable timely reporting and investigation of incidents.

2.5 The **Head of Health and Safety** supports the development of arrangements for incident reporting and is responsible for providing assurance to the Executive Directors that appropriate systems and processes are in place for health and safety related incident reporting, management and monitoring. The post holder will also ensure that the appropriate level of support is provided to the Clinical/Service Boards to enable timely reporting and investigation of health and safety incidents.

2.6 The **Patient Safety Team** and **Health, Safety and Environment Unit** are responsible for supporting the implementation of this procedure. They will also undertake to raise staff awareness and training on incident reporting and investigation.

2.7 The **Clinical/Service Board Management teams** are responsible for ensuring that staff within their Board are briefed on their individual and collective responsibilities within the incident reporting process. They must ensure that all incidents are reported, investigated and analysed, so that learning and improvements can be embedded in practice.

2.8 **Department/Line Managers** are responsible for cascading the procedure to staff ensuring that they are fully conversant with the process to be followed for all incidents.

Department/Line Managers are responsible for reviewing, escalating, taking appropriate action and feeding back to incident reporters in a timely manner in line with UHB procedures.

Significant incidents, for example, those that may require onward reporting to an external agency must be escalated promptly with actions recorded on the electronic incident reporting system. Welsh Government expects Serious Incidents to be reported to them via the Patient Safety Team within 24 hours of the incident occurring where possible.

There is an expectation that incidents reported on the electronic reporting tool will be reviewed by the relevant manager within 7 days. Where possible, incidents should be concluded within 30 days. More complex incidents, for example Serious Incidents reported to Welsh Government should be concluded within 60 days in order to comply with the Welsh Government closure process. Timescales are further described in the Welsh Government Putting Things Right guidance (November 2013) which can be accessed by clicking here.

It is imperative that managers review and conclude incidents in a timely manner in order that the UHB fulfils its quality, safety and governance responsibilities, which also includes uploading incident information to the National Reporting and Learning System (NRLS) within prescribed timescales.

Department/Line Managers are responsible for ensuring that an appropriate investigation is undertaken for all incidents that have occurred in their area of responsibility and ensuring that measures to prevent recurrence are implemented within the shortest appropriate timescale. Timeframes regarding general incidents and Serious Incidents have been outlined in Section 2.8. RIDDOR incidents are to be investigated within 21 days although there will be exceptions for more serious incidents. Incidents which are also investigated by the Health and Safety Executive may result in an extended investigation period.

It is the responsibility of Department/Line Managers to ensure that appropriate disclosure of incidents is made to patients and their families in line with the UHB's Being Open Policy.

It is also important that Department/Line Managers are conversant with the Just Culture Guidance from NHS Improvement in order that the appropriate support can be provided to staff. The guidance can be accessed here.

2.9 **All employees** are responsible for ensuring that the immediate area and staff and patient safety is secured following an adverse incident. The incident must be promptly reported to an appropriate senior member of staff if significant harm or injury has occurred. Employees must ensure the incident is reported on the electronic incident reporting tool provided by the UHB, available via the intranet, as soon as it is safe and practical to do so. The incident form can be accessed here.

Employees may be required to provide additional information on incidents during investigations; this may include provision of statements or attendance at interviews.

Under the Safety Representatives & Safety Committees Regulations 1977, **Safety Representatives** are also allowed to investigate: potential hazards, dangerous occurrences, and causes of accidents and occupational ill-health within the area of their responsibility.

2.10 **Contractors** such as estates and equipment maintenance contractors and building contractors have a statutory responsibility to report adverse incidents, hazards and near misses that have occurred on UHB sites to the UHB in line with their contract arrangements.

3. TRAINING

3.1 Information on incident reporting is provided to all staff on induction and supporting materials are available on the intranet on the incident reporting pages.

3.2 Incident reporting is included in Health and Safety mandatory training through an e-learning module or via face to face presentation.

3.3 Incident reporting procedures must be included in local departmental induction.

3.4 Support for staff is available via a Help Desk, intranet page and Datix Superuser Group.

3.5 Training for line managers who require log-in to the electronic incident reporting system will be provided by the Patient Safety Team and Health, Safety and Environment Unit.

3.6 Root Cause Analysis training is provided by the Patient Safety Team.

4. ADVERSE INCIDENT, HAZARD AND NEAR MISS REPORTING AND MANAGEMENT

4.1 When an incident occurs staff must first ensure the people or area concerned are made safe. The incident must be reported through the recognised UHB incident reporting mechanisms, this being the Datix system available on the intranet; a link is provided in Section 2.9.

All incidents will be graded according to the actual impact on the individual(s) involved using the Grading Framework for Dealing with All Concerns in the Putting Things Right guidance (November 2013) which can be accessed here.

Grade	Harm
1	None
2	Low
3	Moderate
4	Severe
5	Death

Staff are also able to reflect the potential future risk to individuals and to the organisation on the incident reporting system.

4.2 **A duty of candour to tell a patient** / Being Open

If adverse events have occurred to patients, the incident should be communicated to the patient or their representative as soon as is practical. There is an expectation that incidents of moderate, severe and catastrophic harm will be disclosed. In exceptional circumstances, if it is deemed that the impact of disclosure will adversely affect the patient's psychological wellbeing, a decision may be taken not to inform the patient. Reasons for this decision must be clearly documented in the patient's health records. Advice can be sought from the Patient Safety Team.

Further guidance on Being Open can be found in the Being Open policy and procedure.

4.3 Serious Incidents

If a Serious Incident occurs, supporting information to guide staff can be located within the Serious Incident flowcharts on the intranet which can be accessed here.

The organisation recognises that Serious Incidents or incidents requiring investigation may be potentially stressful and difficult for staff, patients and their families. It is essential that appropriate and timely support is offered and made available to everyone involved.

4.4 Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

Never Events require full investigation under the Serious Incident framework. This includes the need to fully and meaningfully engage patients, families and carers at the beginning of and throughout any investigation.

Further information on the management of Never Events is provided in the Serious Incident Flowcharts which can be accessed on the intranet, here.

Further information from Welsh Government on Never Events can be found on the Patient Safety Wales website.

4.5 Supporting staff to report incidents and following an incident occurring

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about their concerns allows valuable lessons to be learnt so issues can be dealt with and prevented from being repeated.

The UHB actively encourages staff to raise concerns about safety. If for any reason they feel unable to report an incident in line with this procedure, there are other routes for them to raise their concerns. These would include Freedom to Speak Up, Safety Valve and Whistleblowing Policy. Click here for more information about raising a concern.

The UHB recognises that being involved in an adverse incident can have devastating effects on staff. It is vital that the appropriate supporting mechanisms are put in place.

The Just Culture Guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Further information can be found here.

4.6 Legal Status and Retention of Incident Reports

It is a requirement of WHC 2000(71) that Incident Reports relating to adults will be retained for ten years after the date of the incident, and Incident Reports relating to incidents involving children will be retained until the child is 25 years of age or for eight years after the death of the child (whichever is the sooner).

The electronic incident reporting system fulfils the requirement of the UHB to maintain accident book(s) at strategic locations in accordance with the Social Security (Claims and Payments) Regulations 1979.

4.5 Reporting Information Governance breaches

Events of failure to comply with information governance requirements are considered to be an incident and should be promptly reported using the electronic incident reporting system. These events can be viewed by the Information Governance Department for appropriate further action, monitoring of investigation and remedial actions.

On occasion, onward reporting to the Information Commissioner may be required. Appropriate incidents must be reported to the Information Commissioner within 72 hours of the incident occurring and so prompt incident reporting and review by line managers is of critical importance. Further guidance can be sought from the Information Governance Department.

5. INVESTIGATION

All incidents will be investigated appropriately. Investigations will be proportionate to the incident that has occurred. Investigations may also be undertaken if there is repetition of similar incidents or clusters of incidents.

Due consideration must be given to the independence of the investigating officer in order that the UHB and its staff, patients and their families can have confidence in the transparency of the investigation process.

Investigation of patient safety incidents will be carried out in line with the All Wales How to Learn Lessons from Concerns Toolkit which can be accessed here.

Information is available on the intranet to support staff who are required to write a statement following an adverse incident by clicking here.

The Patient Safety Team will provide regular Root Cause Analysis training opportunities and maintain a record of staff who have attended the training.

There is an expectation that staff who attend Root Cause Analysis training will support the investigation of patient safety incidents across the UHB.

Timeframes for investigation of incidents are outlined in Section 2.8.

6. REPORTING TO EXTERNAL AGENCIES

Some specified incidents are required to be reported to external agencies. The Serious Incident Flowchart and standard agenda template prompt attendees at the SI meeting to consider whether communication with external agencies is required.

Communication with external agencies will be undertaken through the agreed UHB incident reporting mechanisms by the appointed persons as outlined below. It should be noted that this list is not exhaustive.

External Agency	Requirement	Appointed Department
National Reporting Learning System (NRLS)	All patient safety incidents (irrespective of seriousness and degree of harm) to the National Patient Safety Agency (NPSA) Reporting and Learning System.	Patient Safety Team
Health and Safety Executive - RIDDOR The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995	Work related deaths, specified injuries, dangerous occurrences and accidents resulting in over 7 day injury which results in incapacity to undertake normal work duties. Also specified diseases.	The Health and Safety Department Occupational Health Department
Welsh Government *Guidance on dealing with concerns about*	Reporting of Serious Incidents and No Surprise/Sensitive Issues to Welsh Government should be undertaken within 24 hours of the incident occurring where possible.	Patient Safety Team

the NHS from 1 April 2011 (November 2013)		
Medicines and Healthcare Products Regulatory Agency (MHRA)	Incidents involving a medicine or medical device may be reportable to the MHRA. Breaches to the Blood Safety and Quality Regulations may be reportable to the MHRA as Serious Adverse Blood Reactions or Events.	UHB nominated liaison officer in Pharmacy or Clinical Engineering respectively Blood Transfusion Team
Communicable Diseases	In the event of an infectious disease outbreak and any serious single infection with public health implications.	The Consultant in Communicable Disease Control, Health Protection Agency (HPA) should be contacted
Healthcare Inspectorate Wales – Ionising Radiation Medical Exposure Regulations (IRMER)	Breaches in IRMER to Healthcare Inspectorate Wales. Such incidents will also be reported to Welsh Government in line with Serious Incident reporting if significant harm has occurred.	Patient Safety Team
Information Commissioner (ICO)	Breaches of the Data Protection Act may require reporting to the Information Commissioner.	Information Governance Department
Welsh Health Specialised Services Committee (WHSSC)	WHSSC would expect to be informed of any incidents of a catastrophic nature to an individual; any incidents which raise concerns in relation to delivery of a particular commissioned service or emerging themes/trends. The Assistant Director of Patient Safety and Quality and Patient Safety Team representative meet with WHSSC on a regular basis where appropriate concerns are raised for discussion.	Assistant Director of Patient Safety and Quality
Human Tissue Authority (HTA)	Breaches of the Human Tissue Act require reporting to the Human Tissue Authority under the Human Tissue Authority Reportable Incident (HTARI) process https://www.hta.gov.uk/sites/default/files/Guidance_for_reporting_HTARIs.pdf	Designated Individual or Deputy.

7. IMPLEMENTATION

This procedure reflects existing practice across the UHB and will therefore be implemented with immediate effect. The requirements of this procedure will be re-enforced within Clinical/Service Boards and Directorates/Departments by local risk management, health and safety and quality and safety arrangements.

8. EQUALITY

We have undertaken an Equality Impact Assessment and received feedback on this policy and procedure and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no adverse impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

9. MONITORING

It will be necessary to ensure that Clinical/Service Boards are adhering to the requirements of this procedure. This will be monitored via a number of agreed performance indicators.

The Quality, Safety and Experience Committee and Health and Safety Committee will monitor implementation of this policy.

10. DISTRIBUTION

10.1 This procedure will be available on the UHB Clinical Portal, Intranet and Internet Site.

10.2 Line Managers/Departmental Managers/Lead Nurses/Directorate Managers/Clinical Directors are responsible for ensuring that all staff have access to this document.

11. REVIEW

This procedure will be reviewed every three years or sooner if required.

12. FURTHER INFORMATION/REFERENCES

HSE (1994), *Management of Health and Safety in the Health Service*, Health Service Advisory Committee, Health and Safety Executive.

HSE (1995) *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.*

HSE Reporting injuries, diseases and dangerous occurrences in health and social care – Guidance for employer. HSE Health Services Information Sheet No 1 (Revision 2)

Ionising Radiation (Medical Exposure) Regulations 2017

NPSA (2006), *Being open: Communicating patient safety incidents with patients, their families and carers* (Re-launched 2009)

NPSA (2004), *Seven Steps to Patient Safety*

Social Security (1987), Claims and Payments Regulations No 1968
Welsh Government *Putting Things Right/NHS Redress (Guidance November 2013)*

Welsh Government (2015) Health and Care Standards

Welsh Government (2004) *Medical Device Alert 054: Reporting Adverse Incidents – Guidance on New Arrangements for NHS Wales Organisations*

HEALTH AND CARE STANDARDS
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 18th September 2018

Executive Lead : Executive Director of Nursing
Author : Patient Safety and Quality Assurance Manager
Caring for People, Keeping People Well : The Health and Care Standards underpin all elements of the Health Board's Strategy.
Financial impact : None
Quality, Safety, Patient Experience impact : The Health and Care Standards are the cornerstone of the quality and safety agenda and provide a framework for the UHB to assess the **services** we provide.
Health and Care Standard Number All standards.
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:

- The comprehensive assessments of each standard.
- Corporate Validation of Self Assessments
- Internal Audit Scrutiny with a reasonable assurance rating

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the outcomes of the Health and Care Standards Assessment for 2017/18.

SITUATION

The Health and Care Standards set out the Welsh Government's framework of standards to support the NHS organisations in providing effective, timely and quality services across all healthcare settings.

The standards provide a consistent framework that enable health organisations to look across the range of their services in an integrated way, to ensure that the care that they provide is of the highest standard and they are doing the right things, in the right way, in the right place, at the right time with the right staff and to allow service users to understand what they can expect.

BACKGROUND

In December 2017 the Committee agreed an ongoing approach to align the Health and Care Standards to existing groups or committees within the UHB. The aim was to support a system that promotes continuous monitoring and development of the services underpinning each of the Health and Care Standards and to reduce variation across the UHB. It has previously been agreed that this process would be undertaken over a three-year period and that in 2017/18 twelve standards would be aligned to committees and the Clinical Boards would undertake self-assessments against the remaining ten standards. The process was subject to Internal Audit assessment and was awarded reasonable assurance.

Standards Aligned to Committees

Standard		Standard	Group / Committee	Corporate Lead
2.1	Safe Care	Managing Risk and Promoting Health and Safety	Health and Safety Committee	Head of Health and Safety
2.2	Safe Care	Preventing Pressure and Tissue Damage	Pressure Damage Group	Director of Nursing Specialist Clinical Board
2.3	Safe Care	Falls prevention	Falls Prevention Group	Assistant Director of Therapies
2.4	Safe Care	Infection prevention control and decontamination	IPC group	Director of Infection prevention and Control
2.5	Safe Care	Nutrition and Hydration	Nutrition and Catering Steering Group	Head of Dietetics
2.6	Safe Care	Medicines Management	Medicines Management group	Director of Pharmacy
2.7	Safe Care	Safeguarding Children and Adults at Risk	Safeguarding Steering group	Head of Safeguarding
2.8	Safe Care	Blood Management	Blood Transfusion Group	Clinical Director Haematology

2.9	Safe Care	Medical Devices, Equipment and Diagnostic Equipment	Medical Equipment Group	Deputy Director of Therapies
3.4	Effective Care	Information Governance and Communications Technology	ITG Sub Committee	Head of Information Governance
7.1	Staff and resources	Workforce	Resource and delivery Committee	Assistant Director of Workforce

ASSESSMENT

Clinical Boards undertook self-assessment of eleven of the Health and Care standards. It was intended that Standard 1.1 Health Promotion, Protection and Improvement would be amongst the standards aligned to committees, however after some discussion it was agreed that there was no appropriate forum identified to oversee all elements of this standard and so this reverted to self-assessment. Each self-assessment is multi-factorial and considers a number of components relating to the individual standard. To reduce variation between Clinical Boards a scoring matrix has been developed for each standard with definitions aligned to four scores:

- Getting Started
- Getting there
- Meeting the Standard
- Leading the Way

Self-assessments support analysis of compliance against the various elements of each Health and Care Standard as well as the development of actions for the following financial year. Despite this 68% of self-assessments undertaken by the Clinical Boards attributed the same score as the previous year. No Clinical Boards recorded an improvement in their scores against standards 1.1 Health Promotion, Protection and Improvement, 3.5 Record Keeping, and 4.2 Patient Information and while one Clinical Board recorded an improvement against standard 3.2 Communicating Effectively, two recorded a deterioration in their scores. Despite the specific criteria underpinning each standard and the scoring matrix, some variation in self-assessments remains. The corporate validation of Standard 5.1 Timely Access challenged three Meeting the Standard scores that had been attributed in the self-assessments stating that Getting There would be more appropriate as a result of RTT breaches in those Clinical Boards. A review of the supporting guidance for each of the standards that will continue to be subject to self-assessment will be undertaken to ensure that they reflect the strategic direction of the Health Board and the development of specific and achievable outcomes within the Clinical Boards.

There was a notable difference in the development of actions to support the progress of Health and Care Standards aligned to groups and committees with SMART outcomes identified by corporate leads that will be implemented and monitored through those groups. Standard 2.8 Blood Management recorded deterioration in the score since 2016/17, however it is likely that this is because it is the first year that it was aligned to the Blood Transfusion Group and reflects the reporting of a Never Event in 2017 which has led to the development of a robust action plan.

Work will continue to align the remaining standards to groups and committees and progress against Clinical Board improvement Actions will be detailed in 2018/2019 self-assessments which will be reported to the Committee in September 2019.

[Appendix 1]

Health and Care Standard Rating and Corporate Assessments

⇧ Improvement on score from 2016/17 ⇦ Same score as 2016/17 ⇩ Deterioration in score from 2016/17

Standard	Corporate rating	C&W	CD&T	Dental	Med	MH	PCIC	Specialist	Surgery	Corporate Assess-ments
1.1 Health Promotion Protection and Improvement		Getting There ⇦	Getting There ⇦	Meeting the Standard ⇦	Getting There ⇦	Getting There ⇦	Meeting the Standard ⇦	Getting There ⇦	Meeting the Standard ⇦	Corporate Assessment
2.1 Managing Risk and Promoting Health and Safety	Meeting the Standard ⇧									Corporate Assessment
2.2 Preventing Pressure Damage	Getting There ⇦									Corporate Assessment

Standard	Corporate rating	C&W	CD&T	Dental	Med	MH	PCIC	Specialist	Surgery	Corporate Assess-ments
2.4 IPC and Decontamina-tion	Getting There ⇦									Corporate Assessment
2.5 Nutrition and Hydration	Getting There ⇦									Corporate Assessment
2.6 Medicines Management	Getting There ⇦									Corporate Assessment
2.7 Safeguarding Children and Adults at Risk	Leading the Way ⇧									Corporate Assessment
2.8 Blood Management	Getting There ⇩									Corporate Assessment

Standard	Corporate rating	C&W	CD&T	Dental	Med	MH	PCIC	Specialist	Surgery	Corporate Assess-ments
3.1 Safe and Clinically Effective Care	Getting There ⇦	Meeting the standard ⇧	Meeting the standard ⇧	Getting There ⇦	Getting There ⇦	Meeting the standard ⇦	Meeting the Standard ⇦	Assess-ment not submitted	Leading the Way ⇧	Corporate Assessment
3.2 Communicat-ing Effectively	Getting There ⇦	Getting There ⇦	Getting There ⇦	Getting There ⇦	Self assessm ent compl-eted but no score attribu-ted	Meeting the Standard ⇧	Getting There ⇩	Getting Started ⇩	Meeting the Standard ⇦	Corporate Assessment
3.3 Quality Improvement Research and Innovation	Meeting the Standard ⇧	Meeting the Standard ⇦	Getting There ⇦	Meeting the Standard ⇦	Self assess-ment comple-ted but no score attributed	Meeting the Standard ⇧	Meeting the Standard ⇦	Meeting the Standard ⇧	Meeting the Standard ⇦	Corporate Assessment

Standard	Corporate rating	C&W	CD&T	Dental	Med	MH	PCIC	Specialist	Surgery	Corporate Assess-ments
3.5 Record Keeping	Getting There ⇦	Getting There ⇦	Getting There ⇦	Getting There ⇦	Getting There ⇦	Getting There ⇦	Getting There ⇦	Getting There ⇦	Meeting the Standard ⇦	Corporate Assessment
4.1 Dignified Care	Getting There ⇦	Meeting the standard ⇧	Meeting the standard ⇧	Getting There ⇦	Meeting the Standard ⇧	Meeting the Standard ⇦	Meeting the Standard ⇦	Getting There ⇦	Leading the Way ⇧	Corporate Assessment
4.2 Patient Information	Getting There ⇦	Getting There ⇦	Getting There ⇦	Getting There ⇦	Meeting the Standard ⇦	Meeting the Standard ⇦	Getting There ⇦	Getting There ⇦	Meeting the Standard ⇦	Corporate Assessment
5.1 Timely Access	No Corporate Rating Attributed	Meeting the Standard ⇧	Getting there ⇦	Getting There ⇦	Getting There ⇦	Meeting the Standard ⇧	Meeting the Standard ⇦	Meeting the Standard ⇦	Meeting the Standard ⇦	Corporate Assessment
6.1 Planning Care to Promote Independence	Meeting the Standard ⇧	Getting There ⇦	Leading the Way ⇧	Getting There ⇦	Meeting the Standard ⇦	Leading the Way ⇧	Meeting the Standard ⇦	Getting There ⇩	Meeting the Standard ⇧	Corporate Assessment

Standard	Corporate rating	C&W	CD&T	Dental	Med	MH	PCIC	Specialist	Surgery	Corporate Assess-ments
6.3 Listening and Learning from Feedback	Meeting the Standard ⇦	Meeting the Standard ⇧	Getting There ⇦	Getting There ⇦	Leading the Way ⇧	Leading the Way ⇧	Getting There ⇦	Getting There ⇦	Meeting the Standard ⇧	Corporate Assessment
7.1 Workforce	Meeting the Standard ⇦									Corporate Assessment

PUTTING THINGS RIGHT (PTR) ANNUAL REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 18 September 2018
Executive Lead : Executive Nurse Director
Author Angela Hughes, Assistant Director of Patient Experience Tel 029 21846108 **angela.hughes5@wales.nhs.uk**
Caring for People, Keeping People Well : avoid harm , Waste and Variation
Financial impact: The Health Board has both a patient safety, quality and experience commitment in line with a financial responsibility for the effective investigation and management of claims.
Quality, Safety, Patient Experience impact : the work underpins the delivery of the Ministerial objectives for supporting carers
Health and Care Standard Number 3.1 Safe and Clinically Effective Care and Standard 6.3 Listening and Learning from Feedback
CRAF Reference Number Delivering outcomes that matter to people
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION
ASSURANCE is provided by: the annual report

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report for information

Publication of Concerns Annual Report

SITUATION
A review of putting things right (PTR), Concerns, Compliments Claims and Redress cases for 2017-18

BACKGROUND

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (hereafter, the 'Regulations') apply to all Welsh NHS bodies, primary care providers and independent providers in Wales, providing NHS funded care and were introduced in April 2011. The Regulations set out the process for the management of concerns and is known as Putting Things Right (PTR). The Regulations are supported by detailed guidance on raising a concern. The application of the process is outlined in the report.

As a Health Board we are committed to listening to people who use our services, resolving their concerns where possible in a proportionate and empathetic manner. We aim to provide an effective and timely process for responding to concerns, which enables the Health Board to improve services based on lessons learnt, with the aim of achieving high quality, compassionate and effective care for all service users, whether in provided or commissioned services.

ASSESSMENT AND ASSURANCE

We have a robust review system for all concerns. There is a commitment to investigate concerns in a proportionate, transparent and thorough manner.

Concerns

The Health Board is committed to improving the performance times but never compromising the quality of the investigations. The 30 day response time is following a trajectory of improvement.

The Health Board has a robust process in place to manage concerns in a proportionate manner in accordance with the regulations.

Ombudsman

Internal Audit have undertaken a review of the Concerns Team management of Ombudsman cases in 2017/18 and provided substantial assurance with no recommendations. They noted areas of good practice throughout the process.

Redress

We are committed to using the redress process when appropriate this enables a timely resolution for those people seeking an apology, remedial treatment and/or financial compensation to the value of £25,000. As indicated in the report our use of the redress system has steadily increased since 2011. It should be noted that to date since NHS Wales Shared Services Partnership - Legal and Risk Services began charging individual organisations for legal advice we have not incurred any costs to date.

Claims

Claims Managers try to engage with clinicians' at all available opportunities. We are targeting training for individual Clinical Boards and this has been supported by solicitors from NHS Wales Shared Services Partnership - Legal and Risk Services. The feedback has been very positive. We are mindful of reviewing costs throughout the process of the claim to avoid any unnecessary expenditure. The lessons learned from claims are identified as early as possible in the investigation to ensure that we do not wait for completion of the process to embed the learning.

HTA INSPECTION AND THE RESPONSE TO INDEPENDENT REVIEW OF THE MORTUARY AND CELLULAR PATHOLOGY SERVICES AND RCA INTO TISSUE TRACEABILITY
Name of Meeting : Quality, Safety and Patient Experience **Date of Meeting:** 18th September 2018
Executive Lead : Chief Operating Officer
Author : CD&T Clinical Board Director, Director of Operations and Director of Quality, Safety and Patient Experience Tel 029 2074 6546
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: N/A
Quality, Safety, Patient Experience impact: Ensuring that the health board has effective systems for the management of the mortuary and associated laboratory functions is critical for effective care of our deceased patients and their families
Health and Care Standards: 2.1 Managing Risk and Promoting Health and Safety, 2.9 Medical Devices, Equipment and Diagnostic Systems, 3.1 Safe and Clinically Effective Care, 3.5 record Keeping, 4.1 Dignified Care
CRAF Reference Number. 5.3.4 and 8.1.7
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION:

ASSURANCE is provided by:

- The actions developed and progressed

The Quality, Safety and Experience Committee is asked to **NOTE**

- Progress against the HTA inspection findings
- The action plan
- The intended monitoring mechanism through CD+T governance structures

SITUATION

The organisation received, on the 6th September 2017, a letter and report from the HTA following the inspection of the Cellular Pathology Laboratory and Mortuary on the 9th and 10th August 2017.

The feedback from the inspection demonstrated that there were a number of areas of deficiency linked to governance and quality, tissue traceability and the premises, facilities and equipment. In response to this the Clinical Board and service developed a response plan in order to begin corrective actions within a governed framework (CD&T Gold Command).

Following this inspection a root case analysis investigation (RCA) was commissioned into the tissue traceability failures identified. Additionally an external review was commissioned to review both the governance arrangements and cultural position of the service.

The purpose of this paper is to review the recommendations, lessons learnt and improvement actions agreed following these reports.

BACKGROUND

On the 9th and 10th of August 2017, there was a routine inspection of the Mortuary facilities and associated Cellular Pathology facilities at the University Hospital of Wales. The purpose of this visit was to assess compliance against the HTA standards and the suitability of premises on which HTA licensed activities take place.

The HTA report has been structured to provide detailed feedback on the non-conformances and the corrective actions that are required. This structure is supportive to the organisation in ensuring that there is absolute clarity on the work required to ensure that the Mortuary and Cellular Pathology laboratory can be sustainably compliant to the standards. The Clinical Diagnostics and Therapeutics Clinical Service Board, who hold the responsibility for this service fully accepted the findings of the HTA report.

The Clinical Board in partnership with Cardiff University commissioned an RCA to specifically review the circumstances surrounding tissue traceability. The purpose of this was to ensure that beyond the recommendations of the HTA that the root causes were established, and further lessons identified.

In January 2018, the organisation commissioned an external review into the governance and culture of the department including reporting to the Clinical Board and organisation.

The service and Clinical Board is grateful for the detail in both reports which supports the process of ensuring an improvement plan to deliver sustained good practice within the service. All of the recommendations of both reports are fully accepted.

ASSESSMENT

HTA Report non-conformances:

The non-conformances in the HTA report are broken down into critical, major and minor with the organisation having received the following:

1. Critical – 3
2. Major – 14
3. Minor – 9

In addition to this there are a number of pieces of advice that have been given to ensure further improvements. The volume and criticality of the collective shortfalls has led to the HTA instructing a requirement to replace the Designated Individual (DI). The previous DI, Dr David Griffiths has now been formally replaced by Mr Clive Morgan, Assistant Director of Therapies and Health Science.

The Clinical Board and Service are committed to delivering against each of the non-conformances in the timescales that are set out by the HTA and a significant amount of work has already been undertaken to ensure this. The resources required to deliver the improvements have been committed and the Laboratory director has confirmed in writing commitment to ensuring that this will be reviewed on an ongoing basis to meet the needs of the improvement work.

To date all of the requirements have been met on time in relation to submissions. The HTA has confirmed that 25 of the 26 non-conformances have been reviewed and have been confirmed as closed. The remaining action relates to the historical block and slide audit which was additional evidence requested by the HTA following the findings of the original wet tissue audit (given that the same processes applied to both tissue archives). This audit has been completed and individual reviews of cases found during the audit as non-complaint are being worked through with the DI. The service is in regular dialogue with the regulator to ensure that the improvement work continues as expected.

It is understood that the HTA will return to inspect the organisation to ensure compliance following closure of all the non-conformances.

Independent Review of the Mortuary and Cellular Pathology services and RCA into tissue traceability:

In reviewing both these reports the service and Clinical Board has developed an action plan to reflect progress against recommendations made. The action plan is included in appendix 1.

The RCA report reviewed the outcome of the tissue audit where it was identified the Health Board was holding relevant material without the appropriate authority and consent. The investigation team ascertained the root cause to be a failure in the quality governance framework.

The main findings of the RCA were that –

1. The traceability and disposal procedures did not cover the whole lifecycle and were not followed.
2. The Quality Management System (QMS) did not provided suitable assurance or escalation.
3. There was a lack of a robust governance structure in place.

Within the RCA there were 35 separate recommendations. These recommendations can be grouped as follows:

1. Governance
2. Leadership
3. Staffing responsibility and accountability
4. Quality management system improvements
5. Procedural reviews
6. Audit
7. Interaction with external agencies

As this RCA was a retrospective view on the events pre-inspection it was expected that there would be significant recommendations and of the breadth represented above.

Of the 35 recommendations the progress against associated actions is as follows:

1. Completed – 22
2. In progress - 13

Within the external review report there were 21 recommendations made. The recommendations can be grouped in to themes as follows:

1. Governance
2. Leadership
3. Designated individual (DI)
4. Culture
5. WIFM

Of the 21 recommendations the progress against associated actions is as follows:

1. Completed – 12
2. In progress – 7
3. To be started – 2

The areas to be started include the substantive DI role and the Organisational Development work required.

The process of appointing a substantive DI has not begun. It has been agreed with the interim DI that this would not be considered until such time that the current requirements from the HTA are signed off as complete. Whilst the organisation has met all of the deadlines required by the HTA and is on target to meet the final deadline which is the block and slide audit, until this is all completed and the HTA has formally provided sign off all of the actions the DI role would not be considered further. At that point detailed conversations between the service, Clinical Board, Licence Holder and organisation would be required to agree a way forward.

The Organisational Development work was not formally started in agreement with the Executive Director for Workforce and Organisational Development. The Clinical Board was guided to await the outcome of the external review prior to starting this work. The plan has been developed with the Head of Workforce and Organisational Development and has a planned start date of the 1st of September 2018. In lieu of this the Clinical Board team have undertaken several informal steps to work with staff on culture and team work.

The Clinical Board will now work with the service to ensure that all of the actions are reflected within the programme plan for improvement and will closely monitor progress through the implemented governance structures.

Appendix 1 - POST HTA REVIEW ACTION PLAN

	Recommendation	Action	Timescale	Action owner	Progress
1	The DI post holder should have a substantive contract with the UHB with remuneration to reflect the time and responsibility of the role.	The move from a temporary DI to a sustainable solution will need careful consideration. Appointing an individual with sole responsibility for the role on a substantive basis may present challenges. This is due to the fact that in the view of the HTA the DI has the ability to step down from the role at any point. How this is managed contractually will need to be developed in conjunction with HR.	September 2018	HWOD DoO	To be started at point of sign off from HTA of current remedial action
2	At least monthly meetings with the licence holder (LH) to provide support to the DI and assurance for the LH.	Minimum monthly meetings in place which are minuted	Ongoing requirement	DI LH	Complete
3	The new Terms of Reference developed for the HTA Licence 12163 compliance group should include mechanisms to directly escalate concerns in terms of the DI to the LH or vice versa.	Revise TOR for HTA Compliance Group	22-6-18	DI	Complete
4	Robust checks and sign off processes should be put in place in respect of the development of Standard Operating Procedures (SOPs)	All SOPs have been reviewed and signed off by the DI. SOPs are recorded on Q-pulse and are acknowledged electronically	18-5-18	DI SM DQSPE	Complete
5	Work needs to take place within the Directorate to ensure clarity in respect of roles and responsibilities In addition as part of the management and appraisal process any gaps in terms of either manager's or staff's ability to undertake their roles needs to be identified and appropriate training and development provided.	This action will be completed as part of the OD intervention covering a number of recommendations. The detailed planning of the OD is included within the programme plan for the Mortuary and Cellular Pathology. The informal elements of OD have begun with mortuary staff supported by the clinical board and service management team	1/9/18	HWOD DoO	In progress

6	Work should be undertaken with managers to develop their confidence in giving timely and appropriate feedback to staff.	The management team have been met with in order to further develop skills of feedback, including listening to staff, a number of meeting have been held with both mortuary and cellular pathology staff to encourage feedback both to and from the staff teams	Started and ongoing	HWOD	Complete but ongoing
7	An assessment should be made of the time allowed for the DI and Laboratory Director roles to ensure they are in line with the responsibility and accountability expected of the roles.	The Laboratory Director job plan has been reviewed on appointment of the new post holder and now reflects the time required to discharge the responsibility and accountability of the role. The current temporary DI has sufficient time to undertake the role through prioritisation although this will need formal review when there is a move to a substantive solution	Completed	DoO	Complete
8	The Clinical Board should review its hand off and escalation processes to ensure that they are as robust and clear as possible.	The Clinical Board has tested a written formal hand over process with associated meetings to ensure that the risks experienced are minimised. This will be utilised moving forward	Completed	CBD DoO DQSPE	Complete
9	WIFM itself is largely outside this review (see section 7), nevertheless there is an onus on the UHB to manage its impact on UHW as the licenced premises. The existing service level agreement with Cardiff University is already being re-written and needs to be made more robust in respect of mutual expectations across a range of areas.	Review SLA with WIFM to reflect findings of the review. The SLA is now in final draft and has been reviewed by the Clinical Board and Cardiff university	13/7/18	DI LD SM	In progress
10	A revised governance structure has been developed to replace the Mortuary Management group (The HTA Licence 12163 compliance group) which will now have a dual reporting and accountability to both the UHB and Cardiff University in respect of compliance.	The terms of reference have been completed to reflect this requirement and will subject to annual review. The DI is embedded in the university's Human Tissue management governance structure	22-6-18	DI	Complete

	As with 6.3.3(i) issues of non-compliance and the actions that will be taken and by whom will need to be clarified as part of the development of the TOR.				
11	There are some real positives in terms of culture that should be acknowledged and built on	The Clinical Board team has undertaken regular visits to the service both in Cellular Pathology and the mortuary, at all levels within the team. This has focussed on positive engagement of the staff and the current good culture that exist in parts. This will be sustainably managed through the OD intervention and specifically the listening exercise to be undertaken	1/9/18	HoWOD	In progress
12	Across the Directorate there needs to be an urgent piece of OD work to ensure that staff are engaged and feel valued.	A detailed OD plan has been developed as part of the overall plan. Informal engagement has started across the service to ensure that staff feel valued in there roles in advance of wider OD interventions	1/9/18	HoWOD	In progress
13	Both mortuary and the laboratory staff work in challenging – though very different environments – and thought should be given to how they can be supported. I would recommend asking each team what approach would work for them and then working with them to set something appropriate in place.	A central part of the OD plan is to undertake a formal listening exercise with all staff groups to ensure that any solution is co-produced.	1/9/18	HoWOD	In progress

14	Crisis management solutions need to be converted into sustainable business as usual and the evidence shows that changing culture is not a quick task. OD interventions need to be set against a longer timeframe – to avoid the perception that management are only interested when there is a crisis – but also to avoid dis-empowering line managers in the Directorate and build trust between staff and line managers.	The OD plan has been developed to ensure that there are development opportunities for the management team so that there is sustainable development with all of the teams within the governance structure. Ensuring ownership of ongoing team development at service level will provide the greatest chance of success of sustainability	1/9/18	HoWOD	To be evidenced post OD intervention
15	All staff also need to be regularly reminded of the existing structures in the UHB for raising concerns; the open phone line to the Chair and the "Freedom to Speak Out" telephone line – as well as the formal whistle blowing policies and procedures.	Promotion of process of escalation for concerns throughout the service will formally be completed as part of the OD work, however this has begun informally through staff meetings	1/9/18	HWOD	In progress
16	A number of changes have already been put in place by the UHB; I would recommend that these and any future changes are checked against the best practice approach outlined in Section 6.5 to ensure a focus on the right actions to ensure sustainable and robust governance arrangements are in place.	Review changes in Governance are in line with best practice is being undertaken.	29-6-18	DQSPE	In progress
17	Robust checks and sign off processes should be put in place to quality assure SOPs in regulated areas – this could be via the compliance and/or service groups that are being developed.	SOPs are reviewed by DI All stakeholders have access to Q-pulse Monitoring is through the HTA Compliance Group	18-5-18	DI SM LD	Complete

18	The terms of reference for the HTA compliance group have been drafted. I would recommend that the terms of reference of the meetings into which the group reports are also amended to make explicit their expectations from this key group, (e.g. minutes, metrics, reports), to ensure that if the group falls into abeyance for any reason this is picked up immediately as a matter of routine.	Now that the regulatory compliance group has formally begun, the reporting mechanisms will be reviewed within the HTA compliance group to ensure expectations as per the TOR of the compliance group are met. CB Director for QSPE is a member of the HTA Compliance Group	22-6-18	DI	On-going
19	Effective internal and external review and audit are a key defence in governance terms and in achieving the UHB's ambition of "Always Inspection Ready"– reports that the Quality Team was held at "arm's length" are concerning and should be rectified immediately with a clear direction to all concerned that there should be open audit access to these teams.	Direction given to team that there must be open audit access. Independent audit has been conducted across the service. Monitoring of compliance will be through QSE escalation route and Regulatory Compliance Group.	31-5-18	DQSPE LMQM SM LD	Complete
20	The "Always inspection Ready" approach should make the need for audits prior to inspections less important. Nevertheless while this is being achieved pre-inspection audits in advance of regulatory inspections should take place in a timely manner and any issues escalated to the Directorate, Clinical Board and /or Board as a matter of urgency.	Audit and self-inspection form an important part of the Quality Management System. Audit schedule to be risk assessed to ensure timely self-inspection undertaken. DQSPE will actively support audit within the service. Metrics include audit performance. Metrics reviewed by DQSPE, reviewed at Clinical Board and Regulatory Compliance group.	31-5-18	DQSPE LMQM	Complete

21	It is imperative that a smaller suite of key metrics in respect of HTA compliance are identified which can be used by the Clinical Board and other committees to triangulate other sources of information and provide assurance or highlight the need to escalate concerns.. The Directorate management team, Clinical Board and DI should work together to establish which key metrics provide the best temperature test of the areas.	Metrics have been modified and simplified. 'Temperature gauge' indicator gives quick visible measure of compliance. DQSPE has access to metrics via Q-pulse and regularly reviews and acknowledges.	31-5-18	DQSPE LMQM	Complete

Key

DI	Designated Individual
LH	Licence Holder
DoO	CD&T Director of Operations
CBD	CD&T Clinical Board Director
DQSPE	CD&T CB Director for QSPE
LMQM	Laboratory Medicine Quality Manager
SM	Cellular pathology Service Manager
LD	Cellular Pathology Lab Director
HWOD	CD&T Head of Workforce and OD

RCA ACTION PLAN

	Recommendation	**Action**	**Timescale**	**Action owner**	**Progress**
1	The Health Board through its integrated governance structures should ensure service provision is in line with best practice, adopting a continuous improvement approach, ensuring it achieves the key performance indicators and user requirements. The procedure advises operational services to review new, revised regulation, accreditation and professional standards.	A gap analysis has been performed against the revised standards. Model will be adopted for any new, or revised standards/legislation.	1-11-17	SM DQSPE DI	Complete

	This list is not exhaustive, and perform a gap analysis should be undertaken to identify the resources or investment required to ensure compliance.	This will be monitored through the Regulatory Compliance Group			
2	The UHB must put in place a leadership and governance structure around HTA regulatory compliance that provides the Executive Team with robust assurance that compliance with contemporaneous standards is regularly and consistently monitored.	HTA Compliance Group established CB Regulatory Compliance Group established	1-6-18	DI DoO DQSPE CBD	Complete
3	Key personnel appear to be unaware of the HTA consultation process before the changes to the Codes of Practice.	Standing agenda item for the HTA Compliance Group This will be monitored through the Regulatory Compliance Group	8-11-17	DI SM LD	Complete
4	Inadequate dissemination of changes in Code of Practice for working on human tissue	Standing agenda item for the HTA Compliance Group	8-11-17	DI SM LD	Complete
5	The organisation should identify clear lines of accountability and authority in relation to the unification of the Cellular Pathology, Mortuary and Post Mortem governance (including HTA compliance) and staff need to be supported in those roles.	Organisational chart completed and circulated and staff discussed		DI SM LD	Complete
6	Dedicated and protected time allocation did not appear to be available to allow role(s) to be successfully completed, there did not appear to be adequate support or independence to facilitate escalation as and when required. Therefore key roles, e.g. both the Traceability Lead and Cellular Pathology Quality Manager must have a salary that is commensurate of the skills required and have sufficient protected time (whole time equivalent) to complete the legal duties required of the post holder	Through the restructuring dedicated roles for these in place and tested		SM LD DoO	Complete
7	All establishments under the HT Act 2004 must complete a compliance update. The information provides the HTA with a risk based approach to scheduling establishments' inspections. There is no evidence of a procedure to complete and manage the submission.	Forms part of the agenda of the HTA Compliance Group This will be monitored through the Regulatory Compliance Group	8-11-17	DI SM LD DQSPE LMQM	Complete

8	The documents held on Q-Pulse by the service do not provide clear and unambiguous guidance, roles and responsibilities are not captured in one document but three - *the Quality Manual Cellular Services* [QM-CPY-QualMan], *Histopathology Services Management Structure: Lead Staff* [MP-CPY-MANSTAFF] and *Review of licensed activities at the University Hospital of Wales (HTA licencing number 12163*) [MP-CPY-HTAactivity]. The content of the document requires updating due to recent staff changes.	These documents are in the process of undergoing a review to ensure that there is clarity for staff due to the recent changes in key staff and leadership roles. They will be streamlined through this process.	29/6/18	DI SM	In progress
9	The procedures in use contravened the HT Act 2004 but staff were expected to follow these procedures, e.g. *Disposal of blocks and Slides*, [LP-CPY-DispBlk&Sl], Revision 6, active 08/10/2015.	The SOP has been revised and agreed with the HTA	18-5-18	DI SM	Complete
10	There were seven Tissue Traceability audits undertaken in 2017, the Lead Auditor was the Lead Biomedical Scientist responsible for traceability, therefore no independent review of the procedure.	Audit and self-inspection will be performed by independent auditors. DQSPE will actively support audit within the service. Independent audit of traceability has been completed	2-11-17	LMQM DQSPE SM	Complete
11	The process for disposal lacked a structured approach, including traceability of specimens, consent review and appropriate disposal. The roles and responsibilities of the individuals was not clearly defined resulting actions and forms being altered post approval	New role for Traceability (HTA Compliance Officer) in place to monitor compliance and ensure timely disposal	complete	DoO SM DI	Complete
12	There was a failure to respond to the internal self-inspection audit findings, the quality team had restricted access to the service to undertake audit, escalation of the internal audit findings is not defined.	Direction given to team that there must be open audit access. Independent audit has been conducted across the service. Monitoring of compliance will be through QSE escalation route and Regulatory Compliance Group.	31-5-18	DQSPE LMQM	Complete

13	The service meetings that were defined to support the infrastructure were lapsed, including the • Operational Management Group meeting which had ceased • Cellular Pathology Service meeting (CPSM), evidence the meetings were not held in line with the pre-defined timescales of quarterly in 2017. • Mortuary staff meeting, evidence of only one meeting held not the required eight per year.	HTA Compliance Group established Service meetings are re-established and minuted Mortuary staff meetings in place Operational management meetings in place	complete	DoO LD SM DI	complete
14	Failure to engage with the local Quality Manager to ensure independence.	Direction given to team that there must be open audit access. Independent audit has been conducted across the service. Monitoring of compliance will be through QSE escalation route and Regulatory Compliance Group.	31-5-18	DQSPE LMQM	Complete
15	There is no evidence of the DI formally informing the licence holder (Health Board) of the performance and/or compliance with the licence, e.g. annual compliance submission to HTA not escalated	Regular monthly meetings are now in place	Completed and ongoing	DI LH	Complete
16	A clear structure for governance of the Cellular Pathology, Mortuary and Post Mortem Services should be developed to include criteria for the establishment of on-going reviews of processes and maintenance of holdings. The line management relationship between the Health Board, Cardiff University and WIFM should be clearly communicated to all staff	Whilst this structure has been implemented via the new governance arrangements at the next service wide meeting this will be shared with the wider cellular pathology service	5/7/18		In progress

17	From discussions with the Clinical Board and Cellular Pathology Management Team it is apparent that a single overview for quality management does not yet exist. The Investigation Team note that a new DI has been appointed and both a Deputy Cellular Pathology Manager and Deputy Mortuary Operational Manager role will be introduced. This should be an opportunity for UHW to work collaboratively with the mortuary and laboratory teams, WIFM and the HTA Compliance (Traceability) Manager to ensure procedures are fit for purpose and trained out	With new individuals in leadership roles and the new governance arrangements in place within the service and clinical board the ability to have a point of testing of the QMS is in place. The success of a QMS cannot be measured at a single point in time as sustained improvements to the quality metrics are required, which include the implementation and training of policies and procedures. It is recommended that the current structures continue to measure effectiveness and that it is formally retested in 12 months time	June 2019	DQPSE LD SM DI LMQM	In progress
18	The Mortuary and Post Mortem Service should undertake an end-to-end service review that includes the relationship between CVUHB, Cardiff University, WIFM, Coroner and Police. The review should feed into the design of a Service Specification with associated key performance indicators based on the needs of the stakeholders. The staff interviewed as part of the investigation process were uncertain how CVUHB, WIFM and the Coroner Office fitted into the structures, other than through the Post Mortem process. Specimen storage and consent, requiring further clarification.	Process mapping completed Redesign of service/pathway under development Final product will be reliant on completion of recommendation 19 below	Completion date dependant on external agencies		In progress
19	There is a lack of consistency between how CVUHB interacts with separate Coroner's offices and the Police. It is recommended that a forum with representatives of each be established so that a consistent pattern of working with each agency can be agreed and put in place e.g. standardisation of forms should be agreed. The current method under which CVUHB has to manage the different working practices of different agencies is in the Investigation Team's opinion a	In progress – PACE process has started and coroners process is under review, forum will be considered following	Completion date dependant on external agencies		In progress

	contributing factor to the issues that have occurred in the disposal process highlighted in the HTA Inspection in 2017. Further recommendations in regard to the disposal process are noted below				
20	The SLA document between CVUHB establishment and WIFM is overdue a review and does not appear to detail the practices required by both parties to fulfil the requirements of HT Act 2004, ISO 15189:2012 and Health and Safety at Work requirements.	SLA with WIFM currently under review	13/7/18	DI SM LD Cardiff Uni	In progress
21	It was apparent there were several points of entry for documentation that supports the post mortem activity, leading to a lack of chain of custody, extended timelines for processing and loss of supporting documents, examples were request for post mortem, consent forms, notification of coroner inquest complete.	Process mapping has been completed. Re-design of the pathways underway in conjunction with external agencies Long term sustainable management will be provided via the development of a single IT system for tissue management	Completion date dependant on external agencies	DI SM LD Cardiff Uni	In progress
22	Develop a clear process regarding the retention of specimens that deals with the complex chain of events, i.e. forensic or coronial authority. There needs to be a document to support and identify specimens seized under PACE or retained under CPIA.	PACE SOP has been developed and currently under review with Home Office/HTA	29/6/18	DI SM DQSPE	In progress
23	Storage of holdings under PACE/CPIA – it is the Investigation Team's opinion that the risk and associated costs of storing items under PACE/CPIA should not rest with CVUHB but the Police/CPS. It is recommended that such holdings should be stored offsite in a non CVUHB facility e.g. Police facility or addressed in the contract/SLA for such services with the Police	PACE tissue has now been placed in a separate location. Off-site storage would cause difficulties for service	12/2/18	DI SM LD Cardiff Uni	Complete
24	The mortuary storage areas need to be mapped with secure access that is reviewed on a regular basis. Within the storage areas there needs to be clear segregation between specimens retained under PACE, Coronial authority, CPIA or as part of a hospital consent post mortem.	PM tissue has been clearly segregated	12/2/18	DI SM LD Cardiff Uni	Complete

25	All requests for additional work should be captured in a clear and consistent method, using a standardised format to facilitate interpretation with regard to transcription, audit and disposal.	To be defined in SOP	6/7/18	LD	In progress
26	Timelines for additional testing should be defined in the procedure, one case within the 42 investigated [X,17.0000467.H] had additional testing performed after the Coroner had concluded the inquest.	To be defined in SOP	6/7/18	LD	In progress
27	The authority to dispose of specimens following completion of the case i.e. Coroner authority ended, Police case/appeal process ended, and family wishes to dispose is by the managing Pathologist. No disposal forms must be changed, amended or added to after this approval has been granted. There is evidence of specimens being added to the disposal inventory by laboratory staff after the Pathologist has approved the disposal, [X,14.0000076.F].	All staff communicated to regarding practice expectations, SOP to be re-circulated within 2 weeks	21/6/18	SM	In progress
28	The definitive disposal date and should be agreed by all parties, there is evidence of the Pathologist requesting specimens be retrieved from the disposal bin after they have been deposited, see statements Appendix_I.	completed	complete	SM	Complete
29	Specimen type, volume, number need to be recorded on the original worksheet to facilitate cross-reference to the disposal records. There is evidence of specimens being 'missed' on a disposal run and being disposed of on subsequent disposal runs.	Updated form in place	complete	LD	Complete
30	Specimens sent away for additional work, such as urine and samples for toxicology, should be covered by a Technical Agreement or SLA, with the third party to ensure the specimen is used in totality or returned.	SOP has been revised	complete	DI SM	Complete
31	Cases where that post mortem was undertaken outside of CVUHB and specimens referred to C&V for further analysis require a separate review. The evidence from these cases, within	To be defined in SOP	6/7/18	LD SM DI	In progress

	the 42 post mortem cases reviewed, showed the documentation to be ambiguous as to the type and volume of specimen transferred.				
32	Disposal – there should be a far more proactive approach to the disposal of holdings	SOP for disposal has been revised HTA Compliance Officer now in place to ensure proactive timely disposal of tissue		DI SM LD DoO	Complete
33	The current IT systems and recording methodology (i.e. the use of four separate systems) is not fit for purpose. CVUHB should update the four separate systems with one application to mitigate the risk of multiple transcription areas and greatly assist in the traceability of holdings	A market review of the available systems for tissue traceability has been undertaken, and no system is available which is fit for purpose. The Clinical Board is actively working with IT to manage the recruitment of an individual to develop a bespoke solution.	November 2018	CBD DoO	In progress
34	The Clinical Diagnostic and Therapeutic Clinical Board, Cellular Pathology Management Team and the Designated Individual should review the directorate and departmental quality management system (QMS). The review should examine document control, record keeping, stakeholder information and communication, training and development, standard operating procedures, self-inspection, premises and equipment. This list is not exhaustive. The Investigation Team reviewed multiple examples of areas where the QMS identified non-compliance or opportunities for improvement	Metrics have been modified and simplified. 'Temperature gauge' indicator gives quick visible measure of compliance. DQSPE has access to metrics via Q-pulse and regularly reviews and acknowledges. The Regulatory Compliance Group will monitor QMS effectiveness	Started but ongoing action	DQPSE DI LD SM LMQM	In progress
35	Non-conformities and incident management should be reviewed, and a good reporting culture developed Evidence reviewed revealed - a) an inconsistent and low volume reporting culture b) limited experience in root cause analysis tools, identification	Root cause analysis training to be rolled out Audit schedule to be risk assessed to ensure timely self-inspection	Ongoing actions in place 31/8/18	LMQM DQSPE SM LD	On-going

	of robust corrective and preventive actions, change and risk management, process for periodic review c) a limited self-inspection programme that does not meet the regulatory and accreditation requirement d) a self-inspection programme that has no independent review	undertaken. Audit and self-inspection will be performed by independent auditors. DQSPE will actively support audit within the service. Metrics include audit performance. Metrics reviewed by DQSPE, reviewed at Clinical Board and Regulatory Compliance group.			

PATIENT SAFETY SOLUTIONS - ALERTS AND NOTICES – UPDATE ON OUTSTANDING AREAS OF NON-COMPLIANCE
Name of Meeting: Quality Safety and Experience Committee **Date of Meeting :** 18th September 2018

Executive Lead: Executive Nurse Director
Author: Patient Safety Facilitator, Contact number 029 2074 6548
Caring for People, Keeping People Well: This paper underpins the 'reducing waste, variation and harm' element of the University Health Board's strategy.
Financial impact: Whilst there are no financial implications associated directly with this report, failure to fully implement patient safety alerts and notices has the potential to impact financially on the University Health Board (UHB) in relation to failure to manage clinical risk.
Quality, Safety, Patient Experience impact: The work outlined within this report reflects the significant activity taking place to improve patient safety and experience leading to improved quality and care outcomes for patients.
Health and Care Standard Number: 2.1, 3.1, 3.3 **CRAF Reference Number:** 5.1, 5.1.5, 5.6, 5.7
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

ASSURANCE is provided by:

- The UHB has continued to increase compliance with Patient Safety Solutions and is currently compliant with 94% of alerts and notices.
- The actions that are being undertaken to address the outstanding areas of non-compliance.

The Committee is asked to:

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

SITUATION

This report has been written to provide the Committee with an update on the UHB's position relating to Patient Safety Solutions, which include alerts and notices from Welsh Government, as well as a number of outstanding notices from the now disbanded National Patient Safety Agency (NPSA).

BACKGROUND

The UHB regularly receives alerts and notices from Welsh Government. These cover a range of patient safety issues. Each notice or alert contains a list of actions to be completed before compliance can be declared. The timescale given to undertake these actions varies according to the complexity of the actions required. By the specified deadline, the UHB must report a position of compliance, non-compliance or not applicable.

The notices/alerts are issued to all Welsh Health Boards and Trusts. Each organisation's compliance status is published on a monthly basis by Welsh Government.

An internal flowchart is in place to compliment the UHB's Safety Notices and Important Documents Policy and ensure the UHB complies with necessary Welsh Government requirements.

The UHB participated in an event hosted by Welsh Government and the Delivery Unit in November 2017 where Health Boards and Trusts shared their progress and challenges with Patient Safety Solutions over the previous 12 months. A further event is anticipated to take place in November 2018.

ASSESSMENT

The Committee should be advised that there are several elements to each Patient Safety Solution (PSS). In all cases where the UHB is currently reporting non-compliance, the UHB has further work to undertake against one or two elements of the PSS i.e. there is partial compliance with elements of each PSS. In all cases there are other mitigating factors in place to address the patient safety risks.

Since the last report to Committee in December 2017, the UHB has declared compliance with:

- PSA002 – The prompt recognition of treatment for sepsis for all patients
- PSA003 – Update to the NPSA alert for safer spinal (intrathecal), epidural and regional devices
- PSN034 – Supporting the introduction of the National Safety Standards for Invasive Procedures
- PSN035 – Risk of death and severe harm from ingestion of superabsorbent polymer gel granules

- PSN037 – Resources to support the safety of girls and women who are being treated with Valproate
- PSN038 – Risk of severe harm and death from infusing Total Parenteral Nutrition too rapidly in babies
- PSN039 – Safe Transfusion Practice – Use a bedside checklist
- PSN041 – Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders
- PSN042 – Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids

This means that current UHB compliance overall has increased from 90% compliant to 94% with current Patient Safety Solutions (46/49).

Details of the PSSs where the UHB remains non-compliant are given below (Table 1). This includes our position in comparison with our peers across Wales.

Table 1

Patient Safety Solution	**How do we compare with our peers**
PSA008 – Nasogastric tube misplacement: continuing risk of death and severe harm	As of July 2018 (the most recently available compliance data), Cardiff and Vale is one of 7 Health Boards reporting non-compliance.
PSN026 – Positive patient identification	Cardiff and Vale is the only Health Board reporting non-compliance. The timeframe to address this is outlined in Appendix 2. However the UHB will be fully compliant by December 2018.
PSN030 – The safe storage of medicines: Cupboard	The UHB is one of 7 Health Boards which has reported non-compliance with this notice. Only Velindre NHS Trust and Public Health Wales have reported compliance.
No 24 – Standardising wristbands improves patient safety	All other Health Boards in Wales to which the notice applies are already using electronically printed ID wristbands. Cardiff and Vale is the only Health Board that is non-compliant with this notice. However the UHB will be fully compliant by December 2018.

A summary of overall UHB compliance status is included at **Appendix 1.**

An improvement plan to secure compliance with outstanding notices is included at **Appendix 2**

Appendix 1 – Summary of Patient Safety Solutions for Cardiff and Vale UHB

Patient Safety Alerts				
PSA Ref.	**Date Issued**	**Title**	**Date for response to WG**	**Compliance Status**
PSA 008	May 2017	Nasogastric tube misplacement: continuing risk of death and severe harm	30/11/2017	**Non-compliant**
PSA007	January 2017	Restricted use of open systems for injectable medication	01/08/2017	Compliant
PSA006	January 2017	Risk of death and severe harm from error with injectable phenytoin	10/03/2017	Compliant
PSA005	July 2016	Minimising the risk of medication errors with high strength, fixed combination and biosimilar insulin products	14/10/2016	Compliant
PSA004	July 2016	Ensuring the Safe Administration of Insulin	28/10/2016	Compliant
PSA003	May 2016	Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices	01/07/2016	Compliant
PSA002	September 2014	The prompt recognition and initiation of treatment for sepsis for all patients	28/11/2014	Compliant
PSA001	June 2014	Legionella and heated birthing pools filled in advance of labour in home settings	30/06/2014	Compliant

Patient Safety Notices				
PSN Ref.	**Date Issued**	**Title**	**Date for response to WG**	**Compliance Status**
PSN045	August 2018	Resources to support safer modification of food and fluid	01/04/2019	(Not yet due for response)
PSN044	May 2018	Resource to support safer care for full-term babies	21/10/2018	(Not yet due for response)
PSN043	May 2018	Supporting the introduction of the Tracheostomy Guidelines for Wales	03/10/2018	(Not yet due for response)
PSN042	April 2018	Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids	11/06/2018	Compliant
PSN041	March 2018	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders	23/04/2018	Compliant
PSN040	January 2018	Confirming removal or flushing of lines and cannulae after procedures	12/09/2018	(Not yet due for response)
PSN039	January 2018	Safe Transfusion Practice – Use a bedside checklist	15/02/2018	Compliant
PSN038	October 2017	Risk of severe harm and death from infusing Total Parenteral Nutrition too rapidly in babies	08/12/2017	Compliant
PSN037	April 2017	Resources to support the safety of girls and women who are being treated with Valproate	06/10/2017	Compliant
PSN036	November 2017	Reducing the risk of oxygen tubing being connected to air flowmeters	04/08/2017	Compliant
PSN035	August 2017	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	16/10/2017	Compliant
PSN034	September 2016	Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSIPPs)	28/09/2017	Compliant
PSN033	June 2016	Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients	27/07/2016	Compliant
PSN032	May 2016	Risk of patient harm from an interaction between miconazole and coumarin anticoagulants	09/06/2016	Compliant
PSN031	April 2016	Risk of Patient Safety Incidents Resulting from Errors in the British National Formulary for Children 2015-2016 and British National Formulary 70	31/05/2016	Compliant

PSN030	April 2016	The safe storage of medicines: Cupboards	26/08/2016	**Non-compliant**
PSN029	March 2016	Standardising the early identification of acute kidney care	04/04/2016	Compliant
PSN028	February 2016	Medicines Reconciliation - Reducing the risk of serious harm	30/03/2016	Compliant
PSN027	February 2016	Risk of severe harm or death when desmopressin is omitted ordelayed in patients with cranial diabetes insipidus	08/04/2016	Compliant
PSN026	April 2016	Positive Patient Identification	13/05/2016	**Non-compliant**
PSN025	February 2016	Risk of death or severe harm due to inadvertent injection of skin preparation solution	04/04/2016	Compliant
PSN024	January 2016	Risk of using different airway humidification devices simultaneously	01/03/2016	Compliant
PSN023	January 2016	The importance of vital signs during and after restrictive interventions/manual restraint	12/02/2016	Compliant
PSN022	December 2015	The risk of harm from the inappropriate use and disposal of fentanyl patches	31/01/2016	Compliant
PSN021	December 2015	Risk of death and serious harm by falling from hoists	15/02/2016	Compliant
PSN020	October 2015	Minimising risks of omitted and delayed medicines for patients receiving homecare services	27/11/2015	Compliant
PSN019	August 2015	Harm from delayed updates to ambulance dispatch and satellite navigation systems	30/09/2015	Compliant
PSN018	August 2015	Risk of severe harm and death from unintentional interruption of non-invasive ventilation	31/08/2015	Compliant
PSN017	July 2015	Risk of using vacuum and suction drains when not clinically indicated	31/08/2015	Compliant
PSN016	July 2015	Risk of inadvertently cutting in-line (or closed) suction catheters	31/08/2015	Compliant
PSN015	July 2015	The storage of medicines: Refrigerators	31/08/2015	Compliant
PSN014	July 2015	Patient Safety Notice: Residual anaesthetic drugs in cannulae and	31/08/2015	Compliant

		intravenous lines		
PSN013	July 2015	Managing risks during the transition period to new ISO connectors for medical devices used for enteral feeding and neuraxial procedures	13/08/2015	Compliant
PSN012	May 2015	Advice sheet: Adrenal insufficiency (Addison's disease) in adults - information for general practitioners	12/06/2015	Compliant
PSN011	May 2015	Patient Safety Notice: Risk of associating ECG records with wrong patients	18/06/2015	Compliant
PSN010	May 2015	Patient Safety Notice: Failure to act on known contraindications to Low Molecular Weight Heparins	25/06/2015	Compliant
PSN009	April 2015	Awareness of NICE Clinical Guidelines on head injuries	28/05/2015	Compliant
PSN008	April 2015	Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	28/05/2015	Compliant
PSN007	April 2015	Risk of death or serious harm from accidental ingestion of potassium permanganate	31/05/2015	Compliant
PSN006	March 2015	Risk of hypothermia for patients on continuous renal replacement therapy	30/04/2015	Compliant
PSN005	December 2014	Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment	30/01/2015	Compliant
PSN004	December 2014	Risk of death and serious harm from delays in recognising and treating ingestion of button batteries	19/01/2015	Compliant
PSN003	December 2014	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	31/01/2015	Compliant
PSN002	July 2014	The Surgical Management of Urinary Incontinence and Pelvic Organ Prolapse	31/07/2014	Compliant
PSN001	July 2014	Risk of harm relating to interpretation and action on Protein Creatinine Ratio (PCR) results in pregnant women	31/07/2014	Compliant

Outstanding NPSA Notices			
Date Issued	**Title**	**Date for response to WG**	**Compliance Status**
June 2009	Risk to patient safety of not using the NHS Number as the national identifier for all patients	18/09/2009	Compliant
July 2007	Early identification of failure to act on radiological imaging reports	28/02/2008	Compliant
July 2007	Standardising wristbands improves patient safety	18/07/2009	**Non-compliant**

Appendix 2 - Action plan to address outstanding areas of non-compliance with Patient Safety Solutions

Reference	Title	Action required to secure compliance	By whom	By when
PSA008	Nasogastric tube misplacement	Address provision and uptake of competency-based training and a process for ongoing audit of compliance of the implementation of safety critical measures in the resource set provided.	Nutrition and Dietetics	December 2018
PSN026	Positive Patient identification	Review and revise Positive Patient Identification Policy Roll out the printed wristband solution. (see No.24 below)	Patient Safety team Patient ID Wristband Task & Finish Group	December 2018 October 2018
PSN030	The safe storage of medicines cupboards	The UHB is awaiting the publication of revised guidance form WG which is being issued due to widespread non-compliance across Wales with the requirements of this Notice. NB –the UHB has robust mitigation in place for the safe and secure storage of medicines which is subject to annual audit across the UHB, and to regular scrutiny during pharmacy visits and unannounced internal and external inspections	WG	Keep under review until revised guidance is issued
No 24	Standardising	Roll out the printed	Patient ID	October 2018

	wristbands improves patient safety	wristband solution.	Wristband Task & Finish Group	

CLEANING STANDARDS
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 18th September 2018

Executive Lead : Director Strategy & Planning
Author: Head of Estates & Facilities. Tel 029 2074 6593
Caring for People, Keeping People Well: This report underpins the Health Board's "Our Service Priorities" and "Sustainability" elements of the Health Board's Strategy.
Financial impact : Not Applicable
Quality, Safety, Patient Experience Impact: Cleaning review to ensure patients have a clean and safe environment to ensure optimum care.
Health and Care Standard Number 2.1 Managing Risk 2.4 IPC
CRAF Reference Number 5.1 5.1.5 6.2 6.4.8
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- KPI scores on Very High and High Risk areas are meeting targets

The Board is asked to:

- **AGREE:** Paper update content is appropriate and proportional.

SITUATION

The UHB monitors its cleanliness using the all Wales "Credits 4 cleaning" system, deployed across all sites. Areas and departments are categorised as being very high risk, high risk, significant risk or low risk based on the potential consequences to patient outcomes. For example the intensive care unit is a very high risk area. This system is currently undergoing an upgrade on an All Wales basis and will be more interactive with the clinical boards.

Cleanliness audits are undertaken weekly, with the 4 week average being used to determine for each clinical area, and as a UHB as a whole, whether the acceptable level of cleanliness has been achieved. This information is shared with each clinical board.

The UHB has set a priority for high risk and very high risk areas to ensure we get up to WG standard and meet targets as soon as possible.

WG Standard **Very High** Risk Areas	98%	Target
WG Standard **High Risk** Areas	95%	Target

BACKGROUND

Ensuring our estate is clean, is essential to achieving both good clinical outcomes and patient and their carers satisfaction with the environment of care.

Working in a clean, smart environment improves the morale of staff and can influence in general, behavior, culture and attitudes.

Any perception of lower standards of any of the UHB's estate and services does reflect badly on the reputation of the UHB and has an overall negative impact on patients, visitors, staff and overall culture and image.

Internal Audit has previously reviewed our cleaning standards and the C4C system and gave several recommendations relating to the National Standards for Cleaning in NHS Wales. The overall assurance back in 2017 was "limited Assurance". Most recommendations and risk were however on the meeting of the standards from a governance perspective and not a C4C clean ward and hospital perspective where the performance and cleanliness was of a high standard and meeting the required Very High and High Risk Standards on average.

Main IA findings were:

Management Audits not taking place jointly with Ward Managers and Facilities.
Old UHB Strategy and Operational Plan not meeting current standards.
Governance and assurance of the C4C score.
No Separate formal meeting with relevant parties discussing a standard agenda identified in the National Standards for Cleaning in NHS Wales.

ASSESSMENT AND ASSURANCE

Latest C4C Score Performance (As of August 8th 2018):

		4 Week Avg	13 Week Avg	Target
UHW	Very High Risk	**99.32%**	**98.96%**	98%
UHW	High Risk	**97.94%**	**97.69%**	95%
UHL	Very High Risk	**99.91%**	**99.86%**	98%
UHL	High Risk	**98.04%**	**98.14%**	95%

I am assured from the Cleaning Management Team that management audits are now in the main being achieved jointly with the Clinical Ward Management, and a system of reporting non conformance is in place.

A final draft of a new C&V UHB Cleaning Services Draft Plan is available and has been ratified by the Clinical Nursing Team. This document now needs to go to a Cleaning Forum to be signed off and actioned. This forum is still to be established with terms of reference.

C4C scores are being collated and reported each month, Clinical on some wards have asked for clip frames for display from a standard template showing the wards individual performance, whilst others have not requested frames as they intend to display on a standard notice board. Facilities Teams however are fulfilling the duty of sending out the scores each month.

Following success of some projects initiated within Capital, Estates & Facilities (CEF) Service Improvement Programme (SIP), for example: Implementing hand dryers and removing hand towels in non clinical areas have resulted in cleaning time savings which has in turn has enabled the teams to clean some of the main public areas which is a non funded service for no additional cost. This in turn will raise scores in our non-priority areas such as those in the significant category.

BLOOD PRODUCTS - HEALTH AND CARE STANDARD 2.8
Name of Meeting : Quality, Safety and Patient Experience Committee **Date of Meeting :** 18th September 2018

Executive Lead : Medical Director
Author : Consultant Haematologist and Blood Transfusion Lead
Caring for People, Keeping People Well : This underpins the UHB's principle of sustainability, making the best use of resources that we have and reducing waste , harm and variation.
Financial impact : Nil within the scope Standard 2.8 – with improving transfusion practices financial savings are potentially available to the organization.
Quality, Safety, Patient Experience impact : Ensuring the safe and appropriate delivery of blood products is central to high quality services and patient safety**.**
Health and Care Standard Number 2.8 Blood Products
CRAF Reference Number. 5.1 Deliver safe and effective care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current annual self-assessment for Health and Care Standard 2.8 is assessed as "Getting There" (appendix one).
- Evidence of continuing improvement is provided for 2018/2019

The Quality, Safety and Experience Committee is asked to:

- **AGREE** the report

SITUATION

This report is submitted to update the Committee on progress with Health and Care Standard 2.8.

BACKGROUND

In order to meet this standard people require timely access to a safe and sufficient supply of blood, blood products and blood components when needed.

The full list of criteria can be found here in section 2.8 of the Health and Care Standards.

ASSESSMENT AND ASSURANCE

The Committee is asked to note the following improvement actions have been identified as key deliverables for 18/19

The development of a 'Regulatory Compliance Group' within the Clinical Diagnostics and Therapeutics Division that will monitor key aspects of regulatory compliance of the Quality Management System.

Competency assessments for pre-transfusion sampling and the administration of blood products to be held within the Electronic Staff Record and discussed as part of annual PADR. Monitoring of the compliance position will be a standing agenda item at the Transfusion Group.

To strengthen the representation attending the UHB transfusion group and review the Terms of Reference.

The UHB to look towards the implementation of electronic blood tracking and electronic fating of blood products at the patient bedside.

It is noted that the assessment in the previous year was "Meeting the Standards". There is recognition of a significant amount of progress made with this service. However that there is increasing rigour around formal external inspection and the author recognizes that it is appropriate to record this Health and Care Standard as "Getting There" with further improvement expected from above actions for this year.

APPENDIX ONE
ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**2.8 Blood Management** **People have timely access to safe and sufficient supply of blood, blood products and blood components when needed**
B **Background**	**Please Confirm the rating from the following definitions*:*** **Getting there**
A	The UHW transfusion laboratory was inspected by the MHRA against the BSQR 2005 regulations in Dec 2017. Four major non conformities were identified. These are being addressed through an action plan. In April 2018 the transfusion laboratory was inspected as part of

Assessment	the haematology department by the United Kingdom Accreditation Service against the ISO 15189:2012 standards. Accreditation was maintained with very positive feedback from the inspectors. As part of the response to the MHRA inspection CD+T are developing a 'Regulatory Compliance Group' (see recommendations) The transfusion laboratory participates in the National Blood Stock Management Scheme and has a local procedure to optimise stock management. The UHB has a 'Blood and platelet shortage planning procedure' in line with national guidelines and successfully responded to the recent 'Amber' shortage of platelets. The response to the activation of the 'Massive haemorrhage procedure' is audited on each occasion. The clinical rating of the response is generally excellent. The procedure has been modified for patients presenting to the E.U Resus department. The UHB transfusion team is actively involved in incident management and investigation and reports all significant clinical incidents, including all externally reportable incidents to the UHB transfusion group. One never event has been reported to the Welsh government. This event involved a RBC unit being administered to the wrong patient, fortunately with no patient harm. The final version of the Serious Incident report and action plan is awaited. The transfusion team delivers education and training within the UHB including -Annual All-Wales half day standardised training and assessment to all year 5 medical students -Participation in Nurse foundation programme -Participation in I.V study days -Porter training and assessment -Assessor workshops x4 per year -Link Nurse Study Days The present system of recording which staff have successfully completed training and competency assessment is not robust and requires strengthening (see recommendations). The transfusion team participate in National Comparative audits. The UHB transfusion procedure is updated regularly in line with national guidelines The attendance at the UHB transfusion group is weak at times and this should be strengthened to improve the dissemination of lessons learnt from incidents, audits and national guidelines. (see recommendations) The UHB is represented on several All-Wales transfusion groups including the 'National Oversight Group', the 'Transfusion team all Wales group' and 'Transfusion manager group'. The cold chain and final fating of blood products rely on paper

	records. This is a potential weakness and requires significant time to maintain. It is recommended that these should be replaced by electronic solutions including electronic blood tracking and the electronic final fating of products by the patient bedside. There are several areas where the UHB has led the way in transfusion. The most notable being the OBS Cymru initiative.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for 18/19** The development of a 'Regulatory Compliance Group' within the Clinical Diagnostics and Therapeutics Division that will monitor key aspects of regulatory compliance of the Quality Management System. Competency assessments for pre-transfusion sampling and the administration of blood products to be held within the Electronic Staff Record and discussed as part of annual PADR. Monitoring of the compliance position will be a standing agenda item at the Transfusion Group. To strengthen the representation attending the UHB transfusion group and review the Terms of Reference The UHB to look towards the implementation of electronic blood tracking and electronic fating of blood products at the patient bedside.

NUTRITION AND HYDRATION REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 18th September 2018

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

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- The status report attached

The Quality, Safety and Experience Committee is asked to:

- **NOTE** progress on actions listed within the Patient Nutrition, Hydration and Catering experience management action plan particularly in relation to the model wards and the development work around the nutrition and dietetic service and speech and language service within the integrated team Emergency Unit.

- **BE ASSURED** that the Nutrition and Catering steering committee keep a regular review of the action plan to ensure and update on progress.

SITUATION

The Health Board is continuing to ensure that all elements of Nutrition and Hydration Standard 2.5 are being met as well as addressing the 10 key recommendations set out in the Public Accounts Committee report on Hospital Catering and Patient Nutrition. Excellent progress has been made in many areas notably staff catering and Public Health with reference to the ongoing delivery of the corporate health standard framework. A workshop was held in August 2018 to refresh the Hospital Restaurant & Retail Standards and identify next steps. A 1 year model ward project on 4 medical wards - C6 and A 4 UHW and E2 E8 UHL funded by the charitable funds will commence

from September 2018 following the success of last years' pathfinder project and associated outcomes.

Actions outlined in the action plan document are monitored, reviewed and reported to the Nutrition and Catering Steering Group which meet quarterly.

BACKGROUND

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

The extensive action plan developed by the Nutrition and Catering Steering committee pulls together all standards resulting in twelve core themes. It encompasses ongoing Health Board wide audits on assistance to eat, meal service (adults and paediatrics) and nutrition screening. Nutrition related training logs are also being collated on a monthly basis.

ASSESSMENT AND ASSURANCE

Timescales for implementation of the actions listed in the plan are continually reviewed. The actions to be taken are detailed in the implementation (contact author for copy). An inter-disciplinary group of Therapy, Nursing and Facilities colleagues collaborated to deliver a pilot model ward for Nutrition and Hydration project and identify and quantify what impact it could make on the patient's journey and UHB resource utilisation. The project has involved cross clinical board integrated working, and fits within the UHBs programme of transforming care and turning the curve.
Based on the results of the pathfinder pilot (see below) the UHB charitable committee has agreed to fund the model ward project for 1 year. 4 wards, A4, C6, East 2 and East 8 have been identified. Recruitment of the support workers for the 4 wards is underway. A Bevan commission application has been made for the model wards. We have engaged Research and Development regarding submitting a forthcoming research application for a patient and public benefit (RfPPB) grant .Following a session on results based accountability with CSI team including reps from nursing, finance and dietetics the following measurable outcomes were agreed:

1. Cost savings (reduced waste, staffing costs including sickness & bank, reduced LOHS)
2. Bed days
3. % Patients discharged to original place of residence
4. % Patients with pressure damage and UTIs
5. Patient satisfaction

A precursor to this work was the pilot of the nutrition and dietetic service in the Emergency dept within UHW. This work has been completed and the SBAR report attached. The work has been submitted to Steve Curry , Chief Operating Officer .

MEDICAL DEVICES, EQUIPMENT AND DIAGNOSTIC SYSTEMS HEALTH AND CARE STANDARDS UPDATE: 2.9

Name of Meeting : Quality, Safety and Experience Committee
Date of Meeting 18 September 2018

Executive Lead: Executive Director of Therapies and Health Science.
Author: Deputy Director of Therapies and Health Science
Caring for People, Keeping People Well: Medical Equipment is used in nearly every care pathway across all Cardiff and Vale UHB health systems and underpins the delivery of the majority of the UHB's service priorities. The effective life cycle management of Medical Equipment also supports the priorities outlined in 'Shaping Our Future Wellbeing'. It will enable clinical services to deliver outcomes that matter to people; it will improve service efficiency and sustainability, and the optimal use of the appropriate medical device supports prudent healthcare outcomes.
Financial impact: Effective system level Medical Equipment life cycle management processes are costly. The UHB does not have sufficient predictable capital or revenue funds to consistently deliver medical equipment management processes to the required standards. It is heavily reliant on adhoc Welsh Government 'end of year slippage' funding for medical equipment replacement.
Quality, Safety, Patient Experience impact: Having fit for purpose medical equipment available to deliver effective care when needed is a fundamental tenet of good healthcare.
Health and Care Standard Number: 2.9 Medical Devices, Equipment and Diagnostic Systems
CRAF Reference Number: 5.1, 5.1.6, 6.6, 8.1, 8.1.4 & 8.2
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- Action plan to the Welsh Audit Office Report.
- Capital Management Group work programme
- Medical Equipment Group work programme
- The medical equipment library

The Quality Safety and Experience Committee is asked to:

- **NOTE** the findings of the Welsh Audit Office progress report, the assessment of corporate level compliance to Health and Care Standard: 2.9 Medical Devices, Equipment and Diagnostic Systems and the outstanding medical equipment risks which require capital funding
- **SUPPORT** the recommended system level improvement activities.

SITUATION

The management of medical equipment is not a corporate function in the same way as other system wide enablers such as Estates or IT. It relies on a diffuse system level network of risk management structures, functions and processes. It does not have a predictable capital funding stream which is proportionate to the known medical equipment replacement risks. It does not have any dedicated central revenue funding stream to replace medical equipment and this function is devolved to the Clinical Boards. The medical equipment library does provide an effective central service for the management of a limited number of medical devices.

BACKGROUND

The Welsh Audit Office's "Review of Medical Equipment: Update on Progress – Cardiff and Vale University Health Board" report noted that The "*Health Board has made progress in addressing recommendations made in our 2013 report, but more action is needed to improve the arrangements in place for managing medical equipment."* The report does however provide assurance that *"The Health Board has adequate assurance and internal control processes for medical equipment, however, there is scope for improvement"* The report notes the main areas where further work is required are:

- The Health Board has not introduced a single medical equipment inventory
- There is no defined approach to the replacement of medical equipment under £5,000
- Clinical Boards do not review medical equipment issues/incidents
- The Health Board has introduced an integrated working approach for capital spending; however, collaboration across operational services regarding medical equipment is still a problem

A comprehensive action plan has been developed and is expected to be fully closed out by the 1st April 2019. The Artificial Limb and Appliance Service (ALAS) are also undertaking an extensive audit of compliance to the UHB's Medical Equipment Management Policy and the learning will be shared with all Clinical Boards as part of the annual Health and Care Standards Assessment Process.

The UHB was also subject to a follow up Welsh Government audit on the decontamination of endoscopes in August 2018. Whilst the verbal feedback received was not as positive as the previous audit, no significant patient safety risks were highlighted. The audit team acknowledged that there were significant opportunities for standardisation which would yield both safety and financial benefits. However the lead auditor felt that to achieve these benefits the existing fragmented decontamination services should come under a single management structure.

The Capital Management Group is regularly appraised by way of a report on the current status of medical equipment risks which will need capital funding to resolve. In 2017/18 the UHB received significantly less capital slippage

monies from WG than in previous years and although £3m was deployed, not all of the known high priority medical equipment risks could be addressed. As a result of this the UHB is currently holding £1.065m of known medical equipment replacement requirements against a £530K discretionary capital budget. This leaves the UHB exposed to a number of safety, performance, reputational and financial risks. Of the £1.065m the UHB has only developed partial solutions to address these risks:

£86K to provide networkable electroencephalogram (EEG) and electromyography (EMG) equipment. This will allow the UHB to deliver local neurophysiology services. This local service resilience will not extend to the regional service and therefore regional business continuity plans are being developed.

£215K for a theatre microscope and stack to enable the transfer of SSSU ENT to UHL. This has been agreed in principle but funds will only be released when we know that the equipment will be immediately deployed.

An 'invest to save bid' for £134K has been made to WG to install ultra-violet decontamination systems into ENT OPD. If this is unsuccessful this will have to be funded from the discretionary medical equipment budget as this was highlighted as an area requiring improvement during the recent WG decontamination audit.

The UHB has written to WG seeking additional capital funding but currently there are no firm plans to address the remaining equipment risks which include:

1. £250K replacement camera system required for minimally invasive mitral valve surgery which is a critical dependency to support a WHSSC commissioned service.
2. £50K TOE probe ultra-violet decontamination system required to commission the Cardiology OPD decontamination facility.
3. £60K CPET exercise machine to enable the transfer the surgical patient stress testing service to UHL. This will enable a move for pre-admission and Heulwen ward on the UHW site to create space for the winter ward at UHW improving flow and operational performance compliance.
4. £135K replacement of our end of life fibroscan units which are ultrasound liver diagnostic devices.
5. A further £135K to replace all end of life neurophysiology equipment with networkable equipment at C&VUHB to ensure robust local resilience. CTUHB and ABUHB will require their own networkable equipment for regional service resilience. We are not responsible for this and this is something that is being raised with both Health Boards.

These five issues are being included on the CRAF as specific medical equipment risks.

It must also be acknowledged that the UHB is managing a significant stock of equipment which is obsolete, inefficient, on best endeavours maintenance or is a single point of failure with no robust business continuity plans available. It is highly likely that during 2018 / 19 there will be a time in the near future where there is no budget to purchase equipment which unexpectedly fails or is damaged beyond repair.

Notable improvements during 17/18 include:

Positive feedback from the WG national audit of UHB sterile service departments
Replacement of all Cardiac Defibrillators
Replacement of the entire UHB bed and mattress stock to a standard low profile specification
All pathology laboratories are fully UKAS accredited.
Replacement of critical care ventilators
Replacement of cardiac echo machines

Improvement actions for 18/19:

Refresh and Strengthen Executive / Clinical Board medical equipment management infrastructure.
Develop a medical procurement officer role.
Develop a UHB wide integrated medical equipment risk register.
Develop a central management model for decontamination.
Explore a integrated medical equipment manage service including expanding the medical equipment library.

ASSESSMENT AND ASSURANCE

The assessment of compliance with Health and Care Standard 2.9 Medical Devices, Equipment and Diagnostic Systems was compiled by the Clinical Board Medical Device Safety Officers and coordinated through the UHB's Medical Equipment Group. Funding for both capital and non-capital items is still the major risk to sustainable service delivery, compliance to national performance standards and assured patient and user safety. Therefore it was considered that on balance and taking into account the views of the WAO a fair assessment the current corporate level of compliance would be '**Getting There**'.

However noting the risks highlighted in this paper it is difficult provide robust provide assurance that there will in future be a sustained improvement in the management of medical equipment to the required standards to enable progression to 'Meeting the Standard' or 'Leading the Way'. Also the Deputy Director of Therapies and Health Science who has been coordinating medical equipment management improvement activities at a corporate level and is also the UHB's decontamination lead is being seconded into another position within the UHB. This further reduces the limited central capacity and expertise to manage medical equipment.

However there are system level opportunities which will mitigate these issues and provide a vehicle to make a step change in performance.
We will develop a model for a centrally managed decontamination service, and will work through opportunities to expand the inventory of the medical equipment library. In addition we will explore the creation of a medical equipment management service by pulling together expertise within the UHB which exists in different Clinical Boards. This will be further explored with the Management Executive.

The UHB is also currently recruiting a medical device procurement office who will look for opportunities to standardise devices and consumables, recommend additional devices to be incorporated into the medical equipment library to improve efficiency and reliability, and to highlight opportunities for managed service contracts for medical equipment which will improve clinical outcomes, improve service resilience and reduce costs.

PROTECTING PATIENTS FROM PRESSURE DAMAGE
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 18th September 2018

Executive Lead : Executive Nurse Director
Author : Deputy Executive Nurse Director Jason.roberts@wales.nhs.uk 029 2184 6167
Caring for People, Keeping People Well : Prevention of pressure ulcers and provision of evidence based treatment if they have occurred will improve the patient experience.
Financial impact : Failure to provide an acceptable standard of care can expose the UHW to compensation claims and litigation which will an adverse financial impact upon the UHB.
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.
Health and Care Standard Number : 2.2 Prevention Pressure and tissue Damage
CRAF Reference Number : 5.1.12
Equality and Health Impact Assessment Completed: No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The range of actions being taken to reduce the occurrence of pressure damage.
- The measures being taken to improve the quality and rate of reporting to establish a reliable baseline.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** progress and the actions undertaken to help prevent the occurrence of pressure ulcers.

SITUATION

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

- Promoting consistency and performance reporting against Welsh Assembly targets for zero tolerance to pressure damage.
- Providing guidance on when pressure damage meets the threshold for referral into adult safeguarding processes.

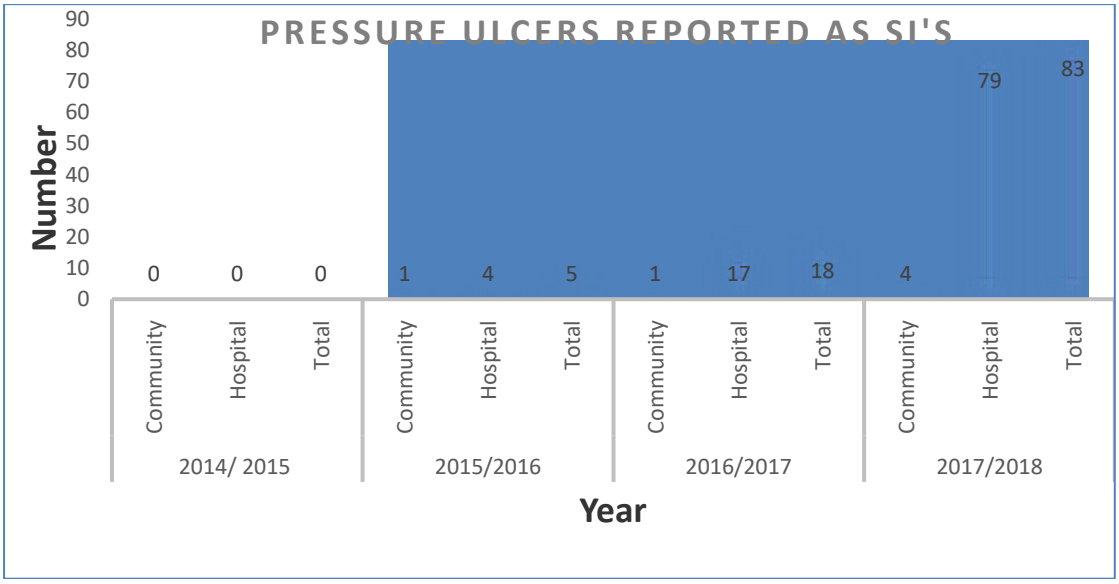
- Facilitating effective learning to enable the risk of further patients suffering the same harm to be reduced.
- Ensuring staff are educated to understand preventative measures and assess pressure ulcers.

The purpose of this report is to provide the Quality Safety and Experience Committee with a summary of ongoing actions in relation to the management of healthcare acquired pressure ulcers in Cardiff and Vale University Health Board. The paper seeks to assure the Committee that action is being implemented which aims to reduce the number of hospital acquired pressure ulcers by improving the reporting and root cause analysis of pressure ulcers, improving knowledge and practice and the prudent use of resources.

BACKGROUND

Pressure ulcers are painful and debilitating and, if left untreated, can lead to serious harm and death. Every year up to 20% of patients in acute care in England and Wales are affected by pressure ulcers. Since 2005, the NRLS has received around 75,000 reports of patient safety incidents relating to pressure ulcers, yet a growing body of evidence suggests these are largely preventable. Preventing them will improve care for all vulnerable patients and reduce inpatient stays and by preventing them in a community setting would reduce complications such as infection and reduce hospital admissions.

The UHB reported 83 Serious Incidents to Welsh Government in relation to Health Care Acquired Grade III, Grade IV or unstageable pressure damage between April 2017 – March 2018. The below graph shows the increase in the number of WG reportable pressure damage over the last four years. The increase in this reporting is due to a heightened awareness of the reporting arrangements and changes to the criteria for the Serious Incident reporting process which were made during 2016.



However a recent UHB audit was carried out in January 2018 by our Tissue Viability Nurses (TVN), supported by Medstrom in which every inpatient with a Waterlow score of over 15 (1576 patients) was review over a two-day period. The audit has shown that despite an increase in the number of pressure damage SI's reported to WG the UHB has reduced its hospital acquired pressure ulcer prevalence considerably over the last five years from 9.1% in 2013 to 3.1% in 2018. See below result:

	2013	2014	2015	2018		2013	2014	2015	2018
Number of Patients	1495	984	1650	1576	Total Number of Pressure Ulcers	263	134	179	146
Number of Patients with Pressure Ulcers	201	95	153	117	Overall Prevalence	13.4%	9.6%	9.27%	7.4%
Number of Patients with Hospital Acquired Pressure Ulcers	136	61	88	50	Overall Prevalence Hospital Acquired	9.1%	6.2%	5.33%	3.1%

PU Category	2013		2014		2015		2018	
Category I	82	31%	36	27%	59	33%	34	23.3%
Category II	131	50%	59	44%	80	45%	40	27.4%
Category III	24	9%	20	15%	16	9%	34	23.3%
Category IV	26	10%	9	7%	22	12%	10	6.9%
Deep Tissue	Not Used		5	3%	Not Used		6	4.1%
Unstageable	Not Used		5	3%	2	1%	22	15%

For noting, the increased occurrence of grade III damage since 2015 is due to a change in the grading criteria for grade III damage from the EPUAP. Any pressure ulcer no matter how small which has slough to the wound bed is required to be categorised as a grade III, previously these Pressure ulcers may have been categorised and as grade II.

ASSESSMENT AND ASSURANCE

Since February 2017 the Pressure Damage group have met monthly in order to progress the improvement work into the management of pressure damage to include:

- Assisting with the development of the All Wales Pressure Ulcer Reporting and Investigation Tool via the TVN Network to support the overall

compliance with and learning from clinical incidents. This is still in draft format awaiting sign off on an all Wales basis.

- The Safeguarding Team have updated their Standard Operating Procedure for the Management of Pressure Damage (PD) Grade 3, 4 and Unstageable cases to ensure that all staff are aware of their requirements to report these via the safeguarding route.

- Revisions have been made to the Health Board Policy and Procedure document on the management of pressure damage to reflect current International and National Guidance on Pressure ulcer assessment prevention and treatment.

- The UHB Mental Capacity assessment documentation has been reviewed and updated to ensure that it is still fit for purpose.

- Support from the Continuous Service Improvement Team has been set up to look and progress with the process mapping of pressure damage incident reporting and will specifically focus on the consistency of documentation completion of pressure damage; accuracy of pressure damage grading and duplication of incident reporting.

- The CNS's for wound healing continue to provide education sessions and bespoke teaching on the wards and in the community setting. This is in addition to the work completed by practice educators within Clinical Boards. The CNS team have reviewed the training they provide to ensure it is fit for purpose and have relaunched the Wound Link Nurse role.

- A Clinical dashboard has been developed (launched in May 2018) which enables a core dataset of indicators including pressure damage occurrence to be displayed in one area, highlighting errors in reporting, duplication of reporting and gaps in reporting. The underlying assumption is that ownership of data at a ward level will improve data quality.

- Updating UHB documentation in relation to the reporting of Serious Incident pressure Damage has been updated to ensure that it reflects the recent implementation of the safer staffing Act.

- A pressure damage passport for patients who have pressure damage and are being transferred in or out of Hospital is currently being trialled.

- Complexities around the Bed Management Contract are being reviewed with procurement and have been instrumental in gaining funding to be able to replace every bed (apart from speciality areas such as critical care and maternity) in the Health Board to a MMO 500 low rise bed along with a Promatt mattress. Work is progressing via the task and finish group and the medical company supplying these beds and mattresses are rolled out across the UHB in a structured fashion ensuring that staff are trained on the use of new Promatt mattresses which has replaced the older Primo Surface before the product is put in.

- Medicine Clinical Board have developed and trialling the use of stickers to be placed in the medical notes to highlight when an e-datix has been completed. The aim of this is to reduce duplication of reporting.

- The Tissue Viability team have developed an information sheet for patient and their families to highlight the risk of pressure damage.

- The development of guidance to improve the rate and quality of the reporting of pressure damage in community settings. This has been associated with a programme of education and training and has already resulted in improved reporting of pressure damage.

SAFEGUARDING UPDATE: CHILD PRACTICE REVIEW
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting**: 18 September 2018

Executive Lead: Nurse Director, Cardiff and Vale UHB
Author: Head of Safeguarding - 029 218 32001
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy. Further information can be found on the Safeguarding web pages of the UHB.
Financial impact: There are no financial implications associated with the actions currently being taken as identified within this report.
Quality, Safety, Patient Experience impact: Not Applicable
• **Health and Care Standard Number** Care Standards for Wales - Standard 2.7- Safeguarding Children and Safeguarding Adults at risk and the National Quality Outcomes Framework for Safeguarding Children
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Safeguarding training and raising awareness across the Health Board encompassing all safeguarding themes
- The number of appropriate safeguarding referrals made
- Consistent approach across the Health Board
- Good working partnerships with statutory agencies

The Quality, Safety and Experience Committee is asked to:

- **NOTE** this report

SITUATION

This report aims to give the committee an overview of the Regional Safeguarding Board, Extended Child Practice Review (CPR) that has recently been published and shared with members of the public through a press conference on 2nd August 2018

BACKGROUND

The review was agreed at the Regional Safeguarding Board (RSB) Child and Adult Practice Review Sub-Group in April 2016 and the process commenced. However there were delays due to both the case going through Crown Court during November 2017 and the retirement of the original Chair of the CPR panel.

Subsequently the adoptive father was found guilty of murder and was committed to life imprisonment in November 2018.

A health chronology of all health contacts was completed and shared with partner agencies on 20/10/17. The chronology collated information from the period of: 1st September 2014 - 29th May 2016 as agreed by the CPR panel.

ASSESSMENT AND ASSURANCE

It was clear from this chronology that there were learning points and processes within health that required further scrutiny. The Deputy Nurse Director discussed this with the Executive Nurse Director and agreed that a discussion with Local Authority and Police should take place to establish their agreement that an internal action plan would be appropriate to learn immediate lessons and consider changes in practice ahead of a CPR action plan. This was agreed and a health action plan was developed. Meetings were held between safeguarding, child health, paediatricians and radiologists. The action plan is now complete and practice has changed as a direct result of robust scrutiny of the action plan.

The Regional Safeguarding Children Board (RSCB) commissioned Independent Reviewers to complete the CPR report, an independent Chair was also commissioned in January 2018. There were two learning events held - one for practitioners and one for managers in March 2018. Involved practitioners from each agency were invited to attend. The Health Visitor did not attend, as, by this time she had left the organisation and worked elsewhere. There is an on-going NMC investigation, awaiting completion of the final report.

The Safeguarding team arranged a Police de-brief for over 30 staff that were involved in some capacity with the Court case. This took place on 30th April 2018; 3 members of staff attended.

Following a number of CPR panel meetings the report was presented at an Extraordinary RSCB meeting on 29th June 2018. There are nine recommendations in total, the one recommendation exclusive to health is:

"A child who has been placed for adoption and presents at hospital with an injury should be overseen by a Paediatrician with safeguarding experience and training"

A communication strategy meeting was held on 6th July 2018 including all involved agencies and the respective communication teams. Following much discussion it was agreed that there would be a joint statement released from all agencies and presented by the RSCB.

A multi-agency action plan has been completed and is ready for RSCB sign off. The UHB will need to give assurance to the RSCB in November 2018 at the next Board meeting that actions have been implemented in line with the time frame. This is on course to be achieved by the UHB.

RECOMMENDATIONS

- CPR report to be shared through the UHB Safeguarding Steering Group
- Request that the report is acknowledged at Clinical Board Quality & Safety meetings
- Ensure implementation of the health action plan across each involved Clinical Board
- Head of Safeguarding to complete a presentation for use across each Clinical Board. This will ensure that a consistent message is disseminated and lessons learnt are clear to each practitioner
- RSCB Learning Workshop for Child and Adult Practice Reviews information, to be shared with Clinical Boards to ensure diverse attendance from across the UHB
- Introduce audit 2018-19 to establish method of monitoring key areas across the UHB to ensure compliance with the RSCB Action plan and the UHB Health Action plan.

OMBUDSMAN PUBLIC REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 18 September 2018
Executive Lead : Executive Nurse Director
Author Angela Hughes, Assistant Director of Patient Experience Tel 029 21846108 **angela.hughes5@wales.nhs.uk**
Caring for People, Keeping People Well : avoid harm , Waste and Variation
Financial impact: The Health Board has both a patient safety Quality and experience commitment in line with a financial responsibility for the effective investigation and management of claims.
Quality, Safety, Patient Experience impact : this was an example of the significant impact of a proplonged waiting time on a patients quality of life
Health and Care Standard Number 3.1 Safe and Clinically Effective Care and Standard and 6.3 Listening and Learning from Feedback
CRAF Reference Number Delivering outcomes that matter to people
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION
ASSURANCE is provided by:

- the completion and evidence of the implementation of the recommendations
- The improved and sustained position of the Clinical Board in relation to referral to treatment times

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report for information

Situation

Report link Ombudsman report

On 27 July 2018 the Ombudsman issued a section 16 Public report against Hywel Dda Health Board and Cardiff and Vale University Health Board**.** Under the Public Services Ombudsman (Wales) Act 2005, the Ombudsman can issue one of two types of reports following an investigation into a complaint by a member of the public that they have suffered hardship or injustice through maladministration or service failure on the part of a public body.

The first type of report (known as a Section 16 report) is issued when the Ombudsman believes that the investigation report contains matters of public interest. The body concerned is obliged to give publicity to such a report at its own expense.

The second type of report that the Ombudsman can issue is known as a Section 21 report. He can do so if the public body concerned has agreed to implement any recommendations he has made and if he is satisfied that there is no public interest involved.

Background to the report

Mr B complained about the care given to his son ("Mr. C") he had been referred aged 11 from Hywel Dda Health Board for specialist nephrology surgery. Mr C received surgery some 151 weeks (two years ten months and twenty days) after he was referred for treatment. During that time he suffered frequent infections, which required antibiotic treatment, and an open wound on his side which had to be dressed three times per week. It was accepted in the initial response to the concern that the waiting time was unacceptable. However the clinical advice at that time had been that more urgent cases with a salvageable renal function had been made a priority on the waiting list. The Ombudsman's clinical expert advisor was of the view that the recurrent infections caused by the presence of the non functioning kidney should have been considered as this had an extremely negative impact on this young man's quality of life. The Health Board accepts that the impact of these factors upon this young patient's quality of life should have prompted earlier surgical intervention.

A further criticism was the failure to regularly review Mr C whilst on the waiting list or to ensure that the referring Health Board was undertaking regular clinical reviews. The criticism is accepted that there was a failure to escalate to the referring Health Board when there was a delay in being able to undertake the surgery so that alternative referrals / options for surgery could have been considered.

The Health Board has accepted the report in its entirety. The Health Board in line with the recommendations will review the complete pathway of care for Mr C from 2009. The Health Board will review the process for communication with referring health boards in relation to paediatric surgery. We will undertake a retrospective audit of the management of all urgent referrals on this consultant's waiting list who have been referred since June 2014 this review will be done by an independent Consultant Paediatric Urologist. If it is established that the waiting list has not been appropriately managed or there are other cases where due to their circumstances, a patient should have been afforded greater clinical urgency, we will create an action plan to address the concerns.

The Health Board will provide evidence to the Ombudsman that it has complied with the recommendations.

There were recommendations for both Health Boards

ASSESSMENT AND ASSURANCE

An action plan has been developed to monitor compliance with the recommendations**.** For reassurance the Clinical Board for Children and Women have demonstrated an improved and consistent performance in relation to RTT (Referral to treatment time) and currently there are not any children on the waiting list who have exceeded the 36 week target.

SAFEGUARDING ANNUAL REPORT 2018
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting**: 18th September 2018

Executive Lead: Nurse Director, Cardiff and Vale UHB
Author: Head of Safeguarding - 029 218 32001
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy. Further information can be found on the Safeguarding web pages of the UHB.
Financial impact: There are no financial implications associated with the actions currently being taken as identified within this report.
Quality, Safety, Patient Experience impact: Not Applicable.
• **Health and Care Standard Number** Care Standards for Wales - Standard 2.7- Safeguarding Children and Safeguarding Adults at risk and the National Quality Outcomes Framework for Safeguarding Children.
Equality and Health Impact Assessment Completed: Not Applicable.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Safeguarding training and raising awareness across the Health Board encompassing all safeguarding themes
- The number of appropriate safeguarding referrals made
- Consistent approach across the Health Board
- Good working partnerships with statutory agencies

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** this report

SITUATION

This purpose of this report is to present the Quality Safety and Experience Committee with the Safeguarding Annual Report for the period April 2017 through to March 2018.

BACKGROUND

The report provides an overview of safeguarding activity across the University Health Board highlighting the diverse, evolving landscape of the multi-agency safeguarding field.

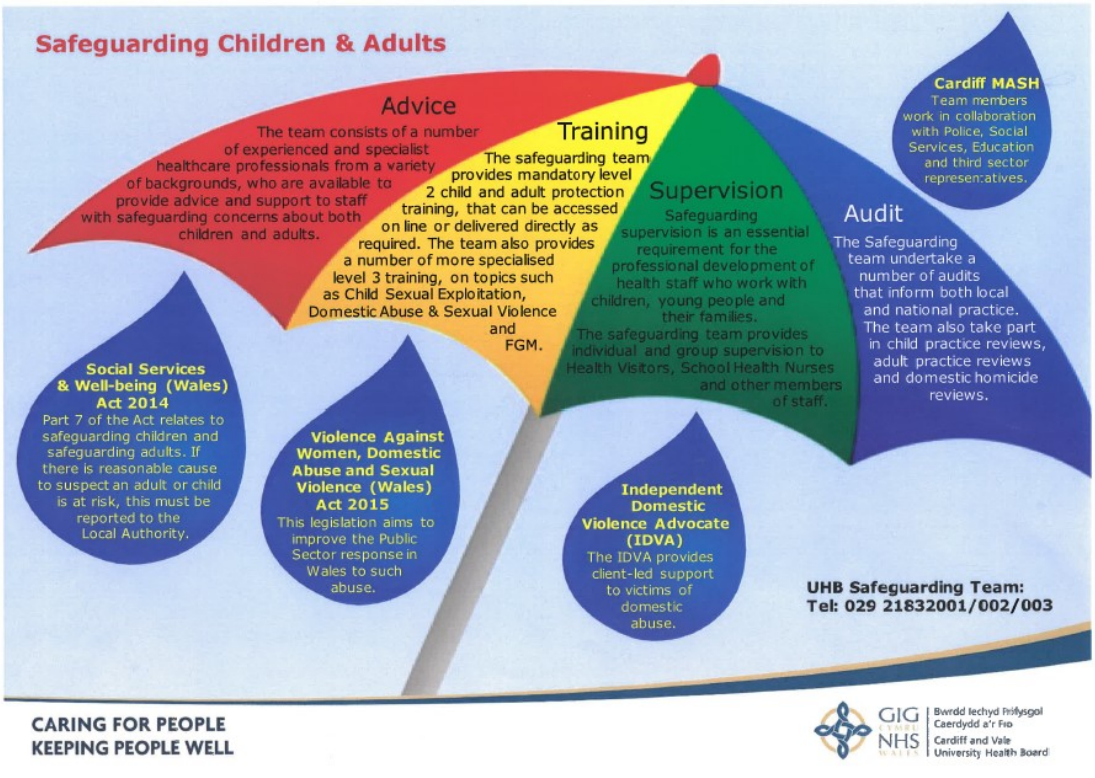
ASSESSMENT AND ASSURANCE

Topic areas covered and included in the Annual Report are the core areas of safeguarding awareness - these are training, audit, research, supervision and expert advice. In addition the report demonstrates the achievements made over the past year and the progress made.

The breadth and depth of safeguarding children and adults at risk is captured in the report emphasising that it is everybody's business and that a multi-agency approach to safeguard people is required. Areas of work where partnership working to enhance service delivery is unfolding, is evident in work undertaken with Female Genital Mutilation (FGM), County Lines and the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Regional Strategy.

Cardiff and Vale University Health Board

Safeguarding Children and Adult's at Risk Report 2018



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1. Introduction

The 2017 Cardiff and Vale University Health Board Safeguarding report portrayed a forecast for the coming year following the integration of the corporate Safeguarding Team. Areas highlighted formed part of the work plan for the team to ensure that progress has been made and projected development is maintained. The forecast areas are shown to demonstrate advancement made:

- The appointment of a Head of Safeguarding: *Appointment made*
- Appointment of a Senior Nurse Safeguarding: *Appointment made*
- Continuing to build on the improved training figures: *Improvements demonstrated especially in Domestic Abuse training*
- Strengthening links with each Clinical Board through alignment of a Safeguarding Nurse Advisor: *Achieved, Safeguarding Nurse Advisors are attending CB Quality & Safety meetings twice a year to give a safeguarding update*
- Successful evaluation and roll out of safeguarding group supervision with the Health Visitor service: *Achieved, Cardiff University has completed a positive pilot evaluation, the group supervision will commence in September 2018*
- Regular safeguarding supervision for Clinical Board DLMs and development sessions: *Achieved, both the Head of Safeguarding and the Senior Nurse are meeting with DLMs and Lead Nurses on a regular basis*
- Ensure that robust and effective information is shared with all practitioners to improve the quality of safeguarding referrals for children and adults at risk: *This is on-going work across the UHB*
- Safeguarding Nurse Advisors attending Paediatric Peer Supervision: *Achieved, Safeguarding Nurse Advisors are attending monthly meetings*
- Developing reasonable assurance that training data for Mandatory Safeguarding Training is supported by CB Training Needs Assessments to measure compliance: *This is on-going work with Learning and Education Department and Clinical Boards*
- Plan, deliver and implement Domestic Violence training as set out in the Welsh Government National Training Framework five year plan: *Achieved, the total number of staff trained at Group 1 has increased to 62% during this year*
- Continue to develop and deliver FGM training across the UHB to targeted groups: *This work has been extremely successful, developments are shared with Public Health Wales National Safeguarding Team*
- Work in partnership with our Regional Safeguarding Board partners to deliver on targeted priority areas: *Safeguarding Nurses are participating in all aspects of the Regional Safeguarding Board work plan*
- Notify the Executive Board of any priorities raised by the National Safeguarding Board: *Achieved, the Executive and Deputy Nurse Director are updated accordingly by the Head of Safeguarding*
- Participate in the multi-agency local strategy for domestic violence: *Achieved, a draft copy of the report has been shared with the UHB Executive Board. The UHB has participated fully in the development of the regional strategy*

- Work collaboratively with the National Safeguarding Team to design an improve the Quality Outcome Framework (QOF) for children and adults at risk: *Achieved, an updated Safeguarding Maturity Matrix for use in 2018 has been shared with the UHB Safeguarding Steering Group*

To continue to improve and develop, the Safeguarding Team will consider the growing population of the region to guarantee that the local public health plan for 2018-21 is respected and provides a bench mark for safeguarding service delivery. The current report states that the Cardiff and Vale Integrated Medium Term Plan (2018-21), the Population Assessment for Cardiff and Vale (2017) and the Well-being Assessments (2017) for Cardiff and Vale of Glamorgan, suggests that the population of Cardiff is growing at nearly 1% per year, the population of Cardiff and Vale is expected to exceed 5000,000 in 2020. The average age of people in the region is increasing and expected to increase for those over 85 years by 15% over the next five years and nearly 40% over 10 years. The region is recognised as one of the most ethnically diverse populations in Wales, with one in five people from a black or minority ethnic (BME) background. These statistics as well as health inequalities identified in specific neighbourhoods across Cardiff and the Vale of Glamorgan impact on safeguarding and well-being of individuals and families, resulting in targeting service to meet demand.

To promote the safeguarding agenda the corporate team consists of:

- Head of Safeguarding
- Named Doctor for Safeguarding Children
- Senior Nurse Safeguarding
- Safeguarding Nurse Advisor x 6
- Safeguarding Nurse Advisor (Flying Start)
- Safeguarding Nurse Advisor (Midwifery Services)
- Safeguarding Trainer/ Nurse Advisor
- Specialist Safeguarding Liaison Nurse
- Health Independent Domestic Violence Advocate (IDVA)
- Administration Team

Safeguarding governance structure sits within the portfolio of the Executive Nurse Director and the Deputy Executive Nurse Director.

The Safeguarding Team work area covers the Noah's Ark Children's Hospital at the University Hospital of Wales, Cardiff Multi Agency Safeguarding Hub (MASH) and the main office for advice and queries based at Global Link, Cardiff Bay. The Cardiff Multi Agency Safeguarding Hub (MASH) launched in July 2015, hosted by South Wales Police at Cardiff Bay Police Station. Agencies located within the MASH include Cardiff Local Authority (LA) Children & Adult services, South Wales Police, Cardiff Local Authority Education, Health, Probation and CRC services. The purpose of the MASH is to ensure that safeguarding of children, adult's at risk and domestic abuse has a timely, appropriate and multi-agency response and approach. By co- locating agencies and providing a platform to share information immediately that a concern is

raised, safeguarding measures are considered and put in to place immediately or within 24 hours. Two safeguarding nurse advisors work within the MASH, sharing appropriate health information to ensure the safety of children and adult's at risk across the UHB locality.

The implementation of the Social Services and Well-being Act (Wales) 2014 (SS&W-b A) and the Violence against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) has determined much of the safeguarding work undertaken across Wales. Ensuring that both Acts are implemented within the organisation has been a priority due to the duty to report and investigate, provide awareness raising training, supporting all staff to undertake their duty, recognise their responsibility and encourage partnership working with other statutory agencies. The Welsh Government (WG), National Training Framework five year plan for Group 1, 2 and 6 has been submitted and reflects the UHB's commitment to deliver the raising awareness training across the organisation in line with WG expectation.

In addition to the Acts there has been the introduction of Home Office Mandatory Reporting of Female Genital Mutilation in October 2015 and Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) under section 9 (3) of the Domestic Violence, Crime and Victims Act (2004). The Well-being of Future Generations (Wales) Act 2015 requires the development of Public Service Boards (PSBs) in each local authority area. PSBs are responsible for assessing the well-being of the local population, the Board agrees for a Domestic Homicide Review (DHR) to be commissioned.

The Safeguarding Team continues to work to provide assurance to the Executive Board that the UHB is discharging its duties in line with Health Care Standards (2.7 Safeguarding). The current corporate assessment for the UHB is: *Leading the Way.* This is an improvement from the previous year and demonstrates the collective progression made by all Clinical Board's (CB) during the year.

The governance arrangements of the Safeguarding Team is unchanged. The Deputy Executive Nurse Director chairs the Safeguarding Steering Group on a bi-monthly basis. The meeting has a multi-professional membership from across all UHB Clinical Boards and Statutory Agency partners. This reflects the ethos of safeguarding being everybody's business and provides assurance to the Board that the safeguarding agenda is being progressed in line with legislative duties and best practice.

Effective safeguarding relies on good working partnerships with other agencies utilising an open and transparent approach. This is reflected by the corporate Safeguarding Team whilst working within the UHB, also work undertaken with GP's, Local Authority, Police, Education, Probation and Third Sector agencies. Since the introduction of the Cardiff MASH the safeguarding referral process across the UHB has been restructured and is transferred to LA and Police by the Safeguarding Team electronically via secure e-mail. Safeguarding referrals continue to be more complex resulting in additional staff time in support and supervision of cases, involving more strategy discussions/ meetings, multi-agency investigations and often legal advice.

The 2018 Safeguarding Report will consider the work stream from April 2017 to March 2018, demonstrating and evaluating the breadth of the safeguarding agenda

and the progression made across the UHB. A summary of the collective safeguarding work undertaken with the Cardiff and Vale Regional Safeguarding Board (RSB), The VAWDASV Regional Strategy and Public Health Wales, NHS National Safeguarding Team validates the enormity of the safeguarding agenda across the region and Wales.

The safeguarding agenda is a continuously evolving schedule where emerging themes are highlighted sometimes through our police colleagues or media interest. During 2017 we were notified of a concerning police development around “County Lines” involving young people and vulnerable adults being exploited across the region. Additional training for specific disciplines and departments across the UHB has been scheduled to address the concerns raised for UHB staff and departments providing frontline services.

Meeting the demands of the growing activity surrounding the depth of safeguarding is a constant challenge for the Executive and Deputy Nurse Director’s and the corporate Safeguarding Team. Ensuring that the UHB is compliant with the legislation is a priority area, however maintaining the ethos of the UHB value and behaviours must be considered when work is undertaken with individuals, families and UHB staff.

2. Training

Safeguarding Training Programme

The Safeguarding Training Programme is developed, reviewed and delivered by Safeguarding Team members and agreed with Learning and Educational Department (LED) to ensure staff are offered adequate levels of safeguarding children and safeguarding adult training sessions to comply with the Mandatory Training, UK Core Skills Training Framework and the Safeguarding children and young people: roles and competences for health care staff, Intercollegiate Document (ICD 2014). Level 2 Safeguarding Children and Level 2 Safeguarding Adults training is also available to complete online via ESR.

The Safeguarding Team provides a number of class room based training sessions and study days. Topics include the following:

Level 2 safeguarding training:

- Level 2 Safeguarding Children (half-day)
- Level 2 Safeguarding Adults (2.5 hours)

Level 3 Safeguarding Study days:

- Level 3 Child Sexual Exploitation
- Level 3 Safeguarding Current Themes
- Level 3 Violence Against Women, Domestic Abuse & Sexual Violence Level 3
- Legal Aspects of Safeguarding
- Level 3 Parental Mental Health and the Impact on Children

- Level 3 Safeguarding Adults

Safeguarding Adults & Adults at Risk training day

This training day has been developed with the aim of increasing training compliance for the following four training subjects - Level 2 Safeguarding Adults, Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) training.

Female Genital Mutilation training

The Safeguarding Team delivers bespoke classroom based training sessions on the topic of Female Genital Mutilation (FGM).

Safeguarding Training Data

Table 1 and **Table 2** below identify Safeguarding Children and Safeguarding Adults Level 1 and Level 2 training completed by staff online or by attending classroom based training. The training data is provided by LED. More specific safeguarding training compliance data is available for each Clinical Board through LED and ESR.

Table 1: Safeguarding Children training			
Number and percentage of staff compliant with Safeguarding Children training at 31st March 2018:			
Level of training	**Headcount** (UHB Total)	**Number trained**	**% trained**
Level 1* *Online training only*	15021	9788	65.16%
Level 2** *Online and classroom based training*	15021	3761	25.04%
Note: • **Level 1 training is relevant for all staff working in health care settings.* • ***Level 2 safeguarding children training sessions are relevant for the following staff to attend/complete i.e. all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers. (Source: ICD, 2014)*			

Table 2: Safeguarding Adults training			
Number and percentage of staff compliant with Safeguarding Adults training at 31st March 2018:			
Level of training	**Headcount** (UHB Total)	**Number trained**	**% trained**
Level 1* *Online training only*	15021	8656	57.63%

Level 2** *Online and classroom based training*	15021	6728	44.79%

Note:

- **Level 1 training is relevant for all staff working in health care settings*
- ***Level 2 safeguarding adults training is relevant for the following staff to attend/complete i.e. all staff that have regular contact with patients, their families or carers, or the public. This is the minimum level of competence for all professionally qualified healthcare staff.*

Additional safeguarding training sessions

Table 3, below, lists additional, Level 2 and Level 3, Safeguarding training sessions and study days delivered by the Safeguarding Team in 2017/18:

Table 3: Additional training sessions delivered, by staff group			
Level 2 Safeguarding training			
Level and type of training	**Staff Group**	**Number of training sessions**	**Total number of staff/professionals in attendance**
Level 2 Safeguarding Children	Nurse Foundation Programme	03	72
Level 2 Safeguarding Children	Child Psychology	01	16
Level 2 Safeguarding Children	Ophthalmology	01	30
Level 2 Safeguarding Children	Psychiatrists	01	40
Level 2 Safeguarding Children	Student Physiotherapists	01	55
Level 2 Safeguarding Children	Undergraduate Dentists	01	51
		Total:	**264**

Level 3 Safeguarding training **Note:** Various groups of health/UHB staff attended the following level 3 safeguarding training sessions and study days		
Level and type of training	**Number of training sessions**	**Total number of staff/professionals in attendance**
Level 3 Child Sexual Exploitation	02	38
Level 3 Current Themes in Safeguarding Children	02	70
Level 3 Domestic Abuse and the impact on children	02	65

Level 3 Parental Mental Health and the impact on children	01	28
Level 3 Legal Aspects of Safeguarding	02	61
Level 3 Safeguarding Adults Study Day	02	55
Female Genital Mutilation (FGM) training sessions	05	142
	Total:	**459**

Note:

- **Level 3 Safeguarding children study days** are only relevant for the following staff to attend i.e. All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

- **Level 3 safeguarding adult study days** are relevant for the following staff to attend i.e. all staff who regularly contribute in the investigation of adults at risk of harm or abuse and/or their families/carers.

Designated Lead Manager (DLM) training

In addition the Senior Nurse for Safeguarding Adults has provided Designated Lead Manager Training (DLM) for staff taking on this role within the safeguarding adult's process of their Clinical Board.

Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) Group 1 training

VAWDASV group 1 training is mandatory and has been developed through Welsh Government. This training is available to complete online via ESR and is also delivered as classroom based training sessions during Mandatory May, September and November. All UHB staff are expected to complete this training.

Table 4: Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV): Group 1 training		
Number and percentage of staff compliant with Safeguarding Adults training at 31st March 2018:		
Headcount (UHB Total)	**Number trained**	**% trained**
15028	8664	57.65%

Workshops to Raise Awareness of Prevent

WRAP 3/Prevent Counter-terrorism training is available to attend as classroom based training, delivered over 2 hours. This is a Home Office developed training package delivered by a Home Office accredited trainer.

Safeguarding Training Quality & Assurance sub-group

The Safeguarding Training Quality & Assurance sub-group meeting, reports to the Safeguarding Steering Group Meeting. This meeting is chaired by the Safeguarding Trainer and the vice chair is a Community Paediatrician and Senior Lecturer at Cardiff University who sits on the group as an educational advisor. The Senior Nurse for Safeguarding also attends this meeting. The sub-group meets bi-monthly and has developed a safeguarding training strategy. The sub-group is currently updating its terms of reference and developing a work plan and focus on quality assuring all level 2 and level 3 safeguarding training developed and delivered by the Safeguarding Team.

Cardiff & Vale Regional Safeguarding Board (RSB) training sub-group meeting

The UHB is represented at the multi-agency RSB training sub-group. The training sub-group reports to the RSB Executive Board and has completed a safeguarding training mapping exercise to consider the different levels and types of safeguarding training partner agencies currently deliver. A task and finish group has been set up to discuss the findings of the training mapping exercise, consider the learning outcomes for each level of training and discuss developing a national approach to safeguarding training as there is a consensus view that we need to improve the consistency of safeguarding training in Wales to both improve quality and efficiency in delivery.

3. Safeguarding Activity

Since July 2016 all referrals for safeguarding children, adults and domestic abuse are sent electronically by practitioners to a central safeguarding referral e-mail address, the referrals are not screened and are sent directly by secure e-mail to Cardiff MASH, Vale of Glamorgan Local Authority teams and Police as appropriate. The referral pathway and referral forms are available on the Safeguarding Children and Adult Web pages. Collating the activity across the UHB allows the safeguarding team to target service areas that may require additional training, supervision or advice.

Safeguarding Children Activity

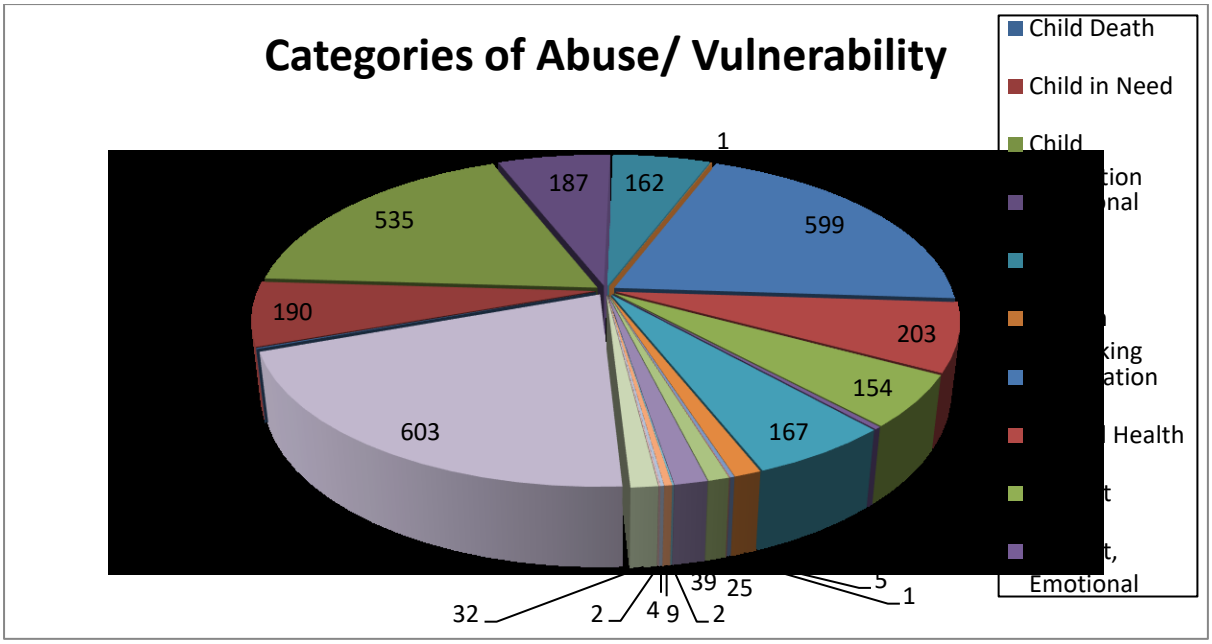
Activity is collated on a monthly basis across the UHB and presented to the Safeguarding Steering Group as a Run Rate Report. The report exhibits activity from April 1st 2017- March 31st 2018 across all CBs.

Clinical Board 2017-18	04	05	06	07	08	09	10	11	12	01	02	03
Medicine	94	162	142	130	102	121	110	114	124	80	88	108
Surgery	0	0	0	0	0	0	0	0	0	0	1	0
Specialists	0	0	0	0	0	0	0	0	1	0	0	0
Mental Health	8	13	11	5	8	6	5	10	12	14	28	16
Children & Women	83	96	124	145	118	124	116	129	95	103	83	87
PCIC	2	6	9	5	4	10	3	8	2	9	9	7
CD&T	0	2	2	3	1	0	0	0	2	0	1	3
Dental	0	1	2	0	1	1	0	2	6	5	3	2
Corporate	0	1	3	2	2	1	0	0	4	3	1	1
Total	187	281	293	290	236	263	234	263	246	214	214	224

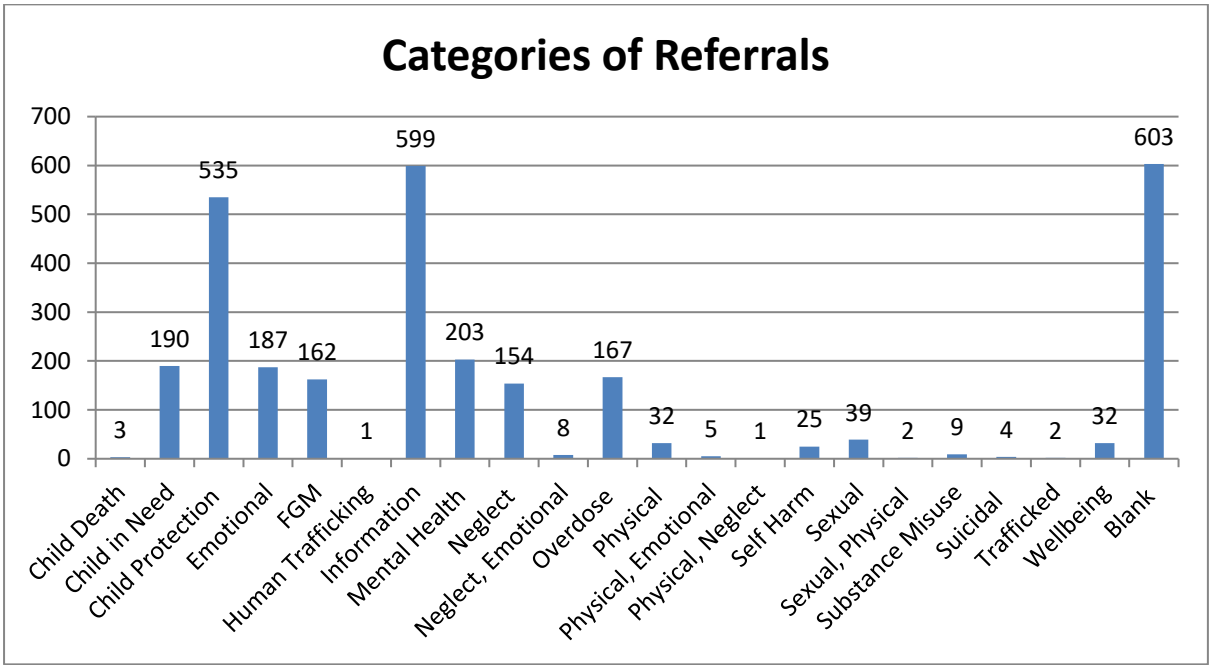
The referrals made by Medical CB are generally generated in Paediatric Emergency Department. Children & Women CB referrals are predominantly made by community based staff such as Health Visitors and School Nurses, however disciplines within the acute sector make a proportionate number of referrals. PCIC referrals will be submitted by GPs and District Nurses. There has been an increase in referrals made by both Dental and Mental Health Clinical Board during this period. An increase in referrals cannot be associated to any particular event although historically it would be considered that increased awareness training and media coverage will heighten professional accountability and alertness. A total of 2,962 referrals were made by UHB staff and submitted to Cardiff, Vale of Glamorgan local authority or a local authority out of area by the safeguarding team during this period. There is no screening of the referral undertaken at the point of the safeguarding team receiving the referral, the referral form is sent securely to the appropriate local authority the same day it is received.

Categories of Abuse or Vulnerability

This chart represents the category of abuse or vulnerability captured on some of the referrals received by the safeguarding team. A number of referrals do not include information that the administration team are able to determine as the category of abuse when collating information.



Categories of referrals:



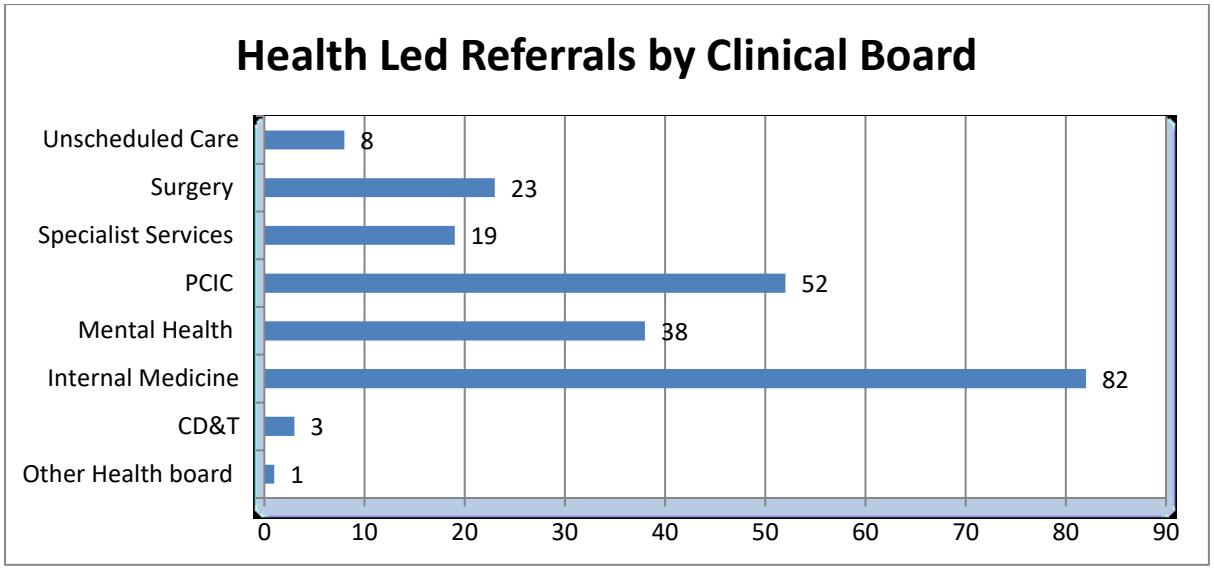
Safeguarding Adult Activity

Activity is collated on a monthly basis across the UHB and presented to the Safeguarding Steering Group as a Run Rate Report. The report exhibits activity from April 1st 2017- March 31st 2018 across all CBs.

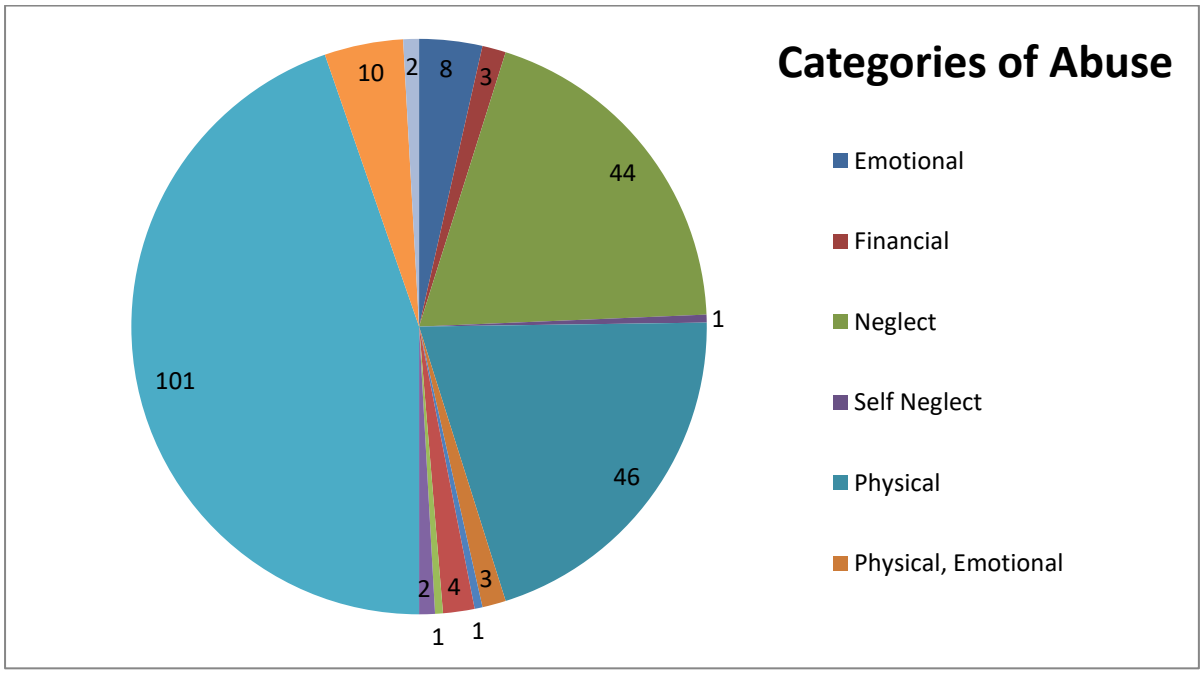
Clinical Board 2017-18	04	05	06	07	08	09	10	11	12	01	02	03
Medicine	2	8	7	6	6	10	7	6	4	8	5	3
Surgery	2	1	0	2	4	2	3	0	1	1	0	0
Specialists	2	1	0	1	0	1	5	0	0	2	1	1
Mental Health	6	6	3	3	3	2	4	4	0	3	2	3
Children & Women	0	0	0	0	0	0	0	0	0	0	0	0
PCIC	2	0	3	0	1	2	0	1	4	9	7	4
Corporate	0	0	0	0	0	0	0	0	0	0	0	0
Dental	0	0	0	0	0	0	0	0	0	0	0	0
CD&T	0	0	0	0	0	0	0	1	0	0	1	0
Total	14	16	13	12	14	17	19	12	9	23	16	11

The safeguarding adult data is collated by the number of health led referrals across the UHB. Each CB has Health Designated Lead Managers (DLM) that take responsibility to lead on the Adult at Risk process for their own area, DLMs are usually Senior Nurses or Advanced Nurse Practitioner's. DLMs are given additional bespoke safeguarding adult at risk training by the Head of Safeguarding or Senior Nurse to undertake this role. An electronic shared drive has been established to enhance the process allowing DLMs in each CB area to be aware of cases in their CB to ensure that cases are maintained and progressed should the named DLM be on annual leave or sick leave. There are 44 DLMs across the UHB. The process has evolved since the implementation of the SS&W-b Act (2014) and since the launch of Cardiff MASH. A total of 225 referrals were made by health professionals to the local authority during this period. This may not be a true reflection of all referrals made, it has been noted recently that health staff based in integrated community teams are making referrals directly to the local authority and bypassing the UHB Safeguarding Team. This is complicated due to the fact that health staff are working from local authority computers and facilities plus their e- mail address is local authority. Measures to ensure that this practice is discontinued are being introduced to ensure that health staff are following the UHB referral process.

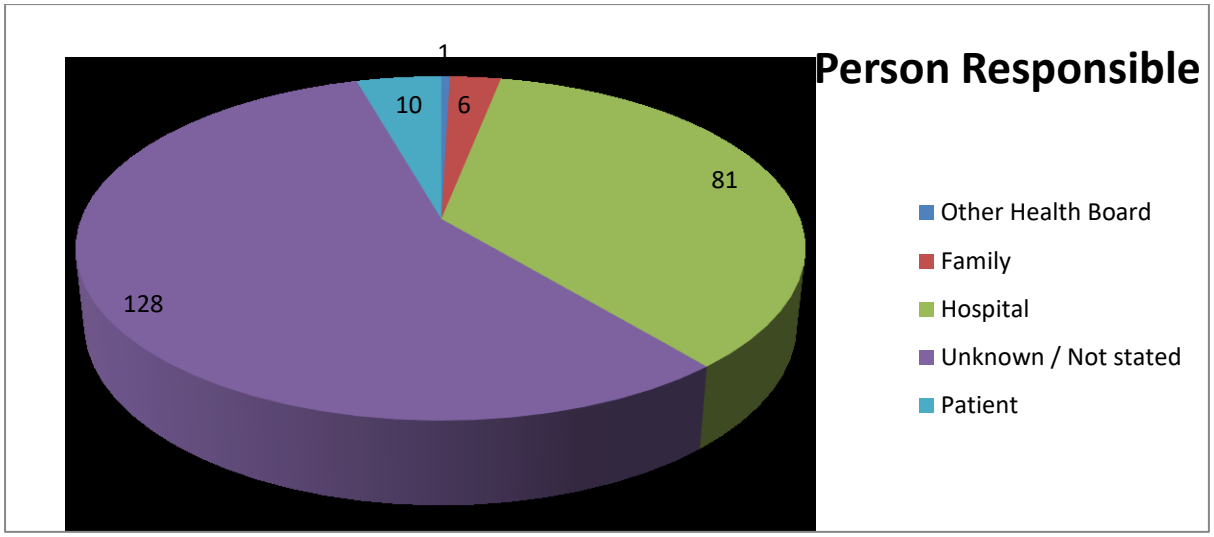
This chart captures the number of health led referrals made by each Clinical Board for this period. Medicine CB has been broken down in to two areas to demonstrate information collated from Unscheduled Care (Emergency Department) and Internal Medicine (Acute Area).



Categories of Abuse:



Categories of abuse are easier to capture on the current adult at risk referral form as opposed to the children's referral form, as there are tick boxes for practitioners to choose. Highlighted here are the areas considered by practitioners to be the reason for submitting the referral to the local authority. The most commonly used category is a multiple category of Physical/ Emotional and Financial Abuse. Adult cases often prove to be complex, determining the main issue at the point of disclosure or reporting is often difficult for referrers; this is often not established until further fact finding is undertaken. This may be in the shape of a criminal or non-criminal investigation. The Health Designated Lead Manager (DLM) will lead on the case if the situation involves the UHB or employees as the alleged perpetrator.



Often practitioners from the UHB or from an outside agency will not have the information to determine who the alleged perpetrator is, this is evidenced in the above chart as no person responsible has been identified on the referral. 81 of the cases site the Hospital as being responsible for the abuse.

Professional Concerns Strategy Meetings and Part 1V investigations

The Professional Concern process ratified by the Regional Safeguarding Boards in 2016 has formalised the approach within the UHB to address concerns of employee's behaviour in or outside of work. The process is in alignment to the Part 1V of the All Wales Child Protection Procedures (2008) although chaired by the Head of Safeguarding or Senior Nurse for Safeguarding within health, for a health employee. Police and LA are invited to each meeting to share information and ensure that the UHB is open and transparent in the approach. Cases will involve staff working predominantly with adults; concerns will include arrest and police investigation around domestic abuse, sexual assault, physical assault etc occurring outside the workplace. Some cases will proceed through the disciplinary process following closure by police and the Court process.

Part 1V strategy meetings are held under the All Wales Child Protection Procedures (2008) and led by the Local Authority. Data detailed below evidences the total number of meetings held:

Period	Number of Meetings
2017-2018	47

Issues raised with UHB employees relate to allegations made against them by family members, patients or a criminal investigation by police. All employees are notified of the concern raised as appropriate and an immediate risk assessment is completed by the line manager and HR representative to ensure that safeguarding measures are in place. This certifies the protection and support of the member of staff if further allegations are made and gives the UHB assurance that appropriate and proportional

measures are in place to protect the public accessing care and services from the UHB. The Head of Safeguarding and the Senior Nurse for Safeguarding will provide advice and support to the line manager to achieve a manageable response ensuring that the employee is directed to the well-being service or General Practitioner (GP) as required.

4. Audit, Survey, Professional Presentations and Publications

Public Health Wales Quality Outcome Framework (QOF) for Children

This work has previously been implemented across Health Boards and Trusts in Wales since Professor Sir Mansell Aylward identified the need for robust monitoring and evaluation to improve and develop services in 2010. Health Boards have participated in the completion of four QOF data tools and reported back to Public Health Wales with the intention to self- assess safeguarding measures for children and ensure standards and best practice is maintained across Wales. The collation of data from each Health Board was analysed by Public Health Wales and published to demonstrate compliance, activity, standard and good practice to drive the motivation to improve services for safeguarding children across each of the identified dimensions.

During 2017-2018 this work has been suspended due to concerns raised by Executive Nurse Directors across Wales. This will be replaced during 2018-2019 by the NHS Wales, Safeguarding Maturity Matrix, work will commence in the summer to collate data from all Clinical Board's (CB) across the UHB. One area that has been continued despite the suspension is the collation of figures from both Midwifery and Health Visiting Services in respect of routine enquiry questions for domestic abuse asked once to women accessing services. The results shown are:

Routine Enquiry Asked:	Total	Percentage
Midwifery Service	410 (notes audited)	90%
Health Visiting Service	1465 (notes audited)	35%

Health Care Standard 2.7 has been completed for 2017-2018. As in the previous year a corporate assessment has been completed based on information received from each of the CBs. The overall self-assessment for the UHB is "*Leading the Way*". Recommendations made to sustain this status for the forthcoming year include:

- Assurance that training data for Mandatory Safeguarding Training is supported by CB Training Needs Assessments to measure compliance
- Domestic Abuse Training in line with Welsh Government targets within the National Training Framework is compliant
- Undertake a corporate audit to ensure that the needs of children aged 16-17 years admitted to adult wards are met and documented on a risk assessment check list

- Continued compliance with the duty to report and investigate cases of child or adult at risk cases where abuse or neglect is suspected using the framework within the Social Services and Well-being Act (2014)
- Develop a UHB and Children's Services pathway for Grade 3& 4 and unstageable pressure damage in children during the coming year Provide assurance that the elevated self- assessment position is sustained within CBs by providing information feedback at the SSG meeting, CB Q&S meetings and audits reported at the named meetings.

During October 2017 the RSB Communication and Engagement Sub-Group focused on raising awareness of safeguarding themes during National safeguarding week. As part of this work the safeguarding team developed a survey tool for use with UHB staff and students attending the UHB, to understand the level of awareness of safeguarding. The findings were analysed and reported by a medical doctor independent to the team. The findings were very inspiring noting excellent awareness by staff and students alike. 71 members of staff completed the survey and 30 students from various studying groups. 83% of students demonstrated that they were aware of the meaning of safeguarding and likewise 87% of staff indicated awareness. Staff and students recognised the themes of safeguarding such as child sexual exploitation, modern slavery and domestic abuse. 93% of students and 96% of staff were aware of health care professionals "duty to report" and 63% of students and 87% of staff were aware of Regional Safeguarding Boards. The survey asked the participants to contribute any ideas they had to promote the safeguarding agenda, this proved to be useful and will inform future UHB campaigns. Although this audit has relatively small numbers considering the number of employees, the survey demonstrates a random snapshot which gives assurance that safeguarding within the UHB is visible. However as expected there is further effort required to sustain awareness with an evolving agenda, ensuring that responsiveness is maintained.

Cardiff and Vale University Health Board, Paediatric Emergency Department (ED) Safeguarding Meeting January 1st 2017- December 31st 2017

There has been 48 meetings in total, meetings are held weekly and discuss children presenting at ED. Attendance at the meeting involves Consultant Paediatrician ED, Community Paediatric Consultant or Registrar, General Paediatric Consultant, Safeguarding Nurse Advisor and/or Specialist Nurse for Safeguarding.

To ensure that the cases discussed at the weekly meeting are in context there were 31, 015 paediatric attendances at the department during this period. Of these there were 3,074 children under the age of one years old. Injuries were identified in 678 children under one year old. Generally children under the age of 16 years old are seen in the Paediatric area of ED. Cases discussed were:

Thermal Injuries	343
Thermal Injuries < 1 years old	29
Injuries < 1 years old	580
Health Visitor/ School Nurse Referrals	99
Safeguarding Referrals (submitted following this meeting)	12 (2 of the cases referred went on to be S47 enquiries)
Total Cases Discussed	923

Whilst appreciating, it would be ideal to discuss all cases attending the ED, this is clearly unrealistic. As a department, however, we are constantly looking to ensure that we safety net the high risk groups. One current piece of work, in the final stages of completion, is looking at whether those patients aged 1-2 years of age with fractures should be incorporated into the weekly safeguarding meeting. Preliminary findings have shown that in 2017 approximately 800 children between the ages of 1-2 years attended the ED with an injury, of which 65 were discharged with a confirmed fracture. Three of these cases were referred to Children's Services with safeguarding concerns, one of which progressed to S47 enquiries. A further nine cases had notifications on PARIS prior to their presentation including Public Protection Notifications (PPN), previous discussion at Multi Agency Safeguarding Hub (MASH) and one child previously on the child protection register. Following a review of the final results of this project, consideration will be given to adding this group to those categories currently discussed. An audit has been undertaken by a medical student, which will include the redesign of proformas and recommendations on improving documentation.

In addition, the department is reviewing children and young people who are 'frequent attenders' – working to develop guidelines and individual management plans in accordance with in-patient teams, CAMHS and the Health Visitor service.

The 'Paediatric ED made easy' study day is a simulation course designed for staff ranging from pre-hospital personnel (ambulance technicians and paramedics) to nursing and medical staff and students from Paediatrics, Anaesthetics and Emergency Medicine. In addition to the management of common paediatric complaints, the day aims to encourage multi-disciplinary working, familiarity and improved communication amongst pre-hospital and hospital teams and to familiarise staff with local and national paperwork and guidelines. Topics covered specifically include safeguarding and PRUDiC and the day is well received by all.

- General Paediatrician, Paediatric Consultants ED and Professor within Dental have been monitoring responses to children injured in community violence. This work has involved considering children in their community environment, children and families have been signposted to services and provided with information on bullying. Improvements to the child's experience following attendance at ED has been demonstrated however further exploration is required to effectively share information with police and schools. The

information is currently shared with the School Nursing Service however greater links with education is required.

- Community Paediatricians are in the process of Evaluating the Diagnostic Yield or Routine CT Scans and Ophthalmological Screening in the Work of Infants Presenting with Suspected Physical Abuse
- Audit of Doctor's Requesting Haematological Investigations Undertaken at Time of Child Protection Medical Assessment

A service evaluation of the child sexual exploitation risk questionnaire as a screening tool in the paediatric emergency department to identify children at risk of Child Sexual Exploitation (CSE) has been undertaken during 2017.

The evaluation has been completed by a medical student with the aim of:

- Determining whether the current CSE Risk Questionnaire used is being completed in all children at risk
- Determine the outcome from the completed questionnaire
- Make recommendations for effective questionnaire use in Emergency Department (ED)

Data was collected from all children aged between 10-15 years old to the ED in a three month period presenting with Contraception or STI testing, Pregnancy, Substance Abuse, Overdose and Self Harm. In total 45 children presented during the three month period, there were 30 girls and 7 boys, 58% of cases were in relation to overdose, 22% Substance misuse, 18% Self-harm, 2% Pregnancy and 0% Contraception or STI testing. The highest age groups were 14 and 15 year olds. In total 26 questionnaires were completed for children meeting the criteria of these 16 (62%) required a child protection referral. Out of the 19 children where a questionnaire was not completed 5 were referred to CAMHS where there is further opportunity to complete the questionnaire.

In summary 58% of children presenting at ED and meeting the criteria had a questionnaire completed for them. Of those, 15 children were referred on to Children's Services, this is an increase since the 2016 audit. The outcome of this study recognises that practitioners are beginning to use this risk assessment tool in practice and are demonstrating an improvement in awareness.

Recommendations include modifying the questionnaire to inform the practitioner that it needs to be included with a referral to Children's Services, add intimate partner violence as an indicator, slightly change question 2 so that it appears less intrusive and provide specific training for practitioners working in ED to improve awareness.

- BuRN-Tool 2: the evaluation of the BuRN-Tool and clinical prediction tool to identify children who have had a burn and are at high risk of maltreatment.

Multicentre study Cardiff, Swansea, Birmingham, Bristol, Manchester and Newport. Funded by Health and Care Research Wales 248K

- Data-linkage study: Study to evaluate the long term outcome of children who have been assessed for child maltreatment: MRC funded
- PhD 1: Evaluation of PredAHT and clinical prediction tool to identify the probability of abusive head trauma given the combination of six clinical features: Laura Cowley funded Health and Care research Wales.
- PhD 2: Improving the recording and forensic assessment of bruises in suspected maltreatment: Sam Evans (self-funded)
- EURO CANN: European network : Developing minimal dataset and data collection of children being assessed for child maltreatment across Europe: Supported by National Centre for Population Health and Wellbeing Research
- Imaging of Bruises: MRC funded
- Clinical prediction Rules in childhood bruising: MRC funded
- External evaluation of clinical prediction rules in abusive head trauma: Collaboration with Franz Babl Australia
- Methodological critique of Swedish systematic review Traumatic shaking: the role of the triad in medical investigations of suspected traumatic shaking'.
- Biomechanics of head trauma: Collaboration with School of Engineering Cardiff University

Professional presentations include

- A Multi-Agency Audit Looking at Children Presenting with Sexually Harmful Behaviour at RCPCH conference March 2018
- The Uptake of HPV Vaccination Rates in Looked After Girls Presented at BACCH September 2017
- The RISCA Audit Looking at Radiological Investigations for Suspected Non Accidental Injury RCPCH April 2017 (since this presentation the UHB has introduced repeat skeletal survey to replace bone scan in children < 2 years
- Presentation at a Cardiff Multi-Agency Female Genital Mutilation (FGM) conference arranged by South Wales Police to raise awareness

Publications 2016-18

Clinical prediction rules for abusive head trauma: a systematic review.
Pfeiffer H, Crowe L, Kemp AM, Cowley LE, Smith AS, Babl FE; Paediatric Research in Emergency Departments International Collaborative (PREDICT).
Arch Dis Child. 2018 Apr 5. pii: archdischild-2017-313748. doi: 10.1136/archdischild-2017-313748. [Epub ahead of print] PMID: 29622594

Abusive head trauma and the triad: a critique on behalf of RCPCH of 'Traumatic shaking: the role of the triad in medical investigations of suspected traumatic shaking'.
Debelle GD, Maguire S, Watts P, Nieto Hernandez R, Kemp AM; Child Protection Standing Committee, Royal College of Paediatrics and Child Health.
Arch Dis Child. 2018 Mar 6. pii: archdischild-2017-313855. doi: 10.1136/archdischild-2017-313855. [Epub ahead of print] Review.
PMID: 29510999

Optimising the measurement of bruises in children across conventional and cross polarized images using segmentation analysis techniques in Image J, Photoshop and circle diameter measurements.
Harris C, Alcock A, Trefan L, Nuttall D, Evans ST, Maguire S, Kemp AM.
J Forensic Leg Med. 2018 Feb;54:114-120. doi: 10.1016/j.jflm.2017.12.020. Epub 2018 Jan 31.
PMID: 29413952

Raising suspicion of maltreatment from burns: Derivation and validation of the BuRN-Tool.
Kemp AM, Hollén L, Emond AM, Nuttall D, Rea D, Maguire S.
Burns. 2018 Mar;44(2):335-343. doi: 10.1016/j.burns.2017.08.018. Epub 2017 Sep 14.
PMID: 28918905

Childhood bruising distribution observed from eight mechanisms of unintentional injury.
Hibberd O, Nuttall D, Watson RE, Watkins WJ, Kemp AM, Maguire S.
Arch Dis Child. 2017 Dec;102(12):1103-1109. doi: 10.1136/archdischild-2017-312847. Epub 2017 Aug 28.
PMID: 28847881

Assessing the medium-term impact of a home-visiting programme on child maltreatment in England: protocol for a routine data linkage study.
Lugg-Widger FV, Cannings-John R, Channon S, Fitzsimmons D, Hood K, Jones KH, **Kemp A**, Kenkre J, Longo M, McEwan K, Moody G, Owen-Jones E, Sanders J, Segrott J, Robling M.
BMJ Open. 2017 Jul 13;7(7):e015728. doi: 10.1136/bmjopen-2016-015728.
PMID: 28710218

Development and validation of a physical model to investigate the biomechanics of infant head impact.
Jones M, Darwall D, Khalid G, Prabhu R, **Kemp A**, Arthurs OJ, Theobald P.
Forensic Sci Int. 2017 Jul;276:111-119. doi: 10.1016/j.forsciint.2017.03.025. Epub 2017 Apr 13.
PMID: 28525774

Ask Me! self-reported features of adolescents experiencing neglect or emotional maltreatment: a rapid systematic review.
Naughton AM, Cowley LE, Tempest V, Maguire SA, Mann MK, Kemp AM.

Child Care Health Dev. 2017 May;43(3):348-360. doi: 10.1111/cch.12440. Epub 2017 Feb 26. Review.
PMID: 28238208

Patterns of bruising in preschool children with inherited bleeding disorders: a longitudinal study.
Collins PW, Hamilton M, Dunstan FD, Maguire S, Nuttall DE, Liesner R, Thomas AE, Hanley J, Chalmers E, Blanchette V, Kemp AM.
Arch Dis Child. 2017 Dec;102(12):1110-1117. doi: 10.1136/archdischild-2015-310196. Epub 2016 Jul 22.
PMID: 27449675

Selecting children for head CT following head injury.
Kemp A, Nickerson E, Trefan L, Houston R, Hyde P, Pearson G, Edwards R, Parslow RC, Maconochie I.
Arch Dis Child. 2016 Oct;101(10):929-34. doi: 10.1136/archdischild-2015-309078. Epub 2016 Jul 22.
PMID: 27449674

5. Supervision

Safeguarding children supervision has historically been provided to health visitors (HV) on a 1:1 basis every three to six months depending on their experience and their caseload. Supervision is provided to midwives, school nurses, Community Health Access Practice (CHAP) nurses, Department of Sexual Health (DOSH), Multi-disciplinary staff in Special Schools and community therapists through a group supervision approach. Safeguarding supervision is provided to other groups such as doctors and acute nurses as required. The aim of supervision is to support staff, facilitate learning and promote best practice. An additional team of psychologists have recently been provided with bespoke safeguarding training in preparation for group supervision to commence.

During 2015 the Safeguarding Team proposed a bold idea, supported by the Executive Nurse Director to undertake a pilot study with the HV service to consider group supervision with HVs in four locations across Cardiff and the Vale of Glamorgan. This is the first pilot in Wales around safeguarding supervision of HVs and has raised much interest from other Health Boards across Wales. The aim of the pilot is to ensure a safe supervision pathway exists that reduces the allocated time required of the Safeguarding Team to provide supervision to 183 HVs on a 1:1 basis.

The pilot idea advanced and progressed through the UHB Leading Innovation in Patient Safety (LIPS) headed by the Head of Safeguarding and joined by two team managers from the HV service. The pilot pathway commenced in October 2015 and

has been overseen by a Lecturer in Cardiff University to provide an independent view, accreditation to the pathway and to undertake group forum's with the HVs involved. The pilot has recently been positively evaluated following individual interviews with the supervision facilitators and interviews with focus groups from the HV service involved in the pilot. Recommendations have been made to improve on the pilot pathway and will be easily adopted to ensure that a robust service will be delivered by the safeguarding team. The pilot evaluation has been shared at the Children and Women Clinical Board, Quality and Safety meeting and the corporate Safeguarding Steering Group meeting. The new arrangements will roll out across the HV service in September 2018. SNAs have undertaken additional training with Public Health Wales to prepare them for the role of facilitator in group supervision. There will be a further evaluation in 12 months to ensure that the Cardiff and Vale Safeguarding Supervision Model is meeting the needs of the service users and deemed to be effective. The Cardiff and Vale UHB model has been discussed with other Health Boards through the NHS Network Meeting and has been presented as a poster presentation at the Chief Nursing Officer Conference in May 2018 by Cardiff University.

Adult safeguarding supervision is provided by the Senior Nurse for Safeguarding to the health Designated Lead Manager (DLM) as required and through arranged sessions within each Clinical Board and/ or through Development Day sessions. The supervision is proposed on a three monthly basis, 1:1 with DLM or ad hoc when required. All open adult at risk safeguarding cases are reported to the Executive Nurse Director and Deputy on a monthly basis and discussed at Nurse Director Professional Performance Review. Cases involving staff are reported through the bi-monthly Executive Quality & Safety meetings.

Nurses within the Safeguarding Team attend organised counselling sessions to ensure that their well-being is maintained given the level of safeguarding detail they are exposed to on a daily basis. Safeguarding supervision is arranged with the Head of Safeguarding on a six monthly basis unless required for specific cases or on request. The Head of Safeguarding receives supervision from a Designated Nurse within the National Safeguarding Team of Public Health Wales.

In addition to the safeguarding supervision provided to Health Visitors, supervision is also provided by the safeguarding team to Midwives, School Nurses, Therapists and Mental Health Nurses on a regular basis.

The Public Health Wales All Wales Safeguarding Best Practice Supervision Guidance (2018) states that:

"*The aim is to provide guidance on the implementation and utilisation of supervision and support within the context of safeguarding. It sees safeguarding supervision as a priority to which staff are actively supported to have the time to attend*"

This approach has been adopted with safeguarding children and adults at risk within the UHB.

"Signs of Safety" Training has been introduced in Cardiff Children's Services during 2016-17. The training has been shared with the Safeguarding Team and rolled out

to some areas within the Health Visitor and School Nurse service to enhance cohesive partnership working with partner agencies and families. Further roll out is expected in the coming year with additional training provided by Cardiff Local Authority. The Signs of Safety approach is used in supervision sessions.

Peer Review

Within Cardiff and Vale UHB, peer review is held on a monthly basis. It is made available to all doctors involved in child protection work in order that Drs undertaking in this difficult area of work are well supported and have the opportunity to receive peer review and clinical supervision in order to feel confident and competent. Pragmatically, the peer review process encourages paediatricians to meet the expected standards and prevents practitioners working in isolation.
Peer reviews are held for suspected cases of physical abuse at St David's hospital, additionally a separate peer review is held at the Sexual Assault Referral Centre (SARC) for cases of suspected sexual abuse.

The meeting is chaired by either the Named Doctor or the Designated Doctor for safeguarding children.

Attendance is consistently good. All child protection cases from the previous month are presented to ensure the management of the case meets the expected standard of practice. The process involves review of the medical report, photo documentation and the multi- agency working. It is an opportunity for professional development and learning within an appropriate environment and allows staff to debrief following difficult cases.

6. Expert Advice

Partnership Working

The implementation of new legislation SS&Wb (Wales) 2014Act and VAWDASV (Wales) 2015 has encouraged partnership working across strategic partner organisations and third sector agencies. Ensuring that compliance, knowledge and awareness raising is understood within each agency has required joined up thinking through shared training and guidance from the Cardiff & Vale Regional Safeguarding Children and Adult Board.

Cardiff & Vale UHB has close strategic and operational links with both the Regional Safeguarding Children and Adult Board. Representation at the imalglemated RSB Meeting is made by the Executive or Deputy Nurse Director, Named Doctor for Safeguarding Children or the Head of Safeguarding. Minutes for the meeting are shared with Clinical Boards through the UHB Safeguarding Steering Group meeting. Sub- groups of the main Board include Training, Child & Adult Practice Review, Children and Adult Audit, Communication and Engagement, Policy and Procedures, Business Planning and an Exploitation Thematic Review are attended by the safeguarding team who participate fully in the work involved with each group. There are also a number of task and finish groups attached to the sub-groups.

The SSWB Act places a duty on health to report and investigate (for adults) situations where a child or an adult at risk may be experiencing or is at risk of abuse or neglect. In line with the Act and in alignment with the launch of Cardiff Multi Agency Safeguarding Hub (MASH) the safeguarding referral process for the UHB changed in July 2016. For the first time this allows mapping of referrals and referral themes from each Clinical Board providing data that will enhance training needs to bespoke areas as required.

The Cardiff MASH launch in July 2016 has brought strategic partners including Local Authority Children's Services, Adult Services, Police, Health Safeguarding Team, Education, Probation and Community Rehabilitation Company together in one co-located venue hosted by South Wales Police. This allows sharing of information using a multi-agency licensed platform to address concerns in a timely manner by gathering information from each agency to make decisions around safeguarding measures required.

Meeting the demand of the workflow within Cardiff MASH is a daily battle for the two SNA representing the UHB in the MASH. It is true to say that all agencies within the MASH report an increase in the amount of referrals and calls made to the MASH in the past year. Two SNAs from the safeguarding team rotate on a daily basis into the MASH working area. Day to day work consists of attending daily discussions for up to eight domestic abuse cases requiring immediate safety planning action, this is in addition to the cases discussed at the fortnightly Cardiff MARAC. Attending child and adult at risk strategy meetings which are called immediately a concern is reported and ensuring that all documentation is recorded appropriately on PARIS, to make certain that community practitioners meeting with families are alert to the concerns raised are a feature of the daily work in MASH.

The Cardiff MASH demonstrates valued multi-agency working, it has evidenced respect and an understanding of roles amongst the different organisations and broken down barriers to working in partnership.

Partnership working is evident in the RSCB/RSAB training and audit sub groups; agencies are brought together to consider available training resources and to undertake specific audits from Child Practice Reviews (CPR) or Adult Practice Reviews (APR) and develop action plans.

Female Genital Mutilation (FGM)

The United Kingdom (UK) Government and UNICEF hosted the first "Girl Summit" in July 2014 aimed at mobilising National and International efforts to end FGM as routine practice in some countries across the World. The UK Government also made a number of commitments for new legislation to tackle FGM.

In 2015 a number of amendments were made to The Female Genital Mutilation Act 2003 through The Serious Crime Act 2015. Section 4 of the 2003 Act specifies that extra-territorial jurisdiction extends to prohibit acts done outside the UK *by* a UK national or a person who is resident in the UK. Considered with that change, section

70 (1) also amends section 3 of the 2003 Act (offence of assisting a non-UK person to mutilate overseas a girl's genitalia) so that it extends to acts of FGM done *to* a UK national or a person who is resident in the UK. This has placed a mandatory reporting duty on all health professionals to report "known" cases of FGM in under 18 year olds to the police, this duty has been instigated since 31st October 2015.

The All Wales Clinical Pathway for FGM was created and completed by a task and finish group in October 2015 and ratified in July 2016.

Specific mandatory training for Midwives has been in place since 2014, 300 midwives received the training during that year. Additional sessions were introduced to other health professionals through an introduction in Level 3 Safeguarding Current Themes training twice during this year involving 70 members of staff.

A continued drive to raise awareness across the UHB has been maintained by the safeguarding team. Midwifery training has been facilitated by the FGM Lead Midwife with additional training across the UHB delivered by members of the safeguarding team.

Online FGM training is also available, endorsed by the Home Office, this is accessible to UHB staff.

Since October 2016 Welsh Government has requested quarterly updates from all Health Boards across Wales identifying FGM, this also includes referrals made to Children's Services where mothers of female children are identified as having experienced FGM. The reason for referring children to Children's Services ensures that professionals are aware of an increased risk that the female children may also experience FGM in the future.

Quarter during 2017-2018	Number of Women Identified	Child Protection Referral Made	Mandatory Reporting
Q1	71	34	7
Q2	33	10	0
Q3	57	22	1
Q4	55	25	0

A FGM working group led by the Head of Safeguarding as the UHB lead and the Lead Midwife working closely with representatives from midwifery, Health Visiting and Safeguarding team are developing a training programme that will provide a regular monthly rolling programme to identified areas across the UHB. This will include "Train the Trainer" sessions for some areas in the future. Sessions aim to capture approximately 20 staff at one time. An FGM pathway has been completed and ratified by the All Wales NHS Leads for FGM through the National Safeguarding Team. The referral process for suspected cases of FGM has been reviewed within the UHB, an example child protection referral is available on CaVweb, an FGM Risk Assessment (RA) will be added to the same site imminently, the RA has been agreed with police and local authority. Cardiff and Vale UHB are intending to promote the Cardiff model to demonstrate the partnership working with police and local authority. An increase in recognition has been apparent as a result of the FGM working party

training, staff have presented at both a South Wales Police (SWP) Conference and the Chief Nursing Officer Conference.

Cardiff and Vale UHB launched a unique Women's Wellbeing Clinic for all females affected by FGM at Cardiff Royal Infirmary in May 2018. This project has been supported by SWP and will provide clinical and psychological support. This clinic is led by the FGM lead in Midwifery services.

Exploitation

Child Sexual Exploitation continues to be a priority for Welsh Government, Regional Safeguarding Children Board (RSCB) and the National Safeguarding team in Public Health Wales. A National action plan has been introduced to ensure that all statutory agencies and Third Sector consider how to Prepare, Prevent, Protect and Pursuit (police) will be driven through each organisation. The RSCB endorsed a CSE Strategic Group to consider the prevalence of CSE across Cardiff and the Vale of Glamorgan by undertaking a mapping study and each agency identifying the training that is delivered and sharing the resources available. This challenges the effectiveness of the activity undertaken by the Board to safeguard and promote the welfare of the children who are at risk of, or being harmed by, child sexual exploitation across the region. This is particularly prevalent as a Child Practice Review Multi- Agency Professional Forum presented a CSE case in 2016 whereby a number of children were exploited by the same perpetrator. This group will stand down during 2018 and will be replaced by an Exploitation Thematic Group looking at vulnerabilities affecting children and adults.

Within the UHB an increase in the workload associated with CSE has continued during 2017-18 following the introduction of additional staff in Children's Services and police to tackle the problem in Cardiff. This has led to regular weekly CSE strategy meetings for individual children suspected to be at risk of CSE. Health professionals involved or working with the age group such as school nurse or Children Looked After nurses are expected to attend the meetings to share information that may be available within health to support the concern raised. As with all strategy meetings held through the All Wales Child Protection Procedures (2008) a plan is implemented to support the child and an attempt made to prevent the child from risk of harm through abuse or neglect. No additional resources are available within Children & Women Clinical Board or the safeguarding team to assist with the increase in workload; this has been identified as a continued cause for concern.

Procedural Response to Unexpected Death in Childhood (PRUDIC)

The process was first introduced across Wales in 2010 with the aim to "*ensure that the multi-agency response to unexpected child deaths is safe, consistent and sensitive to those concerned and that there is uniformity across Wales".*

The National Safeguarding Team in Public Health Wales revised the document in 2018. The procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

The process within the UHB is established, the Head of Safeguarding liaises with police to arrange a multi-agency meeting within 48 working hours of the child's death, the meeting is chaired by police, attendance includes representatives from Children's Services, Education when appropriate, Welsh Ambulance Service Trust, psychology and appropriate representation from health professionals involved with the child. The purpose of the meeting is to ensure that there are no suspicious circumstances surrounding the child's death and to make certain that a robust bereavement package is in place for the family.

Cardiff & Vale UHB are fortunate to have a Bereavement Nurse that liaises directly with the family and supports them through this extremely difficult time by discussing with them any pathology information, arrangements for visiting the child in the morgue and registering the death. Referrals are made to charitable organisations to support the family long term and a memory box is created. The table below identifies the number of child deaths in the UHB locality and also includes children that have died at UHW from out of area:

Period	Number of Child Deaths
2017-2018	15

Child and Adult Practice Reviews (CPR & APR)

Guidance for child and adults practice reviews were updated and came in to force from 6 April 2016 following the implementation of the Social Services and Well-being (Wales) Act 2014. The guidance is addressed at the Safeguarding Children and Adult Board meetings involving all partner agencies. The purpose of the review is to promote a positive culture of multi-agency child and adult protection learning and reviewing in local areas when there are serious incidents resulting from abuse or neglect, there is a system of multi-agency concise and extended practice reviews. The criteria for child practice reviews are laid down in the *Safeguarding Boards (Function and Procedures) (Wales) Regulations 2015.* The outcome is expected to generate new learning to support continuous improvement in inter-agency protection practice.

The process involves agencies, staff and families reflecting and learning from what has happened to improve practice with the focus on accountability and not culpability. This will potentially develop more competent and confident practice, better understanding of knowledge base and perspective of different professional's role and responsibility.

The Head of Safeguarding and Named Doctor for Safeguarding Children participate in the Regional Safeguarding Board sub-group for Child and Adult Practice Reviews when consideration is given to new referrals and the commissioning of a new review. SNAs participate as panel members to individual reviews and complete a health chronology of each health contact to inform the timeline of events that will notify the reviewers preparing the report once collation of each agencies information has been submitted.

Recommendations and learning from the reviews will be identified in action plans or from the learning event. Organising a multi-agency approach for the learning event allows each professional to consider the case in detail, reflect on their own practice and to take learning back to each organisation to prevent the same situation happening again. There are currently six CPR in the process and two APR; one report was completed and published during 2017, in addition two Multi Agency Professional Forums considered learning for two cases with a further learning event to be arranged on another case. The safeguarding team are involved in the collation of information and submitting a chronology in all cases.

Domestic Homicide Review (DHR)

DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). The provision came in to force on 13th April 2011. The Home Office Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews has been updated in 2016. Domestic violence includes physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members. In 2009/ 10, domestic violence accounted for 14% of all violent incidents and affects both men and women. A domestic violence incident which results in the death of the victim is often not a first attack and is likely to have been preceded by psychological and emotional abuse. It is likely that many people within agencies may have known of these attacks and circumstances. This can sometimes make serious injury and homicide preventable with early intervention.

A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect. Similarly to CPR and APR the DHR will consider what lessons can be learnt by professionals and organisations to safeguard victims, what change can be identified, update policies and procedures, make every attempt to prevent domestic homicide by improving services to individuals and their children through improved inter-agency working.

The DHR's are commissioned through Partnership Boards in Cardiff and the Vale of Glamorgan localities. Referrals are received from South Wales Police and consideration is given at the Partnership Boards to undertake a DHR. The UHB Executives are formally notified of the commissioning of the DHR, the Head of Safeguarding attends a multi-agency meeting to agree the Terms of Reference for cases.

As with CPR and APR safeguarding nurses are identified within the team to collate information from each health contact and develop a timeline to inform the DHR report. There has been five DHRs undertaken in Cardiff since 2015 and one case in the Vale of Glamorgan. A further case has been commissioned and will commence soon in Cardiff.

Domestic Abuse

The implementation of the Violence against Women, Domestic Abuse and Sexual Assault (Wales) Act 2015 has seen a change in the referrals, training and width and breadth of the domestic abuse agenda within the UHB as indeed across Wales.

The Regional Multi-Agency Domestic Abuse Strategy for Cardiff and Vale of Glamorgan has been completed, the strategy incorporates a plan to address service need and training actions across the locality of Cardiff and Vale of Glamorgan council area. Welsh Government (WG) has provided guidance for all organisations to consider a five year plan to meet the National Training Framework expectations to raise awareness with all employees within each organisation. Different levels of training are identified with compliance within each organisation expected to be at 100%. No additional resources have been identified by Welsh Government to achieve this target. It is expected that Group 2 and 6 training commences in 2018. The UHB has provided WG with a forecast of the number of staff completing training over the next five years.

The UHB is fortunate to have a Health Independent Domestic Violence Advisor (IDVA) this is the only post within health across Wales.

The Health Independent Domestic Violence Advisor (IDVA) came in to post in October 2016 with a role to deliver advocacy support within Cardiff and Vale University Health Board to clients who have experienced domestic abuse in Cardiff and the Vale of Glamorgan. During the period April 2017 – March 2018 the Health IDVA has continued to raise awareness of domestic abuse and raise the profile of the IDVA role within the UHB. In line with the Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015, the Health IDVA has delivered classroom based VAWDASV group 1 training which is mandatory for all staff. In addition to this, within the reporting period the Health IDVA has co-delivered two Level 3 VAWDASV training days and has also been a guest speaker on other Level 3 safeguarding study days. The Health IDVA delivers training on a monthly basis to the Maternity Department and to staff within the Emergency Unit. Furthermore the Health IDVA co-delivers the Female Genital Mutilation Awareness training and has delivered various sessions to UHB staff as well as to GPs and externally to multi-agency partners. This has included delivering training organised by South Wales Police.

In addition to training, the Health IDVA has used other forums to generate awareness about the role including presenting at the Cardiff and Vale UHB Nursing Conference in October 2017 and at a safeguarding networking event at Public Health Wales, promoting awareness of domestic abuse amongst a wide variety of health professionals from different health boards. As an organisation we also supported the White Ribbon event in October 2017and set up stalls to sell white ribbons and promote awareness amongst staff, patients and visitors.

In May 2017, in line with the work plan the Health IDVA began to generate awareness of the Health IDVA role within mental health services. This included attending at Senior

Team meetings, Crisis Team meetings and at the Crisis Recovery Unit to meet with staff. There has also been an update published in the mental health newsletter. Increased awareness amongst mental health services is a priority however this is on-going, as Ask and Act referrals are increasing from all departments, the Health IDVA has to manage generating awareness about the role with the capacity to respond to referrals and see patients.

During the period April 2017-March 2018, 199 Ask and Act referrals were received. This has shown an increase in referrals with an average of 16.6 referrals per month compared with an average of 12 per month within the first 6 months of post and an average of 4 per month prior to the Health IDVA role being introduced. Following these referrals during April 2017-March 2018 safety planning has been completed with 97 clients either over the phone or face to face and initial assessments have been completed with 61 of these clients, with 33 of these assessed to be at high risk of domestic abuse. In cases where assessments have been completed individualised safety plans have been developed with support including markers and security measures on properties, support reporting to the police, support to access refuge, referrals for counselling and referrals to specialist support services. In addition the Health IDVA has made 31 referrals in to MARAC during this reporting period.

Contest

Contest is the UK Government's counter-terrorism strategy. Part of the strategy, PREVENT is designed to tackle the problem of terrorism at its roots, with the aim of preventing vulnerable people from becoming radicalised. The Safeguarding Team, working directly with the Strategic Partnership and Planning Manager have developed a UHB referral pathway for UHB employees to follow when they have a concern that a service user or a member of staff maybe at risk of radicalisation. Training in this area is disseminated to UHB employees via a workshop designed to help make staff aware of their contribution in preventing vulnerable people from being exploited for terrorist purposes. The Safeguarding Team play a key role in this agenda, working closely with Clinical Boards and the UHB Strategic Partnership and Planning Team.

Human Trafficking/Modern Slavery

Modern slavery is a serious crime in which people are treated as commodities and exploited for criminal gain. The true extent of modern slavery in the UK is unknown. Modern slavery in particular Human Trafficking, is an international problem. Modern slavery includes human trafficking, slavery, servitude and forced and compulsory labour. Exploitation takes a number of forms, including sexual exploitation, forced manual labour and domestic servitude; victims come from all walks of life. The Modern Slavery Act 2015 outlines front line staff responsibility to identify potential victims of modern slavery and human trafficking, refer potential victims and ensure that victims have access to services that they are entitled to. UHB employees are identifying victims and are following the Multi-Agency Response Pathway for suspected Cases. Human Trafficking Multi-Agency Risk Assessment Conferences

(HT MARAC) are held in Cardiff on a quarterly basis, the Safeguarding Team represent the UHB at the meeting.

County Lines

County Lines is an emerging national issue that poses a significant threat to communities and exploits the most vulnerable members of society. Vulnerable local residents will be exploited, coerced and forced to participate. Their properties are targeted and occupied (cuckooing); vulnerable people including children are groomed, intimidated and/or threatened into transporting and hosting drug related activity. The emerging themes for children and adults at risk with this activity is exploitation and abuse in all its forms, human trafficking and any associated criminal action.

Information and training has recently been shared by South Wales Police (SWP) to raise awareness of the growing issue identified as County Lines. Resources have been provided to partner agencies, to cascade training within their own organisations to frontline staff who are likely to see people presenting with injuries or sickness associated with the culture and crime surrounding County Lines.

The nature of any person presenting at Cardiff and Vale University Health Board (C&V UHB) is likely to be a child under the age of 18 years old or a an adult deemed to be vulnerable. The threat linked to County Lines is not only a drug problem but is exacerbated by how the criminality is carried out. SWP are reporting an increase in knife crime connected to the gang culture.

Bespoke training from the safeguarding team will be provided to specific areas within the health board most likely to come into contact with county lines activity – these areas include ED, Maternity Unit, Mental Health, GP's ,DOSH, HVs and school nurses. In addition to this awareness raising sessions is being incorporated into existing training packages. This will inform and reinforce existing reporting arrangements to ensure raised awareness and cascade of information to all UHB staff to be alert to this emerging phenomena. The safeguarding team will reinforce multi-agency working with police and social services to provide assurance that the effects of county lines activity is being addressed by health services. The work plan will ensure delivery of training to all bespoke areas over the next eighteen months commencing in June 2018.

Bespoke Priority Work Areas

Priority Work Area		Target Date
Emergency Unit	A minimum of four bespoke sessions on a monthly basis – to commence in July Followed by annual updates	June/ July/ September / October 2018.

Maternity Services	A minimum of two bespoke sessions – to commence in October Followed by annual updates	October / November 2018
Safeguarding Team	Bespoke session to be given before or after Team Meeting in June Updates provided regularly through team meetings	July 2018
Mental Health Services	A Minimum of three bespoke sessions – To commence in November 2018 Followed by annual updates	November/ December/ January 2018
Gp's	Bespoke sessions arranged for Tuesday 12th June and Wednesday 20th June Followed by annual updates	June 2018
District Nurses	A minimum of three bespoke sessions via locality meetings Followed by annual updates	February 2019
SARC / DOSH/ CHAPS	Stand-alone session	March 2019 – police already delivered session – April 2018
Health visitors/ School Nurses	Three sessions through HV/ school nurse forums	December 2018 / January 2019 / February 2019

Ongoing Work Area	**Scope**	**Target Date**
Level 3 – Current Themes	Bi Annual	Sept 2018
Newsletter updates	quarterly	July 2018 – county lines specific
Level 2 – adults and children	A county lines slide added to existing training package	May 2018
National Safeguarding week	Once a year	Sept 2018
CNO Conference	2018 – submission of poster	May 2018

Deprivation of Liberty Safeguards (DoLS)

The Cardiff and Vale UHB DoLS team operate the supervisory responsibility on behalf of Cardiff and Vale UHB, Vale of Glamorgan Council and Cardiff Council

through a Partnership Management Board consisting of senior representatives of each supervisory body.

The DoLS team provide advice to Care Homes, hospital wards and Health and Social Care staff across the sector in relation to Mental Capacity Act (MCA) and DoLS.

Monthly awareness training sessions are provided at UHW and UHL sites.
There has been an increase in requests for assessments since March 2014 when a Supreme Court Judgement clarified DoLS. This is evidenced in the table below, during 2013-2014 pre judgement there were 55 requests made:

Period	Number of health requests made	Number of Assessments Completed
2017-2018	1036	840

The DoLS coordinator is a Band 7 nurse employed by the UHB and supervised/ professionally managed by the Senior Nurse for Safeguarding. Safeguarding training sessions have been arranged across the UHB incorporating safeguarding adults, MCA and DoLS to increase awareness of the correlation with some vulnerable people within our communities.

Sexual Assault Referral Centre (SARC), Ynys Saff

Cardiff and Vale UHB hosts the multi- agency Sexual Assault Referral Centre (SARC), Ynys Saff, in Cardiff Royal Infirmary, which sits within the Children and Women Clinical Board. The service delivers a comprehensive quality service for victims of sexual assault for adults and children in Cardiff and the Vale of Glamorgan; the role of the Safeguarding Team is to support and assist this service with its safeguarding activity.

The number of referrals of both adults and children to the SARC are increasing. Referrals to Cardiff and Vale SARC are increasing, this is evidenced in year on year statistics. Total referrals in 2017-18 621.This represents an increase of 5.1%, however there has been a decrease in the number of children referred. During this period the SARC has seen an increase of 22% in the number of referrals for Rape with referrals for sexual assault remaining the same.

Serious Sexual Offences 2017-2018

Rape	327
Sexual Assault	216
Total	78

2018 sees the 10th Anniversary of the Cardiff and Vale SARC. A conference will be arranged to celebrate and highlight the changes and developments in the sector during the last 10 years.

Learning Disability

Learning from three Serious Incident reviews in 2015 highlighted the need for service improvements required for Learning Disability (LD) patients. Progress has been made to improve the quality of care provided to patients with LD. This has been achieved through the "1000lives" care bundle launch and implementation development of a "flagging" system of immediate alerting across acute areas, modification of NEWS escalation of deteriorating condition response, risk assessment of immediate need and reasonable adjustments required to care. In addition a daily Business Intelligence System (BIS) report gives notification of all in-patients with LD allowing prompt review of this vulnerable group. Easy read qualitative feedback questionnaires which will be automatically sent out to patients with LD and also to family and carers after an admission in order to enable learning have been introduced. In September the UHB will launch LD Champion Roles and regular training of identified staff from all wards and departments, this will enhance dissemination of available resources and share good practice across the breadth of Cardiff and Vale University Health Board.

7. Safeguarding Team Achievements

- Successful Safeguarding Week campaign working with the RSB and organising individual events with the White Ribbon Campaign. A total of £305 was raised in the UHB from staff, patients and visitors. Additional support was given to the staff at Noah's Ark Hospital with Children's Rights
- Completion of a staff and student survey to assess the understanding of safeguarding awareness across the UHB
- Creating a Safeguarding Team poster, distributed across all Clinical Boards
- Raising awareness at conferences of the Health IDVA role and the FGM working group
- Securing counselling for the SNAs to ensure emotional well-being is considered due to the acuteness and depth of cases discussed in Cardiff MASH

8. Forecast 2018-2019

Continuing with the achievements made, sustaining and maintaining the safeguarding agenda workload is challenging for the UHB safeguarding team. This is an area that continues to evolve with emerging themes such as County Lines on a regular basis. The safeguarding team has proved that it is an innovative team that demonstrates the ability to adapt to contempory situations. Ensuring that staff resources are available to cover three sites is often demanding, particularly the amount of work generated within Cardiff MASH, the multi-agency commitments to the RSB and Public Health Wales. The team will strive to resume the energy demonstrated to address the safeguarding agenda and ensure that staff and the public are safeguarded appropriately by the UHB. Further work during 2018-2019 will include:

1. Audit of Domestic Abuse cases identified in ED
2. Showcase the multi-agency approach to Birth Plans for Unborns

3. Develop an adult version of the Sexual Exploitation Risk Assessment Form (SERAF)
4. Introduce a staff Risk Assessment for FGM to accompany a referral to Children's Services
5. Develop a Cardiff and Vale UHB FGM model that demonstrates the Cardiff multi-agency approach
6. Ensure that the Welsh Government National Training Framework is rolled out across UHB Clinical Boards with identified disciplines for Group 2 and 6
7. Share the multi-agency Regional VAWDASV Strategy across the UHB ensuring that staff and the public are aware of its existence
8. Implement the Safeguarding Group Supervision for HVs following the study undertaken by Cardiff University
9. Work collaboratively with Children's Services to ensure that GPs are notified and invited to attend Child Protection Conferences across the locality
10. Encourage GPs to complete safeguarding referrals for both children and adults via the safeguarding.referrals@wales.nhs.uk mail address so that we are able to capture and promote safeguarding activity in the locality

9. **Summary**

Since April 2014 the National and indeed International safeguarding landscape has broadened. We have seen the introduction of two significant Acts of law in Wales which has impacted on the safeguarding work stream across the UHB requiring significant changes in process, additional training and supervision as well as re-location of existing resources. Further legislation from the Home Office has also defined the need to raise awareness of Domestic Homicide and FGM. The Modern Slavery Act (2015) is another area whereby the safeguarding team need to work with partner agencies to raise staff and public awareness.

The Cardiff & Vale University Health Board Safeguarding Team will strive to continue to meet all of the demands set by the UHB and Welsh Government to ensure the safety and safeguarding of children and adults at risk that become known to us. This will only be achieved by continuing to work collaboratively with our strategic partners ensuring that communication and decision making is embedded in open, honest and transparent practice.

CANCER PEER REVIEW – CANCER PATHWAY
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 18th September 2018

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 patients with cancer leading to improved performance, quality and care outcomes.
Health and Care Standard Number … 3.1Safe and Clinically Effective Care
CRAF Reference Number …… 5.1 Deliver safe, effective and effective care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report
- **AGREE** that appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.
- **NOTE** that the NHS Wales Peer Review Framework WHC 17 037 has been received and will be considered by the QSE in February 2018.

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 review of Cancer Pathways.

BACKGROUND

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

ASSESSMENT AND ASSURANCE: Summary of Peer Review Report for Cancer Pathway

Good Practice:

- **Senior Management**

The UHB have demonstrated a turnaround in senior management in recent years with the senior team not only showing clear leadership on cancer issues but also active engagement at a national level. This is evidence particularly through the peer review process.

- **Infrastructure**

The function of cancer services and information is clear and unambiguous with the associated structure also being relatively straight forward.

- **Improvement**

Whilst not having dedicated cancer improvement resources, the UHB have utilised the HB wide improvement resources to improve pathways in specific areas particularly urology and dermatology. The UHB also has new areas to target in endoscopy and lower GI.

- **Tentacle**

Although the UHB has adopted a system unique in Wales it is able to understand the place of the system and is investing in it further. It understands how to use the system in a manner that replicates the national requirements and as such is a HB which both informs and responds to national requirements regarding data requirements.

Concerns:

- **Management sustainability**

The current Cancer Manager has retired and this post must be replaced on a full time basis.

- **Diagnostics**

Radiology not linked significantly to cancer pathway

- **Straight To Test (STT)**

There is little evidence of STT both operationally or as a principle that might be pursued by the HB on a strategic basis.

- **Governance oversight for tertiary services**

There is a limited understanding of the quality of these services and the governance risks associated with participating in tertiary MDT's.

- **Business Intelligence**

There is no evidence of business intelligence nor its use in planning services

- **Single Cancer Pathway**

Impact of development and adoption of the Single Cancer Pathway across the UHB.

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.

APPENDIX 1

Cardiff and Vale University Health Board

Cancer Pathway Peer Review Action Plan 2018

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
	CONCERNS					
1	Management sustainability The current Cancer Manager has retired and this post must be replaced on a full time basis.	Appointment of a substantive UHB Lead Cancer Manager.	High	Medical Director	October 2018	• Funding approved for a full time post (role previously undertaken on a part time basis) • Job description re-written and matched for Agenda for Change banding (completed 29/08/18) • Recruitment commenced via TRAC process – to be advertised in September 2018
2	Diagnostics Radiology not linked significantly to cancer pathway	Engagement with CD&T Clinical Board CD&T input at weekly performance meeting Clinical Board escalation process to radiology to expedite patients on pathway	High		Completed	Monitoring ongoing

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
		Integration/development of radis for SCP		Cancer Services Lead Manager	April 2019	
3	Straight To Test (STT) There is little evidence of STT both operationally or as a principle that might be pursued by the HB on a strategic basis.	Clarify and deliver STT for primary care.	Medium		Completed	Straight To Test in place for radiology and endoscopy
4	Governance oversight for tertiary services There is a limited understanding of the quality of these services and the governance risks associated with participating in tertiary MDT's.	To work with the clinical network to establish clear governance arrangements for cancer tertiary services.	Medium	Assistant Medical Director for Cancer Services Director of the Wales Cancer Network	March 2019	Several clinical areas identified (Neuro-oncology, Gynaecology, Upper GI, Liver) and discussions with teams ongoing. Engagement with Wales Cancer Network regarding overarching approach. Needs executive level support in collaboration with the Wales Cancer Network strategy.
5	Business Intelligence There is no evidence of business intelligence nor its use in planning services	Development of tentacle and integration with PMS/BI system	High	Head of Information and Performance Cancer Services Lead Manager	March 2019	

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
6	Single Cancer Pathway Impact of development and adoption of the Single Cancer Pathway across the UHB	Full engagement of Cancer Services, cancer Clinical Leads and Clinical Diagnostics and Therapeutics.	High	Exec Lead: Medical Director Managerial Lead: Deputy Chief Operating Officer (until Lead Cancer Services Manager appointed)	April 2019	UHB Single Cancer Pathway Project Team in place, reporting to the Executive Cancer steering group. Assessment submitted, as requested, to the Wales Cancer Network of current position against work streams.

MBRRACE-UK - PERINATAL MORTALITY SURVEILLANCE REPORT - UK PERINATAL DEATHS FOR BIRTHS FROM JANUARY TO DECEMBER 2016 Cardiff and Vale UHB specific Data
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** : 18th September 2018

Executive Lead : Executive Nurse Director/Executive Medical Director
Author : Head of Midwifery/Lead Directorate Nurse 02920 745190
Caring for People, Keeping People Well: This report underpins all elements of the Health Board's Strategy as follows: • Delivering outcomes that matter to people • Avoiding waste, harm and variation • Join up what we do for the people we serve and strive for operational excellence, making the best use of the resources we have • Working better together across care sectors through people, innovation, improvement, research and technology • Offer services that deliver the improvements in population health that our citizens are entitled to expect
Financial impact: There are no current financial costs associated with this report.
Quality, Safety, Patient Experience impact : Baby loss has a significant impact on the quality, safety and experience of women and their families. Reasons for loss are complex and multi-faceted. However, there is a strong commitment to reduction in stillbirth through several programmes of work which demonstrates a reduction in numbers since 2016. The Directorate are also confident that all losses are reported, data is accurate and improvements in care have been identified.
Health and Care Standard Number: Standard 1.1 Health Promotion, Protection and Improvement Standard 2.1 Managing Risk and Promoting Health and Safety Standard 2.4 Infection Prevention and Control (IPC) and Decontamination Standard 2.5 Nutrition and Hydration Standard 2.6 Medicines Management Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk Standard 2.8 Blood Management Standard 2.9 Medical Devices, Equipment and Diagnostic Systems Standard 3.1 Safe and Clinically Effective Care Standard 3.2 Communicating Effectively Standard 3.3 Quality Improvement, Research and Innovation Standard 3.4 Information Governance and Communications Technology Standard 3.5 Record Keeping

Standard 4.1 Dignified Care Standard 4.2 Patient Information Standard 5.1 Timely Access Standard 6.1 Planning Care to Promote Independence Standard 6.2 Peoples Rights Standard 6.3 Listening and Learning from Feedback Standard 7.1 Workforce
CRAF Reference Number : 5.1
Equality and Health Impact Assessment Completed: No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- A reduction in baby loss since 2016
- The recommendations of the MBRRACE-UK report have been adhered to and measures taken
- Evidence of ongoing work within the Directorate to ensure that the reduction of stillbirth and early neonatal death remains a priority area for improvement

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the contents of the report and
- **APPROVE** assurance given for reduction of stillbirth and neonatal death within Cardiff and Vale UHB**.**

SITUATION

The purpose of this report is to provide assurance into the reduction of perinatal mortality rates for Cardiff and Vale UHB as published within MBRRACE-UK Perinatal Mortality Surveillance Report for UK Perinatal Deaths for Births from January to December 2016.

MBRRACE-UK Perinatal Mortality Surveillance Report 2018 – HQIP

BACKGROUND

MBRRACE-UK are commissioned by the Healthcare Quality Improvement Partnership (HQIP) to undertake the Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP) on behalf of NHS England, the Welsh Government, the Scottish Government Health and Social Care Directorate, the Northern Ireland Department of Health, the States of Guernsey, the States of Jersey, and the Isle of Man Government.

The aim is to collect, analyse and report national surveillance data and conduct national confidential enquiries in order to stimulate and evaluate improvements in health care for mothers and babies.
Deaths being reported to MBRRACE-UK since 1st January 2013 through the secure online reporting system are:

- Late fetal losses: a baby delivered between 22+0 and 23+6 weeks gestational age showing no signs of life, irrespective of when the death occurred;

- Stillbirths: a baby delivered at/or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred;

- Neonatal deaths: a live-born baby (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) who died before 28 completed days after birth.

Definitions:

Late fetal loss:	A baby delivered between 22+0 and 23+6 weeks gestational age showing no signs of life, irrespective of when the death occurred.
Stillbirth:	A baby delivered at/or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died before 28 completed days after birth.
Extended perinatal death:	A stillbirth or neonatal death.

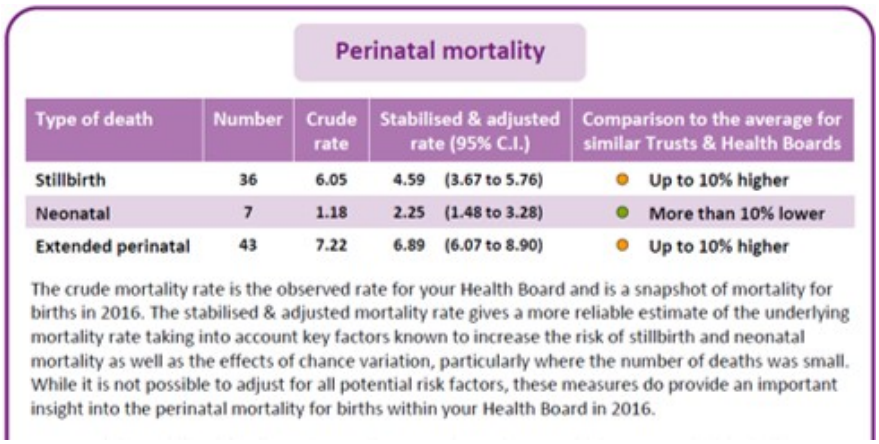
Individual level information on all births in the UK is obtained in order to generate mortality rates adjusted for maternal, baby, and socio-demographic risk factors. This information is acquired through the collaboration of the following organisations:

- Patient Demographic Service (PDS)
- Office for National Statistics (ONS)
- Birth registration data (for England, Wales, and the Isle of Man)
- National Records Scotland (NRS) and Information Services Division (ISD) (for Scotland); Northern Ireland Maternity System (NIMATS) (for Northern Ireland); the Health and Social Services Department (for the Bailiwick of Guernsey) and Health Intelligence Unit (for the Bailiwick of Jersey).

The data is amalgamated to give a single dataset of births for the whole of the UK and the Crown Dependencies with the information about the deaths to obtain the final data for analysis.

This report concerns stillbirths and neonatal deaths among the 5,955 babies born within Cardiff and Vale University Health Board in 2016, EXCLUDING births before 24 weeks gestational age and all terminations of pregnancy. Neonatal deaths are reported by place of birth irrespective of where death occurred. Deaths from all causes except termination of pregnancy are reported, including those resulting from congenital anomalies.

Cardiff and Vale University Health Board is also a tertiary referral centre receiving the most complex and high risk pregnancies for South East Wales. In 2016, Cardiff and Vale were reported to have a higher than average number of stillbirths and extended perinatal deaths when compared to similar Trusts or Health Boards as follows:



Perinatal mortality

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	36	6.05	4.59 (3.67 to 5.76)	Up to 10% higher
Neonatal	7	1.18	2.25 (1.48 to 3.28)	More than 10% lower
Extended perinatal	43	7.22	6.89 (6.07 to 8.90)	Up to 10% higher

The crude mortality rate is the observed rate for your Health Board and is a snapshot of mortality for births in 2016. The stabilised & adjusted mortality rate gives a more reliable estimate of the underlying mortality rate taking into account key factors known to increase the risk of stillbirth and neonatal mortality as well as the effects of chance variation, particularly where the number of deaths was small. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within your Health Board in 2016.

MBRRACE recommends that Health Boards whose mortality rates are marked red or amber should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

ASSESSMENT AND ASSURANCE:

The Directorate were aware of the findings prior to publication of the Report, however MBRRACE-UK have reported some inaccuracies for Cardiff and Vale within the National Report, i.e. there was only one intrapartum death in 2016. Due to reporting changes within the MBRRACE-UK team, this was not conveyed and as such the seven reported within the national report is inaccurate. Local information for Cardiff and Vale has also been received from the MBRRACE-UK team which confirms 1 intrapartum death for 2016 and a high level of data reporting at 95.3-100%.

Data quality issues were also noted as a national concern in that Wales does not collect information such as age leaving full time education or PAPP-A results which reduces data completeness.

This has been raised with the MBRRACE team and acknowledged. As the Report had already been published, MBRRACE-UK were unable to amend. Steps have also been taken locally to ensure accurate and up to date reporting in line with the changes made by the MBRRACE-UK team.

Stillbirth rates were audited in 2016 & 2017 to provide assurance and identify learning. Results revealed for both 2016 and 2017 that women experiencing loss were more commonly:

- Between 24 & 36 weeks gestation

- Multiparous (more than one baby)
- White British
- Normal BMI
- Average age 20-30
- Non Smoker
- No underlying mental health issues
- 2016 and 2017 audit revealed that almost half the babies were small for gestational age <10th Centile
- Post Mortem Consent increased

Stillbirth rates for 2016 and 2017 were previously shared within Cardiff and Vale UHB at both Nursing and Midwifery Board meetings and Quality and Safety Meetings within the Directorate and Clinical Board. Plans to reduce the stillbirth rate were also shared at this time and this included:

- Initiation of a multi-professional stillbirth review forum in May 2016 and reviewed all cases from 1st January 2016 onwards. All stillbirths and fetal losses that meet the criteria for MBRRACE reporting are discussed monthly. Membership consists of the Head of Midwifery, Senior Midwifery Manager, Consultant Obstetrician, Bereavement Midwife, Fetal Pathologist, Risk & Governance Midwife and SANDS (Stillbirth and Neonatal Death Society) representative. Sands | Stillbirth and neonatal death charity
- Implementation of the National Gap & Grow Programme for better surveillance and detection of small for gestational age (SFGA) babies. Providing a customised growth chart for women ensures that there is better detection of genuine SFGA babies.
- Plot fetal growth on customized growth charts post-delivery (since 2016)
- Introduction of the Safer Pregnancy Campaign.1000 Lives Improvement | Safer Pregnancy. Six key messages are given to women including staying active, eating well, attending appointments, stop smoking, stop drinking alcohol, stop taking drugs preventing infections, monitor fetal movements.
- Increasing the number of carbon monoxide monitors for women and encouraging testing for all women. Carbon Monoxide testing is currently 89% and the highest in Wales.
- Neonatal deaths are discussed at monthly multi professional neonatal mortality and morbidity meetings/perinatal mortality meetings.
- 'Teardrop' team of midwives working closely with SANDS to make improvements for bereavement care and taking a proactive role in reduction of stillbirths.

More recent initiatives:

- On-line MBRRACE-UK PRMT review tool used to input data for C&V during stillbirth review forums.
- Implementation of a 'Rainbow Baby' next pregnancy clinic following a previous loss. This ensures women receive serial scans throughout their pregnancy and receive pre-conception care, early and timely access.
- Healthy Pregnancy Clinic introduced following a Service Improvement Methodology Project within C&V, this clinic supports women with a raised BMI of

between 35 and 39.9 to gain a healthy weight in pregnancy and receive serial scans throughout their pregnancy.

- Reduced fetal movements – raised awareness with more timely access to ultrasound scan.
- PROMPT multi professional emergency drills. Commences November 2017, faculties and plans in place to fully implement by Spring 2019.
- Development of a fetal surveillance care bundle for fetal monitoring. The Care Bundle requires staff within C&V to undertake additional training above national requirements for fetal assessment and well-being during labour. The Bundle also takes into consideration the recommendations from Each Baby Counts in that Human Factors / Situational Awareness is considered. Each Baby Counts reports and project updates
- Increased postmortem consent training for staff. Post mortem consent has increased by 50%.
- Funding to become Birthrate + compliant received June 2018, 29 WTE midwives join the UHB in October 2018 to achieve compliance.
- Fetal surveillance midwife post being developed to increase knowledge and interpretation of intrapartum cardiotocograph (ctg).
- Working with Welsh Government to scope antenatal ctg package to improve detection of problems during pregnancy.
- Exploring the feasibility of implementation of PAPP-A results as a strong indicator for detection of small for gestational age babies.
- Development of a second bereavement room from generous funding from SANDS within the obstetric delivery suite, following feedback from bereaved parents where a mother requires close monitoring of her condition.
- Development of a 'Dignity Room' with generous funding from SANDS within the Obstetric Delivery Suite. This is a quiet area where staff can support relatives with memory making and undertake other bereavement tasks.
- Implementation of a new model of community midwifery from November 2018 to strengthen Continuity of Carer for women in the ante and postnatal periods. There is strong evidence to suggest that where continuity of carer is achieved, there is a reduction in adverse outcomes.

Current Position

The Directorate are fully aware of all fetal losses and have robust measures in place to ensure that all losses are reviewed and/or investigated appropriately whilst keeping the family firmly involved and at the centre of care provided.

A breakdown of reportable ≥ 24 week losses for previous (and current year) is as follows:

Year	Total Births	1st Jan-30th June			1st July – 31st December		
		Antenatal	Intrapartum	22-24 wks	Antenatal	Intrapartum	22-24 wks
2016	5962	21	0	1	14	1	4

2017	5700	14	0	2	10	1	3
2018	2719 (6/12)	8	0	0			

N.B: Medical termination of pregnancy and feticide have been excluded. All gestation less than 22/40 have also been excluded as these are not reportable according to MBRRACE-UK requirements.

Challenges

Increased fetal surveillance and changes to national guidance/emerging evidence has resulted in an increasing demand for ultrasound scan provision. The Directorate is exploring demand/capacity issues and work is underway to determine what extra level of support is needed in order to prepare a Project Outline Document/Business Case if required.

Full implementation of NICE Guidance of Diabetes in Pregnancy: Management from Pre-Conception to Postnatal Period (2015) is also challenging due to the increasing number of women with a BMI of ≥30 requiring testing and regular ultrasound scan surveillance to determine fetal wellbeing.

Assurance

Marginal gains are being made in all areas to reduce rates for Cardiff and Vale University Health Board. The Board will continue to receive assurance that work is progressing to reduce stillbirth and neonatal death rates in Cardiff and Vale through Directorate and Clinical Board Quality and Safety Committees and will present this information annually to the Quality and Safety Executive Committee. There are no timescales for completion however ongoing monitoring of improvement will be through Directorate & Clinical Board governance and assurance processes.

CARE OF THE DETERIORATING PATIENT – HOSPITAL AT NIGHT SERVICE HEALTH AND CARE STANDARD 3.1 – SAFE AND CLINICALLY EFFECTIVE CARE
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 18th September 2018

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

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- Control measures that are already being taken and actions identified previously (April 2018).
- Oversight of this risk by the Executive Lead and this Committee.
- Improved monitoring with an improved culture of reporting of incidents
- Plan being developed for Autumn 2018 to address/mitigate shortages

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the update
- **NOTE** suggested service model and update to be provided at the UHB November Board Meeting

SITUATION

Following the April 2018 Quality, Safety and Experience Committee (Corporate Risk and Assurance Framework Update – Revised Risk Assessment for Care of the Deteriorating Patient) the Committee asked specifically for an update for ongoing work on the Hospital at Night (H@N) Service as part of the risk assessment of the care for the deteriorating patient.

This is an interim report on work continued since the April 2018 Committee Meeting to consider service development of the Hospital at Night Service

recognizing a fuller report will be presented at the UHB Board Meeting in November 2018. That will include an update on the actions being taken as part of the Corporate Risk and Assurance Framework - Care of the Deteriorating Patient.

BACKGROUND

The Hospital at Night (H@N) structure for managing the care of patients within the Hospital at night and weekends was implemented in January 2005 in the UHB. Since then there have been significant changes impacting on its ability to deliver a sustainable and safe service in both UHW and UHL and other areas of the UHB which are covered by the H@N teams. Adapting to these challenges has largely been unplanned. Concerns have been raised particularly about rota gaps, resulting in concerns about the sufficiency of the current service.

Currently Hospital at Night provides site practitioners to UHW and UHL and Critical Care Outreach services are provided to patients in acute inpatient beds within Specialist Services and Surgical Services (UHW only). The Medicine Clinical Board provides a Medical Rapid Response Team and work continues to align processes.

The H@N system relies heavily on doctors in training in a complex rota supported by highly skilled Site Nurse Practitioners.

The Medical Director currently has regular one/two monthly meetings with invited representatives from all the Clinical Boards. Also through the HSMB regular updates have been provided to Clinical Board Directors to request that the H@N rota is filled to provide appropriate cover and safe care, including written correspondence to the Clinical Board Directors from the Medical Director.

ASSESSMENT AND ASSURANCE

It has been well recognised that the reporting of incidents concerning the Hospital at Night Service have not been captured as thoroughly as would be expected to assess the effectiveness and safety of the H@N service. Very few incidents were raised previously about the service. To try and improve reporting of the Service since April 2018 a number of actions have occurred.

1. The Medical Director has met with Junior Doctors and the Medicine Clinical Board and the Junior doctors have been encouraged to submit incident reports on a regular basis with regard to staff shortages.
2. The Chief Resident for Medicine (Dr Aarij Siddiqui) has also worked with Junior doctors in the Medicine Service to encourage Junior doctor reporting of incidents. With the Head of Patient Safety and Quality (Maria Roberts) more effective methods of reporting Clinical Incidents have been developed to identify risk in the service.
3. Using representatives from LLandough Hospital a review of hospital services has been conducted and a recognition that additional cover for Llandough is required.

Further actions include planned visits in the autumn 2018 to services in England to consider other H@N models prior to the further report for the UHB Board in November.

Audit of Service
Between 1.5.2018 and 31. 7.2018 with increased awareness of reporting mechanisms by staff the following incidents have been noted. Searching under the relevant categories 53 incident reports relevant to H@N were found. The majority were no or low risk categories. There were 5 referred to as moderate risk. No serious incidents were reported. They were reported across medical and surgical specialities and predominantly referred to rota gaps for both Medical Staff and Site Nurse Practitioners. Escalation to the site manager and relevant Consultant occurred. The concern in the reports was mainly an inability to deliver timely care which does affect our ability to be efficient and will affect the flow of patients through the system.

To assess the completeness of incident reporting further data was obtained from the Site Practitioners as to gaps in service. Over the same three month period there were 39 medical gaps and 77 Site Nurse Practitioner gaps on the UHW site.

Further Work
The Medical Director will continue to work with the Clinical Boards to develop an appropriate service model to be agreed in Autumn 2018 to mitigate service gaps and look to expand the H@N service to cover out of hours and weekend cover.

The current suggestions include;

1. Expansion of the Site Nurse Practitioner workforce, with advanced skills, to include enhanced cover for Llandough.
2. Consideration of the use of Physicians Associates
3. Consideration of the establishment of an F3 grade of doctor (doctors who do not wish to commit to entering into a formal training regime after completion of their F1/F2 training and in return for providing service cover will receive Speciality experience).

QUALITY IMPROVEMENT AND RESEARCH AND INNOVATION – HEALTH AND CARE STANDARD 3.3
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 18th September 2018

Executive Lead : Medical Director
Author : R&D Director, R&D Office, University Hospital of Wales, Heath Park, Cardiff, CF14 4XW.
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Culture" elements of the Health Board's Strategy.
Financial impact : Nil within the scope Standard 3.3 **-** The Research and Development Budget from Welsh Government is approximately £5m per annum. Commercial income to the UHB around £1m per annum together with the added reputational and financial benefits of free drugs. Research grant income also contributes positively to the financial position of the UHB
Quality, Safety, Patient Experience impact : Ensuring access to safe research opportunities and quality improvement through relevant audit processes
Health and Care Standard Number Standard 3.3 - Quality improvement and research and innovation
CRAF Reference Number : 5.1 Deliver safe and effective care 7.2: Invest sufficient resources in innovation, service improvement and knowledge management
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current self –assessment for Health and Care Standard 3.3 as 'Meeting the Standard' (Appendix 1)

The Quality, Safety and Experience Committee is asked to:

- **AGREE** the report

SITUATION

This report is submitted to update the Committee on progress with Health and Care Standard 3.3.

BACKGROUND

In order to meet this standard services should engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.

R&D, Audit and Innovation are all covered in Standard 3.3. In CVUHB, these three areas are managed by separate departments and the SBAR report (appendix 1) is written with input from these three areas. This report is submitted by the R&D Director who is responsible for the R&D elements of this Health and Care Standard.

The full list of criteria can be found here in section 3.3.of the Health Care Standards.

ASSESSMENT AND ASSURANCE

The Committee is asked to note the following improvement actions have been identified as key deliverables for 18/19:

- Deliver 2 cohorts of LIPS (160 people)
- Ratification of Clinical Audit Procedure
- To explore the possibility formal performance reviews around Clinical Audit in conjunction with R&D Exec Performance Review
- Clinical Audit database
- Introduce quality assurance /how are we doing boards in clinical areas
- 6 monthly performance reviews for R&D with the Medical Director to monitor progress, working to increase numbers of studies and recruitment to them.
- Appoint R&D Lead in Surgery Clinical Board.
- Review and revise our assessment criteria as 'meeting the standard' is perhaps too easy to demonstrate and does not challenge enough.

APPENDIX 1

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**3.3 Quality Improvement and Research and Innovation**
B **Background**	**Please Confirm the rating from the following** definitions **Meeting the standard**
A **Assessment**	**The R&D Strategy has been reviewed and updated in the past 12 months.** The corporate review against standard 3.3 in line with the scoring criteria developed in 2016 confirmed that the health board is Meeting the Standard, however, there is recognition that the scoring criteria requires revision to more accurately reflect the progress against the standard including the implementation of R&D plans and Clinical Audit Plans. All Clinical Boards have now reviewed and amended their R&D Implementation Plan which was accepted by the Executive Board in March 2018. 7/8 Clinical Boards have 0.1 WTE R&D leads with protected time to undertake the role in accordance with the job description following Children and Women Clinical Board identifying new R&D Lead. The quality of Clinical Board self-assessments was variable and some appeared to have one person/a uni-professional input. No evidence was provided by any clinical board that the number of commercial or non-commercial studies had increased by 5% and 10%. At UHB level, although the number of studies open has remained static there has been a 50% increase in recruitment in the first quarter of this year, increasing commercial income and an acknowledgement of increasing study complexity:

	• CVUHB recruited 42% of all patients in Wales entered into an interventional study • Increasing numbers in first in man and early phase studies on UHW Clinical Research Facility (CRF) • First two patients in world treated in an international study on CRF • The CRF staff are finalists in the Nursing Times annual national awards First 6 monthly R&D performance reviews chaired by Medical Director took place in February with follow up meeting due in September 2018. First ever R&D performance reports provided by R&D for Clinical Boards in June 2018. First ever CVUHB benchmarking report provided by R&D for CVUHB highlighting that CVUHB is the best performing UHB in Wales but is below equivalent organisations in England. Specialist Services Clinical Board reports that the R&D lead is engaging with all directorate leads to deliver an ambitious research strategy for the clinical board. Each directorate is required to have a strategy for research. Research workforce is being reviewed where appropriate to ensure sustainable and growth of research portfolios. High impact publications continue to be produced by Specialist Services with two New England Medical Journal publications imminent. There continues to be very strong links with Cardiff University, with joint Clinical-Academic appointments in Haematology, Neurosciences, Genetics, ALAS and Nephrology. The Nephrology Research Unit currently employs 3 Research Nurses and has successfully taken on 10 commercial and 5 non-commercial trials. Commercial trial income was over £50,000 in 2017. The Surgery Clinical Board is working with Cardiff University on a Nurse led research project that has been successful in gaining a research grant. This is the first time that nursing research of this classification has been carried out in the Surgery Clinical Board. CD&T Clinical Board report that Governance around R&D is strengthening. The Paediatric Clinical Research Facility continues to

	increase its activity and recently had a very successful meeting with Andrew Goodall although more resources would be most welcome **Local audit is undertaken to give assurance around the quality of care delivery or to address a priority within the directorate and robust action plans are put in place using recognised quality improvement methodology. Recent audit completed and awaiting final feedback.** Very modest clinical audit plans were developed last year by all Clinical Boards incorporating mainly national clinical audit. Local clinical audit activity ad reporting mechanisms vary significantly between directorates/ localities and Clinical Boards. 164 Clinical audits were registered in 2017/18 the majority remain ongoing or have been completed, however, anecdotal evidence suggests that there is significant clinical audit activity that is underway but is not registered on the UHB database. There has been good engagement around the National Clinical Audits with the completion of assurance proformas and improvement plans reported through HSMB. Local clinical audit plans are in place and monitored via the Quality, Safety and Experience Committee structure. Local audits are carried out by a variety of healthcare professionals including doctors, nurses and scientists to assess compliance with clinical standards. **Action plans are developed as necessary to address the outcomes of national clinical audit.** A robust process is now in place to review and report outcomes of national clinical audits. Action plans are developed and monitored accordingly. **There is a considered and planned approach to undertaking quality improvement measures that addresses areas of identified need and delivers evidence based outcomes.** All Clinical Board's support teams to attend the Leading Improvement in Patient Safety programme and work on improvement priorities identified from audit, standards, patient experience etc. The UHB:

	• has a number of Clinical Leadership Fellows undertaking individual projects • has 2 more IHI Improvement Advisors (+ one via the Deanery) • is committed to developing QI capacity and capability through IQT bronze and silver The UHB has a number of nominations for the All Wales Continuous Improvement Community Awards 2018 and submitted abstracts to the NHS Wales Awards and the IHI International Forum.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for 18/19** • Deliver 2 cohorts of LIPS (160 people) • Ratification of Clinical Audit Procedure • To explore the possibility formal performance reviews around Clinical Audit in conjunction with R&D Exec Performance Review • Clinical Audit database • Introduce quality assurance /how are we doing boards in clinical areas • 6 monthly performance reviews for R&D with the Medical Director to monitor progress, working to increase numbers of studies and recruitment to them. • Appoint R&D lead in Surgery Clinical Board. • Review and revise our assessment criteria as 'meeting the standard' is perhaps too easy to demonstrate and does not challenge enough.

NICE GUIDANCE
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 18th September 2018

Executive Lead : Medical Director
Author : Patient Safety and Quality Assurance Manager 02920744018 Alexandra.scott2@wales.nhs.uk
Caring for People, Keeping People Well : This report underpins the Health Board's "Deliver the Outcomes that Matter and offers services that deliver the improvements in population health that our citizens are entitled to.
Financial impact : There are no financial implications associated with the actions currently being taken as identified within this report.
Quality, Safety, Patient Experience impact : Nice guidance are evidence based recommendations that underpin the delivery of effective, safe and efficient care.
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 process of disseminating NICE guidance and recording levels of implementation
- The response rate around implementation rates
- The implementation rate

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the compliance with the current process and the intention to disseminate NICE Quality Standards.
- **NOTE** the intention to circulate this report to the Clinical Boards for review at their Quality and Safety Meetings.

SITUATION

The National Institute for Health and Care Excellence is an independent arm of the NHS that is responsible for providing guidance on treatments and care for people in the NHS in England and Wales.

BACKGROUND

NICE guidance other than Technology Appraisals (TA) are currently disseminated by the Patient Safety and Quality Team to identified Clinical Leads and Clinical Board Directors on a monthly basis.

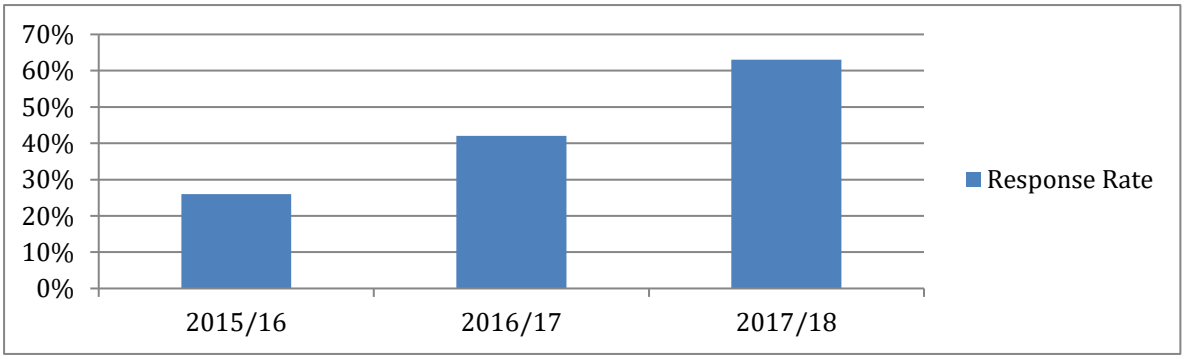
Implementation of Nice guidance other than TAs is not mandated, however it represents independent and objective evidenced based advice about health care provision and implementation is therefore carefully considered. Compliance with medicines related Technology Appraisals (TA) has been mandated since the launch of the New Treatment Fund at the beginning of 2017 and has been recorded since this time. There is a requirement to include medications on the formulary within three months of the publication of the TA and this process is overseen by Pharmacy.

ASSESSMENT

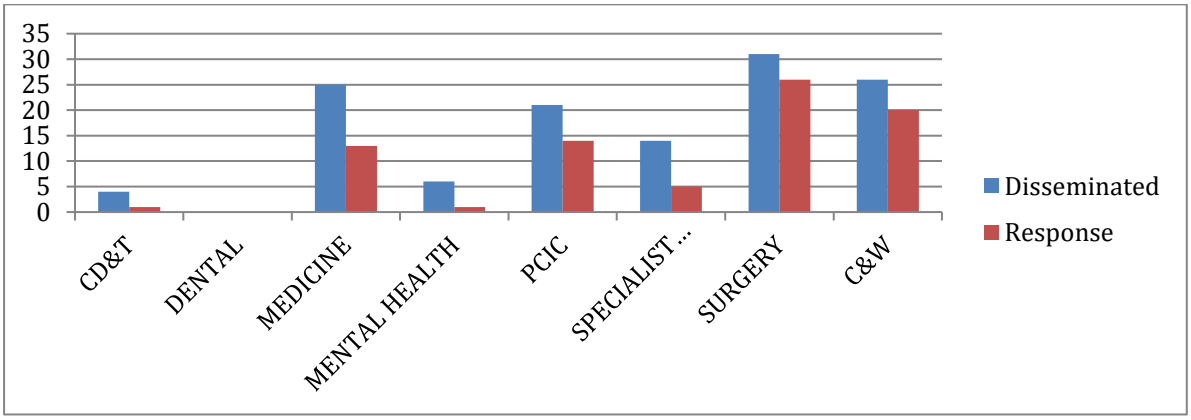
NICE guidance is disseminated to Clinical Boards for action or for information only. NICE guidance circulated "for action" is sent to the Clinical Board Director and the Clinical Lead to consider implementing. Clinical Boards are asked to respond detailing their levels of implementation. Partial or non implementation should be discussed in Clinical Board Quality Safety and Experience (QSE) Committee meeting to mitigate any risk associated with non-implementation.

In 2017/2018 responses were received for 63% of guidance disseminated for action, this represents a significant and sustained improvement since 2015/16. This report will be disseminated to the Clinical Board Directors and Quality and Safety leads for each Clinical Board.

Response rate

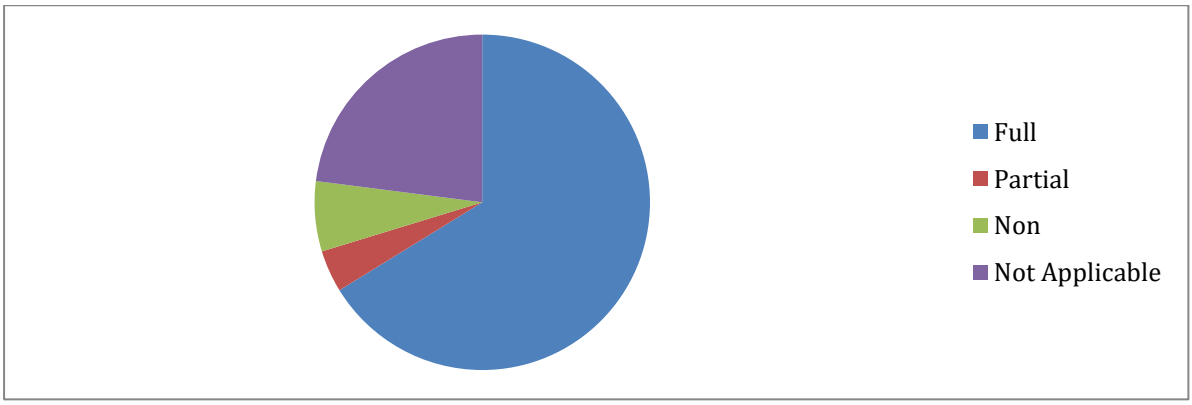


Response Rate by Clinical Board 2017 / 2018



Between April 2017 and March 2018 Clinical Boards were sent 223 pieces of NICE guidance to review. Of these, 127 were for consideration of implementation and the remaining 96 elements were circulated for information only. Of the responses received 61.25% of guidance was implemented in full and a further 3.75% were implemented in part.

UHB % Levels of Implementation



In 2016 /17 the most common reason given for non implementation was financial however in 2017/18 the reasons were more varied and in numerous cases presented the immediate position with recognition that work was ongoing to implement the guidance:

NG80 Asthma: diagnosis, monitoring and chronic asthma management

At the point of reviewing the guidance the expertise and funding was not available for FeNo diagnostic testing to be made available in primary care and the process was not incorporated in the Quality Outcomes Framework (QOF).

The treatment element of NG80 differs from the British Thoracic Society guidance and this is being discussed nationally.

NG71 Parkinson's Disease in Adults
At the point of reviewing the guidance the local expertise to deliver Botox therapy did not exist however training and development was underway.

There is no access to psychological therapies to deliver Cognitive Behavioral Therapy to modify impulse control disorder.

IPG586 Transcatheter Aortic Valve Implantation for Aortic Stenosis
At the point of reviewing the guidance the Individual Patient Funding Request (IPFR) processes was under review at Welsh health Specialist Services Committee (WHSSC).

IPG603 Subcutaneous Implantable Cardioverter Defibrillator Insertion for Preventing Sudden Cardiac Death
Implantation of Subcutaneous Implantable devices is subject to IPFR.

MTG8 MiraQ for Assessing Graft Flow during Coronary Artery Bypass Graft Surgery
At the time of reviewing the guidance the MiraQ was not in use but a Meditrim machine was being used selectively for the same purpose.

IPG591 Ab Externo Canaloplasty for Primary Open-angle Glaucoma
This guidance was not implemented as a result of no patient cohort.

NG77 Cataracts in Adults: Management
The UHB was compliant with NG77 with the exception of intracameral Cefuroxime as not clinical indicated due to low infection rates.

NG37 Fractures (Complex): Assessment and Management
No orthoplastic service provision.

IPG605 Ab Interno Supraciliary Microstent Insertion with Phacoemulsification for Primary Open-angle Glaucoma
No service provision.

MTG35 Memokath-051 Stent for Ureteric Obstruction
At the time of reviewing this guidance a business case was being developed to implement the guidance.

NG75 Faltering Growth: Recognition and Management of Faltering Growth in Children
New guidance is currently being developed which will incorporate NG75 and will be implemented later in the year.

CARERS ANNUAL REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 18 September 2018
Executive Lead : Executive Nurse Director
Author Angela Hughes, Assistant Director of Patient Experience Tel 029 21846108 **angela.hughes5@wales.nhs.uk**
Caring for People, Keeping People Well
Financial impact: There are no financial implications for the UHB associated with the actions currently being taken as identified within this report.
Quality, Safety, Patient Experience impact : the work underpins the delivery of the Ministerial objectives for supporting carers
Health and Care Standard Number Standard 6.3 Listening and Learning from Feedback
CRAF Reference Number Delivering outcomes that matter to people
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION
ASSURANCE is provided by: the annual report

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report for information

SITUATION

Carers Annual Report

There are clear objectives that organisations must deliver for carers.

A – Supporting life alongside caring – All carers must have reasonable breaks from their caring role to enable them to maintain their capacity to care and to have a life beyond caring.

B – Identifying and recognising carers – Fundamental to the success of delivering improved outcomes for carers is the need to improve carers recognition of their role and to ensure they can access the necessary support.

C – Providing information, advice and assistance – It is important that carers receive the appropriate information and advice where and when they need it. The purpose of this paper is to present the UHB 2017 / 2018 Carers activity developed in consultation with the local authorities.

The Social Services and Well-being (Wales) Act 2014 came into force on 6th April 2016 transforming the way social services are delivered. It included significant changes for carers including new rights and new duties, ensuring that they are supported to maintain their well-being and that, they have an equal say in the support they receive.

A recent report by Carers Wales: State of Caring Wales 2017 highlighted the significant impact a caring role can have on both carers' physical and mental health. 59% of the respondents said their physical health has worsened as a result of caring, while 70% said they had suffered mental ill health.

In 2016 a Population Needs Assessment was undertaken and through extensive consultation with the general population, via focus groups, interviews, workshops and surveys, eleven key care and support needs, for young and adult carers, were identified. These are outlined in the Cardiff and Vale of Glamorgan Area Plan for Care and Support Needs Shaping Our Future Well-being: *'Me, My Home, My Community'* 2018-2023. Two of these needs are

1. **Need 1 (N1):** Improve access to information (including financial support and services available)
2. **Need 8 (N8):** Identify carers and provide support to those in need

Along with action one of the plan;

Action 1 (A1): Identify and implement a carer engagement model based on best practice.

All align with the second phase of the carer's engagement project being undertaken by Carers Trust South East Wales (CTSEW), commissioned by Cardiff and the Vale of Glamorgan Councils and Cardiff and Vale University Health Board, to develop a sustainable carer engagement framework or model for the Region.

BACKGROUND

This document sets out the report for 2017/18 of the Cardiff and Vale University Health Board, Cardiff and the Vale of Glamorgan Local Authorities, Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS), highlighting the progress made towards full implementation of the Social Services and Well- Being (Wales) Act 2014. It describes how the transitional funding, provided by Welsh Government, has been utilised, to embed the Act into general practice and support carers within Cardiff and the Vale.

Carers are telling us that they often struggle for recognition from the wider health and care system (State of Caring Wales 2017). The report stated that often carers are not identified or signposted to appropriate sources of information, advice and support. In addition 72% of carers in Wales who responded to the 2017 State of Caring Wales survey felt that their contribution is not understood or valued by society.

As a requirement of the Social Services and Well-being (Wales) Act 2014 a population needs assessment was undertaken in Cardiff and Vale of Glamorgan. Through extensive consultation with the general population, via focus groups, interviews, workshops and surveys eleven key care and support needs, for young and adult carers, were identified. They are outlined in the Cardiff and Vale of

Glamorgan Area Plan for Care and Support Needs Shaping Our Future Well-being: *'Me, My Home, My Community'* 2018-2023
Two of these;

1. **Need 1 (N1):** Improve access to information (including financial support and services available)
2. **Need 8 (N8):** Identify carers and provide support to those in need

Along with the final two actions of the plan;

- **Action 5 (A5):** Provide easily accessible information to carers and relatives in a range of formats
- **Action 6 (A6):** Raise awareness around caring and carers among the public and health and social care professionals to ensure that carers are identified as early as possible and all involved are aware of their rights as a carer

These 'needs' and 'actions' align with the aims of all four carer accreditation schemes:

1. GP Accreditation
2. Young Carers in Schools Project (YCiSP)
3. Health and Social Care Accreditation (H&SC)
4. Pharmacy Accreditation

A carer is defined as someone who provides care on an unpaid basis for another person, with a young carer being aged under 18. They may provide practical or physical care, help with personal care, and help with domestic tasks and/or emotional support.

There are an estimated 50,580 carers in Cardiff and the Vale of Glamorgan and a recent survey in the Vale of Glamorgan indicated that 1 in 12 (8%) of pupils in primary or secondary school could be a young carer. However, the likelihood is that the figure, for both adult and young carers, is much higher.

Carers of all ages can face juggling their caring responsibilities, such as housework, cooking and bathing, with work/school and their own needs. Often there is a lack of understanding from colleagues and/or schoolmates about their role, which can lead to feelings of isolation. Many young carers reported having experienced bullying, social isolation and increased emotional and physical demands being placed on them, which can affect their education. For adult carers it was highlighted in the '*2017 State of Caring Wales'* Report that 73% said that their GP knows they are a carer but don't do anything different as a result.

ASSESSMENT AND ASSURANCE

For many adult carers, the first place they contact for help and support is their GP Practice or Community Pharmacy and for young carers it is often a teacher or staff member in their school. This means that usually GP Practices, Pharmacies and Schools come in contact with carers a long time before there is a social services involvement. Therefore work has been ongoing with Carers Champions in GP

Practices and Schools in order to provide staff, patients and pupils with relevant and up-to-date information about their rights and support they can get as a carer. There is much work on going in the community via GP practices and Schools and in the Health Board to recognise Carers, to value their contribution, to support their caring role and to maintain their health and well being. We also recognise our responsibilities as an employer for the growing numbers of staff who are also carers and recognizing the support that should be offered as an employer.

GP and Pharmacy Carer Accreditations

To improve access to information and raise awareness of carers, among community services, ensuring early identification, in 2015 Cardiff and Vale University Health Board, in partnership with both Local Councils developed a Carers GP Accreditation Scheme. The scheme has a set of criteria that GP Practices need to achieve to obtain recognition for their support to carers. Due to the success of this scheme a similar accreditation has been developed within Community Pharmacy. Plans are to pilot the Pharmacy Accreditation scheme in June during Carers week, in the Vale, with the aim to raise awareness and provide information.

Young Carers in Schools Award

In October 2016 Carers Trust South East Wales was commissioned by the Vale of Glamorgan Council to undertake a Project on behalf of the Vale of Glamorgan and Cardiff Councils and Cardiff and the Vale University Health Board, and supported by Glamorgan Voluntary Services, to provide a Schools Development Worker to encourage and support Secondary Schools in the to work towards the Young Carers in Schools Programme. The Programme, originally developed by Carers Trust and the Children's Society, consists of five standards which schools need to achieve and evidence in order to gain the award.

After the launch of the Young Carers in Schools award the GP Carer Accreditation adapted their documentation to align with the five themes to improve consistency for carers. The themes are:

1. Understand - Assigned members of staff who will take responsibility for understanding and addressing carers needs.
2. Inform - Awareness raising amongst colleagues, sharing knowledge about carers
3. Identify - Carers to be identified
4. Listen - carers are listened to a, consulted and given time and space to talk.
5. Support - Carers are supported and signposted to resources and services
The 'basics' award includes the following key actions:

The bronze/basics' award includes the following key actions:

- Assigning a champion/lead member of staff to understand carers and their needs
- Develop and maintain notice boards and online information carer's issues and support available to them.
- Put in place mechanisms to identify carers.

13 schools across Cardiff and the Vale are now working towards the award. With evidence provided that demonstrates an increase in known young carers;

- Cathays High School - known 8 now 30
- Whitchurch High - known 7 now 25
- Eastern High - known 28 now 46
- Ysgol Gyfun Bro Morgannwg -known 2 now 34

Health and Social Care Accreditation

In addition to the work in the GP Surgeries, Pharmacies and Schools a Health and Social Care Accreditation has been developed. Six areas across health and social settings have been identified for the pilot and meetings undertaken to explain the process and outline expectations. Criteria for this accreditation are consistent with the Young Carers in Schools award and GP Carer Accreditation themes, with a slightly different focus.

Outcomes

In the last three years thirty seven GP practices have engaged with the accreditation scheme with twenty six having achieved the bronze level accreditation across Cardiff and the Vale. In May Birchgrove GP Practice was the first Practice to successfully achieve the silver Accreditation.

Since April 2017 fifteen of High Schools in Cardiff and the Vale have signed up to the Young Carers in Schools award. In December 2017 Barry Comprehensive, in the Vale of Glamorgan became the first school in Wales to achieve the basic level award.

At the heart of the Social Services and Wellbeing (Wales) Act 2014 is the wellbeing of citizens, including carers. Promoting independence and ensuring everyone has a voice is part of the way toward working toward wellbeing.

In 2016 Cardiff and the Vale of Glamorgan Councils and Cardiff and Vale University Health Board commissioned Carers Trust South East Wales (CTSEW) to undertake a short project researching options to establish a sustainable carer engagement framework or model.

There is a clear gap in carer engagement and although carers are more actively involved in decisions affecting the care and support of the person they care for, there is less opportunity for carers to be involved the decision making process of both local authorities and health in general.

Following engagement with carers, professionals across all sectors and a Carer's Workshop in 2017 the development of a Carers Hub was identified as the preferred model to work towards. The need for a one stop shop approach was also identified by carers during the development of the Cardiff and Vale Population Needs Assessment and continues to be highlighted in feedback from carers. This work formed the basis of the second phase of the work undertaken by CTSEW which began in 2017.

ASSESSMENT AND ASSURANCE

Between 2016 and 2017 CTSEW consulted with 128 carers in Cardiff and the Vale of Glamorgan and with 22 support workers. This was to find out their views on carers services and informed the work undertaken in Phase 2.

The following outcomes are expected from Phase 2:

1. Work with Cardiff and the Vale Councils, UHB and Third Sector Councils to develop a proposal to provide a one stop shop facility

2. To form a task and finish 'Expert Panel' of carers to help inform planning and to provide a voice for carers during the project lifetime and beyond

3. Maintain a dialogue between groups who support carers in Cardiff and the Vale of Glamorgan, across all service areas (formal and informal) to facilitate their participation in consultation and engagement opportunities relevant to carers

4. Demonstrate linkages and contact with County Voluntary Councils (GVS and C3SC), the Community Health Council and other relevant representative bodies

The Carer Engagement Service Partnership worked together to develop a proposal for a Carers Hub and Spoke service which includes a centralised point of contact via telephone and email (the hub) and outreach sessions (group or face to face) in community venues throughout Cardiff and the Vale (the spokes). The Hub would also co-ordinate engagement with carers via the Carers Expert Panel.

To date, six carers have joined the Carers Expert Panel and work is ongoing to encourage and support other carers to be involved. This will provide an effective mechanism for ongoing engagement and consultation with carers and will complement the proposed one stop shop service.

MONITORING OF PATIENTS ON WAITING LISTS
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 18th September 2018

Executive Lead : Chief Operating Officer
Author : Deputy Chief Operating Officer – Tel: 02920 744120
Caring for People, Keeping People Well : Timely follow up care underpins the care and sustainability elements of the Health Board's strategy
Financial impact : The cost to reduce planned care waits forms an integral part of the Health Board's Planned Care Plan
Quality, Safety, Patient Experience impact: Timely follow up is integral to the delivery of safe clinical care and good patient experience.
Health and Care Standard Number: 5.1 and 3
CRAF Reference Number: 5.3
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The reducing volume of patients waiting greater than 36 and 52 weeks on a RTT pathway
- The 'backstop' process recently instigated for long waiting patients aims to ensure that reporting arrangements and performance management act as a catalyst to both improving waiting times and ensuring that appropriate clinical governance is in place

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

- **NOTE** the current position and work ongoing in relation to reducing waits, monitoring of and communication with patients waiting greater than 36 and 52 weeks on a RTT pathway.

SITUATION

Timely access to planned care is integral to delivering the Health Board's strategy "Caring for people, keeping people well". Against the backdrop of concerns raised regarding the impact on patients of long waits, the purpose of this paper is to provide an update on three specific areas of concern – waiting times for patients on a Referral to Treatment Time (RTT) pathway, monitoring of long waiting patients and communication with patients waiting.

BACKGROUND

The QSE Committee received a report '*Our lives on hold…Impact of NHS waiting time on patients' quality of life*' prepared by the Community Health Council (CHC) at its June 2018

meeting. Whilst this report was written on an all Wales basis and the CHC, for anonymity reasons, have not been able to provide specific patient stories for Cardiff & the Vale, the patient experience and impact outlined in the report for patients waiting a long time on a RTT pathway is absolutely relevant for the Health Board.

The impact on a patient waiting a long time for treatment was also highlighted recently by the Public Services Ombudsman for Wales following an investigation into a complaint regarding a patient who waited nearly three years for urgent paediatric surgery. This was reported and discussed at the Private Meeting of the Board in July 2018.

ASSESSMENT

The CHC report and Public Services Ombudsman for Wales report highlight three areas of concern. Firstly, they are critical of long waits, stressing the need to reduce these. Secondly, monitoring of patients whilst they are waiting is highlighted as an issue, as is thirdly communication.

Waiting time position

The UHB, up until July 2018, was delivering its RTT Integrated Medium term Plan (IMTP) commitments on a quarterly basis. As at the end of June 2018, there were 686 patients waiting greater than 36 weeks on a RTT pathway, of which 79 patients were waiting greater than 52 weeks. The UHB has seen continuous improvement over the last three years in reducing long waits, as demonstrated in graphs 1 and 2 (Appendix 1). In addition, as part of the progressive agenda to move to monthly RTT delivery, specific action was taken to mitigate the 'bounce back' seen previously in the month following a quarter end, translating into a reported position in July 2018 of 890 patients waiting greater than 36 weeks. Whilst this was an increase of 203 patients compared to the previous month, this should be seen in the context of an increase of 1868 in the same period last year and 1479 from March to April 2018.

For context, the continuous reduction trend seen for RTT long waits in Cardiff is not one mirrored across all of Wales or in England. Graphs 3 and 4 (Appendix 2) show the comparative position of patients waiting greater than 36 weeks in Wales and the greater than 52 week wait position in England.

It is worth noting that the UHB has taken a targeted approach in reducing its longest waits, focusing in the first instance on those specialties assessed as having the highest potential clinical risk. Table 1 (Appendix 3) shows the volume of patients waiting greater than 52 weeks by specialty at year-end and the current quarter. In relation to the Ombudsman report in particular it is worth noting that the UHB has eliminated 36 week waits for Paediatric surgery, with all patients now treated before their 36 week breach date.

Notwithstanding the progress made to date, the UHB is still not where it would wish to be and there is further to work to do to reduce and eliminate the long waits. In 2018-19, the UHB is committed to zero patients waiting greater than 52 weeks by year-end and reducing the 36 week waits to no more than 350 patients (Orthopaedics only).

Monitoring of long waiting patients

The Ombudsman's report specifically highlighted an issue in relation to clinical review and monitoring of the patient whilst they were waiting.

The Chief Operating Officer has recently instigated a 'backstop' process for long waiting patients to ensure that reporting and performance management arrangements act as a catalyst to both improving waiting times and ensuring appropriate clinical governance is in place. On the basis of current volumes, the initial 'backstop' waiting time measure is any patient waiting 62 weeks or more. This 'backstop' waiting time measure will change over time, reducing as volumes reduce. Clinical Board Directors of Operations are responsible for ensuring all patients with a waiting time of 62 weeks or more are tracked and reported to the Chief Operating Officer on a weekly basis. Reported for each patient is the patient's wait in weeks, when they were last clinically reviewed and the planned treatment date. This either provides assurance that the patients have been clinically reviewed or triggers a request for a clinical review for those that could potentially come to harm.

As a result of this process, it has been highlighted that a number of patients on a cardiology or cardiac pathway have been referred by other Health Boards past 52 weeks and, with limited information provided, it is not always clear when the patient was last clinically reviewed. The issue of ensuring responsibility for caring for patients whilst waiting for treatment across two Health Boards was also raised as an issue in the Ombudsman's report for paediatric surgery. There is further work to do, therefore, with Welsh Health Specialised Services Committee (WHSSC) and other Health Boards to ensure that the process and responsibility is clarified for patients referred for tertiary services.

Communication

Poor communication also came through as a theme in both reports – specifically regular communication with patients waiting for treatment but more specifically ensuring patients waiting for treatment know who to contact if they have concerns or need support managing their condition.

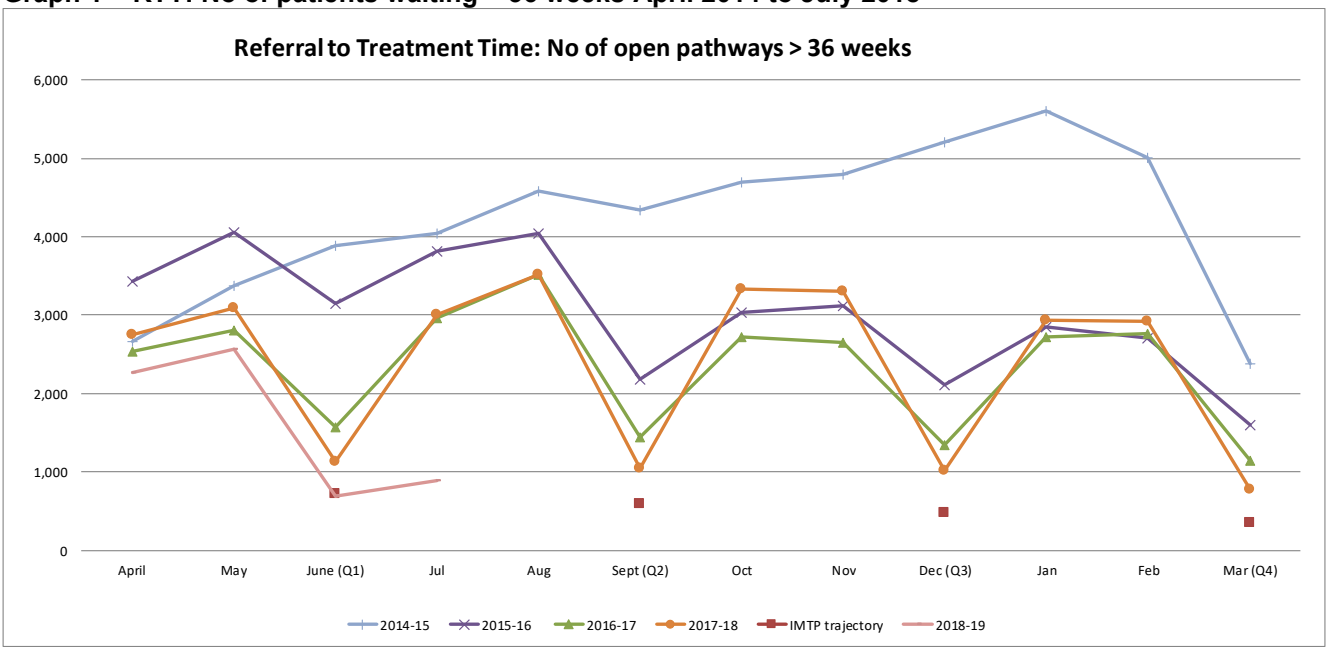
For most specialties, the longest component wait for a patient on a RTT pathway is at new outpatient stage. The letter sent to the patient confirming they have been added to the waiting list includes written guidance directing them back to their referring clinician if their condition deteriorates. This guidance is also detailed on communication patients receive if they are added to the endoscopy waiting list.

There is further work to do, however, for patients waiting on a treatment waiting list to ensure that patients know who to contact if they have concerns or need support managing their condition as communication varies by Directorate. This work will be focused in the first instance on those specialties who have patients waiting greater than 52 weeks.

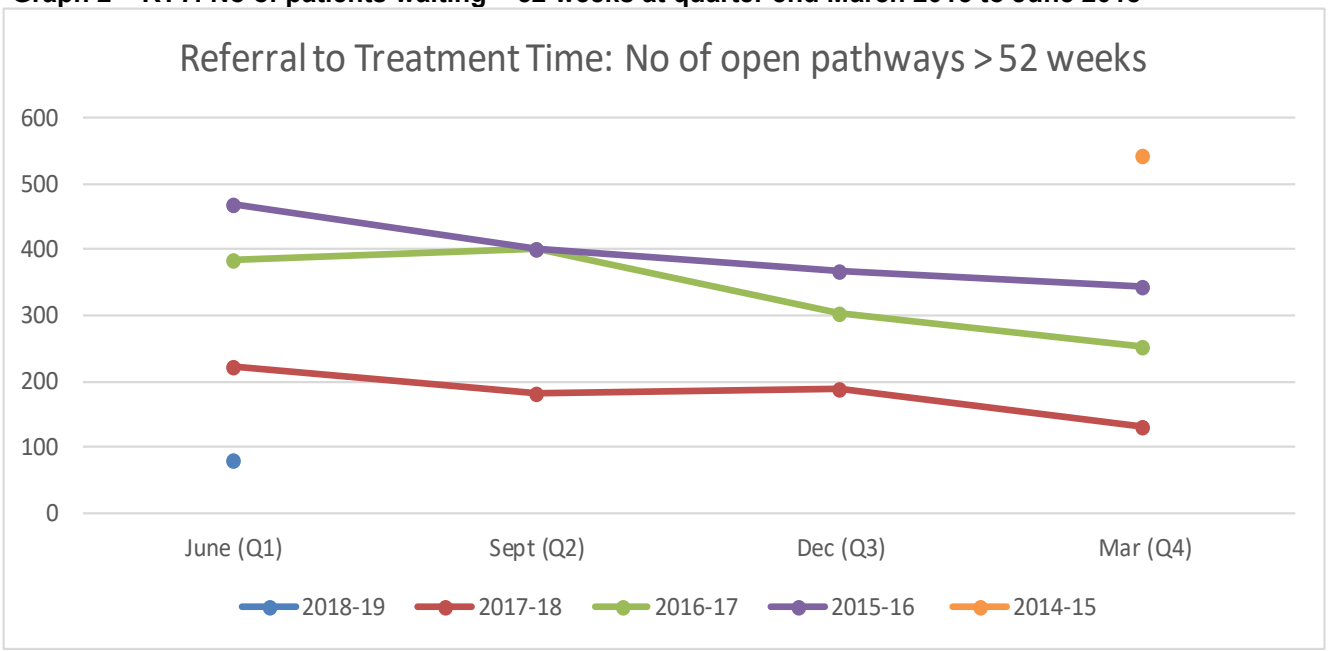
Appendix 1

Referral to Treatment time reported volumes

Graph 1 – RTT: No of patients waiting > 36 weeks April 2014 to July 2018



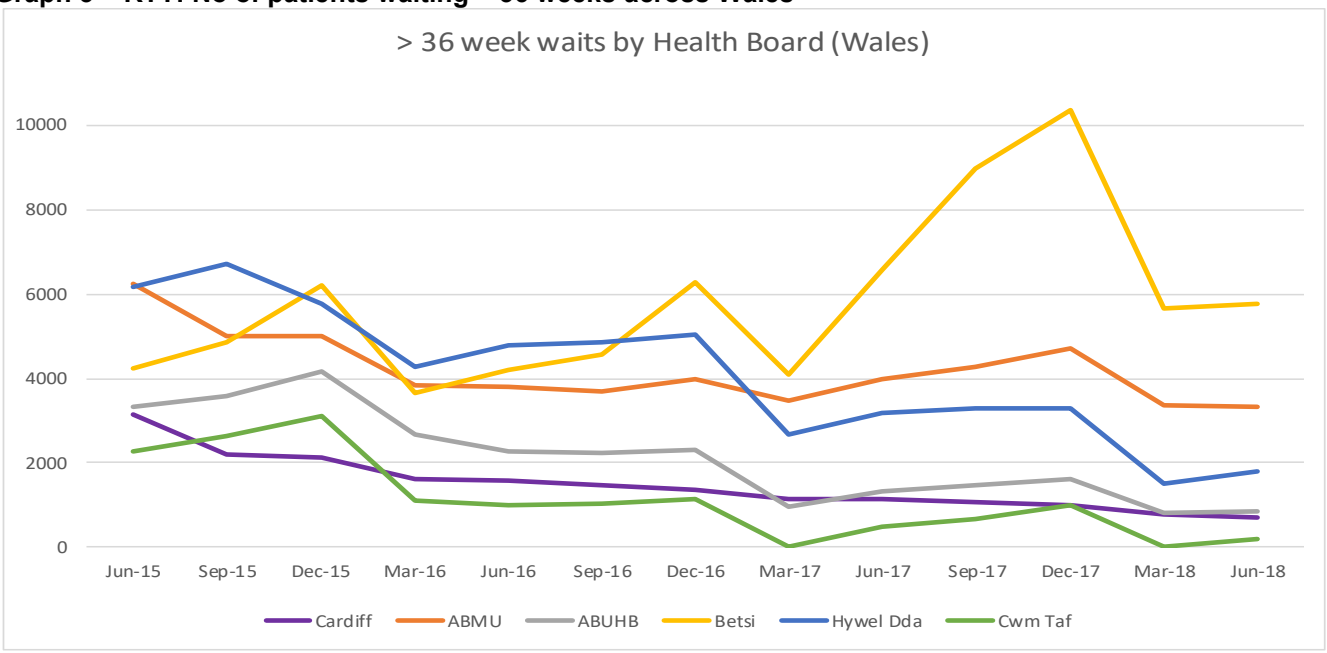
Graph 2 – RTT: No of patients waiting > 52 weeks at quarter end March 2015 to June 2018



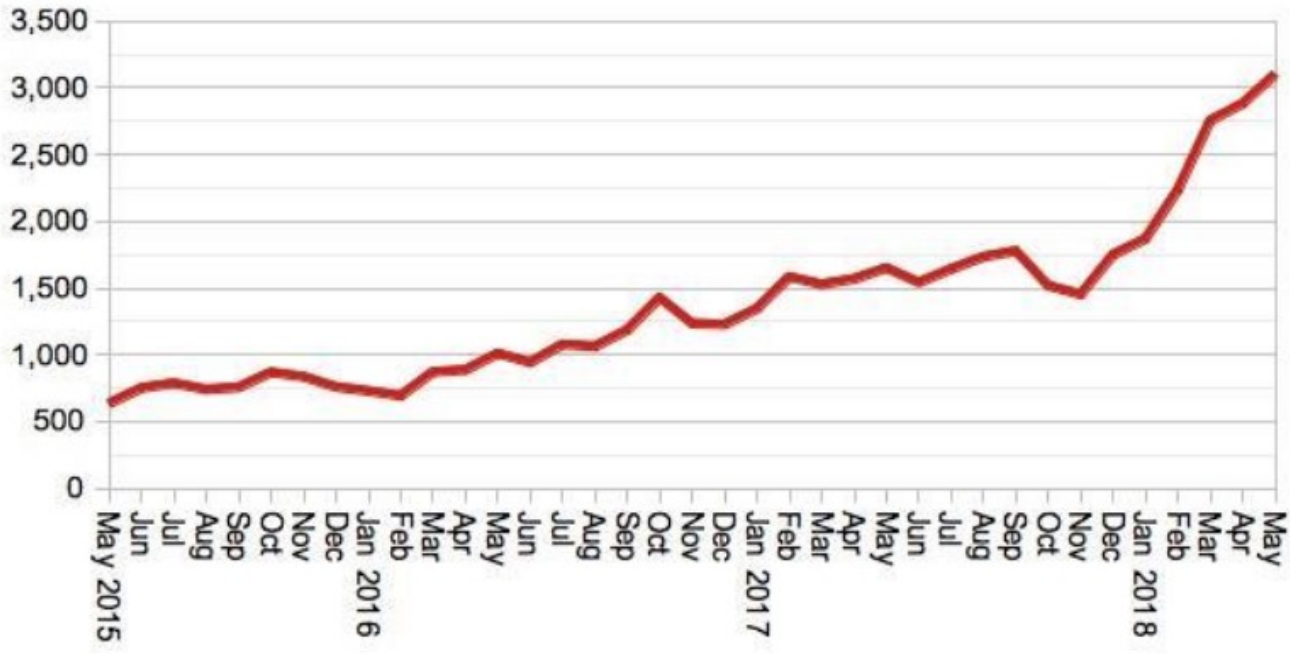
Appendix 2

Referral to Treatment time reported volumes – Wales and England comparators

Graph 3 – RTT: No of patients waiting > 36 weeks across Wales



Graph 4 – RTT: No of patients waiting > 52 weeks in England



Appendix 3

Table 1 – Patients waiting greater than 52 weeks by specialty at year end and current quarter end

Specialty	Mar-15	Mar-16	Mar-17	Mar-18	Jun-18
Paediatric Surgery	30	64	28	0	0
Cardiac Surgery	0	0	3	4	5
Gynaecology	8	1	0	1	0
Dermatology	4	1	0	0	0
Rheumatology	0	1	0	0	0
Integrated Medicine	10	31	15	1	1
Neurosurgery	4	15	86	13	0
Dental	0	0	1	0	0
General Surgery	98	18	7	5	1
ENT	26	113	22	0	0
Ophthalmology	40	47	18	7	5
T&O	1	41	72	95	61
Urology	322	13	0	3	6
Total	**543**	**345**	**252**	**129**	**79**

ANNUAL VOLUNTEERS REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 18th September 2018
Executive Lead : Executive Nurse Director
Author Angela Hughes, Assistant Director of Patient Experience Tel 029 21846108 **angela.hughes5@wales.nhs.uk** Report developed by Michelle Fowler Volunteer's Manager
Caring for People, Keeping People Well : The Volunteers agenda helps to deliver 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 : the work of volunteers aims to enrich and improve the experience of Patients, Carers, families and staff
Health and Care Standard Number Standard 6.3 Listening and Learning from Feedback
CRAF Reference Number delivering outcomes that matter to people
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION
ASSURANCE is provided by: the annual report

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report for information

SITUATION

Volunteers Annual Report

There are approximately 600+ Health Board and Third Sector Volunteers supporting Cardiff and Vale University Health Board. This report will provide an update of volunteer activity and plans to develop additional roles.

Volunteers are unpaid individuals who contribute their time, energy and skills, playing a vital role in enhancing the patient and carer experience. They support existing services and provide alternative approaches and solutions to health and well-being. They are invaluable in their contribution, and they are particularly effective in counteracting potential boredom and isolation that can occur within the hospital setting. By encouraging socialization and activity it links to avoidance of PJ Paralysis and a reduced length of stay.

This is an increasing agenda and the report evidences the planned implementation to recruit more volunteers and from a variety of ages and backgrounds. It is recognised that the skills developed as a volunteers are invaluable in both delivering the Health Board strategy and vision and embedding the organisational values. The ability to effectively communicate, to actively listen and to display empathy are skills that can be enhanced and developed through volunteering. We are delighted that the School of Pharmacy has recognised the value of

volunteering and as part of its core curriculum their first year students will provide weekly volunteer hours.

This is an exciting expansion where early recognition of the importance of campaigns such as " hello my name is" and how to actively listen to people will be embedded from the outset of their training.

BACKGROUND

Cardiff and Vale University Health Board recognises the unique and important contribution that volunteers make in complementing the services it provides and the Health Board has a Volunteer Framework; http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/195560 and Operational Procedure which supports and underpins the development of volunteering across the UHB. This expansion of volunteers has been through the application of the framework which ensures robust governance; providing protection to our patients, volunteers and the organisation.

ASSESSMENT AND ASSURANCE

Volunteers are recruited via a plethora of mechanisms that include television, social media and local newspapers and proactive recruitment. More recently the Health Board has worked collaboratively with Cardiff and Vale College, University of South Wales and Cardiff University. These partnerships have proven successful not only for the Health Board but they have allowed students to flourish and grow, further developing their interpersonal and communication skills. A combination of young and retired people is more effective as providing a level of consistency can be challenging, as the student population is transient. Feedback is gathered ensuring effective evaluation for the roles undertaken.

Examples of Volunteer Roles include;			
Volunteer Role	**Site(s)**	**Activity**	**Future Plans**
Bereavement Volunteers	UHW and UHL	Provide a follow up telephone call to an appropriate contact, approximately four weeks following the death. They provide support and signpost to professional organisations as appropriate.	To expand the service, discussions with Chaplaincy volunteers to be undertaken in the first instance.
Activity Volunteers	UHW, UHL, Hafan y Coed, St David's and Barry	Interact with patients including Digital Reminiscence Therapy, games, dementia friendly activity boxes containing a	Advertise for experienced volunteers to deliver Art and Crafts/ Creative Workshops on wards across the Health Board

		plethora of accessible equipment, including sensory loss aides.	
Musician Volunteers	UHW	Attend wards weekly to play to the patients and their carers	Recruit further and expand service to UHL, Barry and St David's Hospital. Contact to be made with Royal Welsh College Music Drama to discuss opportunities for students to volunteer.
Meet and Greet Volunteers	UHW and CHfW, UHL and Barry	Welcome, provide directions and or take to the area requested	To expand to the Dental Hospital and Cardiac Rehabilitation
Knit and Natter Volunteers	UHL	Weekly meeting at UHL Information and Support Centre	To further expand the service as an activity based role at UHW
Feedback Volunteers	UHW, UHL	Obtain feedback from patients, and their carers, reporting any issues that require immediate resolution – also eliminating bias	Possible engagement with student groups to support this agenda.
Information and Support Centres Volunteers	UHW, UHL and Barry	Provide support, information, signposting and refer to Patient Experience Team if necessary	Continue to support with volunteers looking to increase number at UHW and Barry Hospital.
Chaplaincy Volunteers	UHW, UHL	Providing pastoral support across all UHB sites	Further recruitment will be undertaken once staffing levels are sufficient to provide appropriate support and supervision to volunteers

Art and Craft Volunteers	UHW,UHL	Art Project through University of South Wales, 3 students participated during 2017/18 academic year	To further develop this partnership with UoSW to enable us to roll out on other wards across the Health Board.
Befrienders	UHW, UHL, ST David's, Rookwood, Barry and Hafan y Coed	Volunteers provide a service whereby they can offer companionship and reassurance, by talking to patients, reading books/ newspapers or just listening.	Continue to advertise these roles across all Health Board sites, engaging with Universities and colleges in recruiting students to support.

Future Plans:

1. Include developing a Carer Volunteer role
2. Working with Cardiff University School of Pharmacy to place students within clinical areas undertaken, meet and greet, activity, befriender and patient feedback roles. This will be timetabled as part of their curriculum.
3. To create a 'Lead' volunteer. These identified volunteers will assist with interviewing, planning e.g. for Major incidents etc.
4. We have successfully secured funding from the Pears Foundation who manage the dedicated strand of the #iWill Fund, which supports the growth of inclusive high quality youth social action opportunities in the Health and Social Care sector. This funding will enable us to recruit a staff member for two years focusing on young volunteers.
5. Discussions are ongoing with PCIC re volunteering support at GP Practices.

The purpose of this paper is to present the UHB 2017 / 2018 Volunteer activity

ASSESSMENT AND ASSURANCE

The Health Board has a planned and progressive approach to further developing the roles of Volunteers and over the next 2 years actively recruiting young volunteers as well as increasing the total numbers of volunteers and developing additional role profiles.

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

MINUTES OF THE MEETING HELD ON 23RD MAY 2018

Present:

Alun Morgan (Acting Chair)	Assistant Director of Therapies and Health Sciences
Mike Bourne	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Rhodri John	Deputy Service Manager, Cellular Pathology
Scott Gable	Cellular Pathology Service Manager
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
Rachael Daniel	Health and Safety Adviser
Alison Borwick	Quality Lead, Biochemistry
Maria Jones	Senior Nurse, Outpatients
Claire Constantinou	Senior Dietitian

Apologies:

Sue Bailey	Clinical Board Director of Quality, Safety and Patient Experience
David Lewis	Head of Finance
Ceri-Ann Hughes	Head of Workforce and OD
Suzie Cheesman	Patient Safety Facilitator
Sarah Jones	Quality Lead, Pharmacy
Paul Williams	Clinical Scientist, Medical Physics
Nigel Roberts	Laboratory Service Manager, Biochemistry

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 18/120 Welcome and Introductions

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

CDTQSE 18/121 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 18/122 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 11th April 2018 were **APPROVED.**

CDTQSE 18/123 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 Recommendations

Mike Bourne advised that the Lung Nodule Recommendations have not yet been presented to the LMC.

Action: Mike Bourne

CDTQSE 18/023 Safeguarding Case

The case is still not yet fully closed. Alun Morgan will present it to the meeting when confirmation is received that it is closed.

Action: Alun Morgan

CDTQSE 18/056 Cardiff University RCA Format

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 18/101 Bacteraemia Incident

At the Clinical Board IP&C Group it was agreed to hold a meeting between Radiology and Urology departments to close this off.

Action: Rebecca Vaughan-Roberts/Helen Jenkins

CDTQSE 18/108 Genius Hour Training Session

Positive feedback was received from attendees. It was generally agreed that this process links well to the PADR process.

CDTQSE 18/110 Implications of GDPR

The key issues are being presented in a paper to the Health Systems Management Board. Subject Access Requests is a significant risk financially to the Health Records should charges no longer apply. Also the turnaround times for providing records will be reduced to one month under the new regulations. This is currently 40 days. The Clinical Board is awaiting clarity on the UHB's view in terms of charging.

Guidance for Managers on GDPR has been released this week and Helen Jenkins will circulate this to the Group.

Action: Helen Jenkins

Managers are asked to review the guidance and if they identify risks to their services to advise Sion O'Keefe.

Action: Directorates

On a practical level, managers should continue with current practice and ensure their Information Asset Registers are completed. The Bill has not yet been enforced by parliament and the UHB is in a transitional state.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 18/124 Patient Story

The Front Door Therapy Team were in attendance to present their work which supported the implementation of a new service model in the UHW Emergency Unit (EU) during the winter period. Dietetics, Speech and Language Therapy, Occupational Therapy and Physiotherapy all had an increased presence of therapists and therapy support workers within the EU between January and March 2018.

As an integrated therapy team, they worked closely with Emergency Unit colleagues to maximise efficiency, preventing admission where possible and providing earlier interventions for those patients being admitted. Starting the assessment and planning process as early as possible and initiating rehabilitation programmes within EU has had a significant impact on patient safety, outcomes and length of stay. The Integrated Therapy Team were able to provide rapid interventions to patients at point of admission and proactively manage those at risk of deconditioning before the harmful consequences and adverse clinical outcomes developed. The initiative allowed early indication of:

- Malnutrition
- Dehydration
- Aspiration
- Dysphagia
- Communication concerns
- Pressure sores
- Incontinence
- Muscle atrophy
- Reduced functional engagement
- Cognitive impairment.

There was improved access to nutrition and hydration in the EU. The remit of Physiotherapy was to see those patients that were medically unwell and would be staying in hospital. The aim was to see patients in 21 hours to get people moving and getting families involved early. Occupational Therapy worked with

Physiotherapy to get patients up and mobilising and encourage patients to wash and dress themselves and avoid deconditioning. Information on how patients were managing at home prior to their attendance was collated so that any further needs could be identified in readiness for their discharge.

46 admissions were avoided.

Pressures on working in other areas of the Health Board have been a barrier to putting this project in place in previous years and the choice to implement a project such as this has not been made before. There has been a cultural shift in recognising and accepting that the population is changing with more elderly patients coming into hospital and staying in longer. This has resulted in new and innovative thinking around how to deal with winter pressures and the need to manage elderly patients coming into the EU better.

The team replicated the best practice learned from the joint working within the Stroke Service. It was noted that there is only one other service in the UK that has a full therapy service at the front door, so there will be lessons to be learned year on year. It was commented that it would be useful for the team to look at the 46 admissions that were avoided, and break down these patients by those who avoided admission from within the Emergency Unit and those at the Assessment Unit.

The team commented that working as an integrated team was a positive experience. The success was largely due to a common vision and goal and were clear from the start what was being set out to achieve. The project has been submitted to the HSJ Awards and will be widely promoted in the Director of Therapies and Healthcare Sciences Conference brochure.

CDTQSE 18/125 Feedback from UHB QSE Committee 13th February 2018

The minutes of the UHB QSE Committee 13th February 2018 were **RECEIVED.**

It was highlighted that funding has been secured for an electronic barcode system for patient identification bands.

CDTQSE 18/126 Health and Care Standards

Corporate responses have been submitted to the Executives.

CDTQSE 18/127 Risk Register

Laboratory Medicine and Therapies individual meetings have been deferred. The Laboratory Medicine risk register review has been rescheduled. Claire Constantinou to ask Therapies for an update on when their risk registers will be collated and ready for review with the Clinical Board.

Action: Claire Constantinou

It was noted that work is currently being undertaken on updating the risk registers into the same template format which is a time consuming task. A new risk register

format is being produced for the UHB and Alun Morgan will ask Sian Rowlands when this template is likely to be implemented so if necessary to avoid the department having to duplicate this work.

Action: Alun Morgan

CDTQSE 18/128 Exception Reports

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 18/129 Initiatives to promote Health and Wellbeing

On 8th June Dietitians will be visiting wards to promote the National Dietitians Week.

The Clinical Board will be hosting a stand for the End PJ Paralysis Campaign outside the Radiology department on 20th June.

CDTQSE 18/130 Falls Prevention

Nothing new to report.

CDT QSE 18/131 Concerns and Compliments Report

In April 2018, the Clinical Board received 11 concerns. This compares to 8 concerns in the same period as last year. The 11 concerns are related to Outpatients/Patient Administration, Radiology, Podiatry and Pharmacy.

There were 5 breaches in response times; 4 in Outpatients/Patient Administration and 1 in dietetics.

No AM concerns were received in April.

2 compliments were received compared to 4 received in April 2017-18. The compliments related to staff in Media Resources and Radiology.

The current split between compliments and concerns is 11 concerns and 2 compliments.

The main themes for the formal concerns received are clinical diagnosis and treatment and communication between staff and patients.

Sion O'Keefe was asked to explain the breaches in Outpatients/Patient Administration. He noted that the breaches are due to a current resource issue with investigating officers within the team. Whilst responding to concerns is a priority for the directorate, meeting the timeframes for responses has been a challenge. The Clinical Board Senior Management Team will have a discussion around strengthening the concerns process within the Clinical Board.

Action: Senior Management Team

CDTQSE 18/132 Ombudsman Reports

Nothing to report.

CDTQSE 18/133 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 18/134 Patient Safety Incidents

There are no long standing patient safety incidents.

CDTQSE 18/135 New SI's

An IRMER reportable incident has occurred involving a poorly written request form which was misinterpreted and the patient received an unintended CT Thoracic Spine. This is being investigated.

An SI for Cellular Pathology has been reported to Welsh Government in relation to an incorrect repatriation process for a foetal post mortem. This is being investigated by the Children and Women's Clinical Board.

CDTQSE 18/136 RCA/Improvement Plans

The RCA completed post HTA inspection in the Mortuary has been submitted to the Clinical Board.

CDTQSE 18/137 WG Closure Forms – Sign Off

All currently closed.

CDTQSE 18/138 Regulation 28 Reports

There are no Regulation 28 Reports.

CDTQSE 18/139 Patient Safety Alerts

PSN044 Resources to Support Safer Care for Full-Term Babies

This Safety Notice has been circulated and is not applicable to this Clinical Board.

ISN 2018/002 International Dysphagia Diet Standardisation Initiative (IDDSI)

This Internal Safety Notice was produced by the Speech and Language Therapy and Nutrition and Dietetics Services advising that they are implementing the International Dysphagia Diet Standardisation Initiative for texture modified foods and thickened drinks across the UHB.

WHC 2018/003 Guidance on Administration of Intravenous Contrast Medium to Patients with Renal Impairment

The WHC has been circulated across the Clinical Board. This has implications for Radiology.

WHC 2018/012 Never Events List 2018

The Never Events List 2018 and assurance review process has been circulated across the Clinical Board for information.

WHC 2018/020 HCAI AMR targets 2018-19

The WHC has been circulated across the Clinical Board. This sets out the Antimicrobial Resistance (AMR) improvement goals and Healthcare Associated Infections (HCAI) reduction expectations for Health Boards by March 2019.

CDTQSE 18/140 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 18/141 Medical Device Risks

MDA 2018/012 BD Vacutainer EDTA & BD Vacutainer Lithium Heparin Tubes – Risk of Incorrect Results for Lead Testing or Other Assays Using ASV Methodology

The MDA is applicable to Biochemistry but it was confirmed that this device is not used within the department.

MDA 2018/013 Cobas b 221 instruments with AutoQC Module – Software Limitation Affecting Automatic QC Measurements

This MDA is applicable to Biochemistry but it was confirmed that these instruments are not used within the department.

MDA 2018/014 Infinity Acute Care System and M540 Patient Monitors Software Versions VG2.2-VG6.0 – Risk that Alarms Not Activated

Also applicable to Biochemistry but it was confirmed that the department does not possess this system.

CDTQSE 18/142 IP&C/Decontamination Issues

The Clinical Board has undertaken a final walk round of hydrotherapy held at Rookwood and a good level of assurance was received on the systems that are in place. Installation of a replacement automatic chlorination unit has not yet been actioned and this has been escalated to the UHB Water Safety Group.

CDTQSE 18/143 Key Patient Safety Risks

Safeguarding

The UHB Safeguarding Group is meeting next week.

CDTQSE 18/144 Health and Safety Issues

The Clinical Board Health and Safety Report was **RECEIVED.** There are 2 areas with a red status on the Clinical Board Health and Safety Action Plan:

- Work related stress. There has been an increase in the number of staff reporting sickness episodes of stress that are work related**.**

- Records storage. There is insufficient storage for all records, particularly in relation to archived records in the community. A policy for greater use of electronic storage is being considered and the Medical Records department is producing an action plan for records storage.

Concerns have been raised within the UHB around the dignity and safety of bariatric patients. Bariatric equipment can take up to 2 weeks to be received which impacts on deconditioning of this group of patients. In addition there are concerns of mobilising this group of patients as there are additional risks if the patient falls. An MDT approach is being taken forward involving Nursing, Dietetics, Physiotherapy, Occupational Health and Health and Safety. Rebecca Vaughan-Roberts suggested that Radiology is involved in this due to weight limits imposed on Radiology equipment. Alun Morgan suggested that she links with David Pitchforth who is leading on this.

CDTQSE 18/145 Regulatory Compliance and Accreditation

Nothing new to report.

CDTQSE 18/146 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 18/146 Clinical Audit

It is recognised that there is a gap in the Clinical Board receiving clinical audit information. Alun Morgan and Matt Temby will send out communication to directorates to remind them of the process.

Action: Alun Morgan/Matt Temby

CDTQSE 18/147 Research and Development

The Clinical Board R&D Group has not met since the last QSE meeting.

CDTQSE 18/148 Service Improvement Initiatives

Draft All Wales Stage 2 Mortality Tool

The draft tool was **RECEIVED** and **NOTED.** This has been circulated to directorates for information. It was noted that directorates within this Clinical Board are more likely to help support completion of this form rather than generate one.

Sion O'Keefe reported that a list of people who have attended service improvement training within the Clinical Board has been received.

He also noted that the Clinical Board Improvement Group has been implemented. Consideration as to how this Group is utilised going forward is to be considered in Directorate Performance Reviews and the Clinical Board Operational Delivery Group.

The Q-Pulse system in Laboratory Medicine has the functionality to capture projects and their outputs and there could be an opportunity to expand this across the Clinical Board. It is important that service improvement work is shared with the Clinical Board and the Q-Pulse system could help with this.

CDTQSE 18/149 NICE Guidance

There is no new NICE Guidance to report.

CDTQSE 18/150 Information Governance

This item was discussed under matters arising.

CDTQSE 18/151 Data Quality

Sion O'Keefe advised that the UHB is looking at capturing data for flags and alerts on the PMS system for example patient language preferences, permission rights, safeguarding issues etc.

DIGNIFIED CARE

CDTQSE 18/152 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Matt Temby reported that the CHC visited Physiotherapy Outpatients and a query was raised around plans for the multi convergent therapy service. A discussion was held with the CHC who are supportive and engaging with the Clinical Board and a meeting has been arranged to meet to discuss the service.

CDTQSE 18/153 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

As part of the data quality work around flags and alerts on PMS, it needs to be ensured that patients with dementia/sensory loss are included in this work.

CDTQSE 18/154 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 18/155 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 18/156 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

At the end of the financial Year, the Clinical Board performance was exceptional. Departments are now experiencing 'bounce back' particularly in Radiology and a lot of plans are being put in place to address this. An exercise is also being undertaken in Radiology around predictions for demand and capacity.

There are long standing issues in dietetics and the Clinical Board is awaiting a response from Welsh Government for Planned Care funding that may come into this Clinical Board.

INDIVIDUAL CARE

CDTQSE 18/157 National User Experience Framework

The National User Report for April 2018 was **RECEIVED.** The response rate was 74% and overall the patient feedback received was positive. Comments are received in relation to car parking which is not within the remit of this Clinical Board however, the Group will be interested to note patients' comments when the car parking changes come into force from 6th June.

STAFF AND RESOURCES

CDTQSE 18/158 Staff Awards and Recognition

Nothing new to report.

CDTQSE 18/159 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting a reduction in sickness levels this month to 3.64%.

PADR compliance is 57%.

Statutory and Mandatory training compliance is 80%. Thoughts were requested on why the Clinical Board achieves high percentages for mandatory training, but not for PADRs. Alun Morgan will feed this back comments to Ceri-Ann Hughes.

Action: Alun Morgan

There is no update on the pay agreement for 2018. Details will be circulated when available.

Ceri-Ann Hughes has sent out a request for nominations for Health and Wellbeing Champions. This is an important initiative but no nominations have yet been submitted. Directorates are asked to consider putting forward nominees. The Clinical Board is seeking two or 3 individuals.

Action: Directorates

It was noted that there is a new structure being put in place in the Workforce and OD function. Ceri-Ann Hughes has been appointed as Business Partner for the Clinical Diagnostics and Therapeutics Clinical Board and Surgery Clinical Board with effect from mid-June.

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

Nothing to report.

ANY OTHER BUSINESS

Directorates have been advised by the Information Governance department that the use of fax machines are no longer allowed within the UHB for any reason. It was noted that Sion O'Keefe has asked for further information to be communicated from the Health Board.

DATE AND TIME OF NEXT MEETING

13th June 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 13TH JUNE 2018

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Matthew Temby	Clinical Board Director of Operations
Bolette Jones	Head of Media Resources
Lisa Griffiths	Quality Manager, Laboratory Medicine
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Suzie Cheesman	Patient Safety Facilitator
Sarah Jones	Quality Lead, Pharmacy
Rachael Daniel	Health and Safety Adviser
Maria Jones	Senior Nurse, Outpatients
Judyth Jenkins	Head of Dietetics

Apologies:

Mike Bourne	Clinical Board Director
Alun Morgan	Assistant Director of Therapies and Health Sciences
Robert Bracchi	Consultant, AWTTC
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Ceri-Ann Hughes	Head of Workforce and OD
Paul Williams	Clinical Scientist, Medical Physics

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 18/160 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting. All attendees were asked to describe their role and their representation on this Group:

Sue Bailey, Clinical Board Director of Quality, Safety and Patient Experience and Chair of this Group.

Matt Temby, Clinical Board Director of Operations.

Bolette Jones, representing the Media Resources directorate as Head of Media Resources.

Lisa Griffiths, Quality Manager for Laboratory Medicine, Manager for Pathology IT and representing the Laboratory Medicine directorate. Lisa Griffiths was requested to ask the Laboratory Heads of Service if they feel her attendance appropriately covers the different departments within Laboratory Medicine.

Action: Lisa Griffiths

Maria Jones is representing the Outpatients department as Senior Nurse and also representing Health Records at today's meeting in Sion O'Keefe's absence.

Sarah Jones is representing Pharmacy as Quality Lead.

Suzie Cheesman in attendance as Patient Safety Facilitator.

Rachael Daniel in attendance as Health and Safety Adviser.

Rebecca Vaughan-Roberts in attendance for the Radiology department as Quality Lead for Radiology.

Judyth Jenkins in attendance for Dietetics department as Head of Dietetics and also representing the Therapies directorate. Judyth Jenkins to ask the Therapies directorate to consider the appropriate level of representation for the breadth of Therapies.

Action: Judyth Jenkins

It was noted that there was no representation today from AWTTC and Medical Physics/Clinical Engineering.

Matt Temby stated that it is the view of the Clinical Board that this is the most critical meeting held within the Clinical Board and the level of attendance is concerning.

CDTQSE 18/161 Apologies for Absence

Apologies for absence were **NOTED.**

Matt Temby advised that due to an acute reporting backlog, he has asked Mike Bourne to commit his time to clinical duties today.

CDTQSE 18/162 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 23rd May 2018 were **APPROVED.**

CDTQSE 18/163 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 Recommendations

A meeting with PCIC Clinical Board is being held tomorrow to discuss the introduction of the new protocol for referrals into Radiology. This will then go forward to the LMC.

CDTQSE 18/023 Safeguarding Case

Alun Morgan will present the safeguarding case as a patient story to a future meeting when confirmation is received that the case is closed. The case is currently still open.

CDTQSE 18/056 Cardiff University RCA Format

Concerns were raised that the RCA template completed by Cardiff University is not consistent to the RCA template used by the Health Board. Suzie Cheesman to ask Maria Roberts if the RCA template is an All Wales document and whether there should be consistency.

Action: Suzie Cheesman

CDTQSE 18/101 Bacteraemia Incident

Rebecca Vaughan-Roberts is considering the appropriate attendees to attend a meeting to close off the incident.

Action: Rebecca Vaughan-Roberts

CDTQSE 18/127 Risk Registers

Alun Morgan has asked Sian Rowlands for an update on when the new UHB risk register template will be available and is awaiting a response.

CDTQSE 18/146 Clinical Audit

Matt Temby and Alun Morgan to send out communication to directorates to remind them of the process for informing the Clinical Board of clinical audit information.

Action: Matt Temby/Alun Morgan

CDTQSE 18/15 Health and Wellbeing Champion

The Group asked if they could be sent a copy of the role profile for the Health and Wellbeing Champion. Helen Jenkins will ask Ceri-Ann Hughes for a copy and will then circulate it.

Action: Helen Jenkins

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 18/164 Patient Story

Sue Bailey will issue directorates with dates of when they are required to present a patient story to this Group.

Action: Sue Bailey

Directorates were asked to volunteer to present at next month's slot.

Action: Directorates

This will be an opportunity for directorates to raise key risks and good news stories. A report template will be circulated.

Action: Sue Bailey

Matt Temby stated that he has been hearing remarkable examples of good work being undertaken by front line staff. He observed that good work can often get overlooked in favour of bad experiences and he encouraged directorates to consider presenting good new stories. He also suggested that examples are given of how the good work undertaken within the support services impacts on patients.

CDTQSE 18/165 Feedback from UHB QSE Committee 17th April 2018

The minutes of the UHB QSE Committee 17th April 2018 were **RECEIVED.**

The Clinical Board presented its annual report to the UHB QSE Committee on 12th June. Sue Bailey will circulate the report to the Group.

Action: Sue Bailey

Good practice as well as the challenges were acknowledged by the Committee.

CDTQSE 18/166 Health and Care Standards

Corporate responses have been submitted and Judyth Jenkins asked if there has been any feedback. Feedback will be discussed at the UHB QSE Committee and Sue Bailey will advise when discussions have been held.

CDTQSE 18/167 Risk Register

It was noted that dates for Therapies and Laboratory Medicine risk register review meetings have been arranged.

Judyth Jenkins reported that a very positive risk assessment session was held in dietetics last week. The team gained a better understanding around scoring. Rachael Daniel stated that the Health and Safety department are willing to provide sessions to departments where there are 6 attendees or more present.

CDTQSE 18/168 Exception Reports

Sue Bailey provided an update on the exception reports that have been escalated from services to the Clinical Board Team:

Laboratory Medicine

Loss of analyser due to an automatic PC upgrade. This was a time critical specimen with a potential risk to a patient as a consequence. Work is being undertaken to prevent this from happening again. Directorates were asked to be mindful that data loss can occur during automatic PC updates.

The cold room in Blood Transfusion Laboratory is currently running on 1 of its 2 compressors. A risk assessment is needed around business continuity.

LIMS risks relating to loss of service. Need to consider if any further action is needed to the risk assessments. Lisa Griffiths to send copies of the most recent risk assessments to Matt Temby for Haematology, Biochemistry and Cellular Pathology.

Action: Lisa Griffiths

There is slippage against the MHRA Blood transfusion action plan. Work is needed to bring this back on track.

Spurious high potassium levels from GP specimens are being reported related to untimely transport and the environment they are being transported in.

The HTA action plan is almost completed.

A meeting has been held with WHSCC commissioners in respect of the bone marrow transplant service. There are 3 RCAs being commissioned and Matt Temby has had sight of the early findings. The formal RCAs are to be submitted by the end of July. A minimum of 2 weeks is required to sign these off internally within the Health Board prior to submission to WHSSC. Lisa Griffiths to feed this back to Andrew Goringe, Alun Roderick and Rachel Butler.

Contingency plans are needed in the Stem Cell Processing Unit in the event of the air handling unit breaking down.

Radiology

There are risks within the Radiopharmacy service relating to workforce, equipment and the quality management system.

There are concerns relating to the appointment of regulatory roles of Medical Physics Expert, Radioactive Waste Adviser and MR Safety Expert

An SBAR has been received for acute Thrombectomy cases.

There are discussions being held at Executive level around the turnaround times of CT body reporting. A short term plan has been agreed with the Radiology directorate. Performance will be closely monitored in this area as there is concern for cancer patients.

Pharmacy

Work needs to progress towards the completion and delivery of the MHRA action plan at St Mary's.

Therapies

Speech and Language Therapy staffing at St Davids and Barry is a concern and options for service sustainability need to be considered. Sue Bailey will discuss the issue with Ceri-Ann Hughes.

Action: Sue Bailey

Outpatients/Health Records

A concern has been received relating to the Gender Reassignment Act. Directorates need to be mindful that when releasing patient information it is a breach to release a patient's previous gender.

Following receipt of a patient concern, it emerged that the patient's notes have been lost. A key action that the Health Records department is looking to implement is a process where notes that are required for concerns will be provided in a digital format.

It was emphasised that the responsibility of the health record is for the whole organisation and everyone should take responsibility for the correct tracking of notes.

Clinical Board

The Clinical Board is looking to revise its business continuity plans. New templates have been produced and the Clinical Board will look at holding a workshop with training delivered by Huw Williams.

Action: Helen Jenkins

The Clinical Board will be looking for a nomination for a Business Continuity Lead. Directorates to consider who can take on this role. It was noted that this role will be well supported by the Emergency Planning Team.

Action: Directorates

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 18/169 Initiatives to promote Health and Wellbeing

As part of Dietitians Week held last week, dietetics staff visited wards on the UHW site and provided advice on nutrition and health eating. This was well received by both patients and staff.

CDTQSE 18/170 Falls Prevention

Rebecca Vaughan-Roberts reported that a Group has been brought together in the UHB to address the needs of bariatric patients

CDT QSE 18/171 Concerns and Compliments Report

The Clinical Board received 3 formal concerns in May 2018. This compares to 5 received in May 2017. Since 1st April 2018, 14 concerns have been received. This compares to 13 in the same period as last year. The 3 concerns received in May relate to Outpatients/Patient Administration, Radiology and Physiotherapy.

Since 1st April 2018, the Clinical Board is reporting 12 breaches in response times.

In May 2018 there were 10 breaches with 3 relating to concerns outstanding from March 2018. The Clinical Board is reporting 29% compliance against response times. Matt Temby stated that action needs to be taken to address compliance. He proposed that at Day 10, if a directorate identifies that a concern investigation will not be completed by Day 20 to inform Sue Bailey. This was agreed.

It was noted that there have been 0 AM concerns received since January 2018.

In May, the Clinical Board received 11 compliments. This compares to 3 in May 2017. Since 1st April 2018, 13 compliments have been received compared to 7 in the same period as last year.

The current split between compliments and concerns from 1st April 2018 is 14 formal concerns and 13 compliments.

The key theme reported for formal concerns is communication between staff and patients. It should be noted that only 14% of the concerns recorded in this category relate to attitude of staff. Under the overarching theme of communication between staff and patients sits the sub-category of difficulty in arranging appointments and the majority of the concerns relate to this.

CDTQSE 18/172 Ombudsman Reports

Nothing to report

CDTQSE 18/173 RCA/Improvement plans for Serious Complaints

Nothing to report

CDTQSE 18/174 Patient Safety Incidents

Directorates were asked to make every effort to close out incidents.

CDTQSE 18/175 New SI's

SI Report

Incident No In69239 involved a foetus where the family expressed their wish for any tissue following post mortem of their child to be returned to them prior to burial. Some weeks later some blocks and slides were identified that should have been returned to the family in a timely manner. An investigation is being undertaken.

An IRMER incident has occurred where a request form stated C + T spine and a CT spine was undertaken in error. An RCA is being undertaken.

CDTQSE 18/176 RCA/Improvement Plans

Nothing to report.

CDTQSE 18/177 WG Closure Forms – Sign Off

There are no WG closure forms to be reviewed for sign off.

CDTQSE 18/178 Regulation 28 Reports

There are no Regulation 28 reports.

CDTQSE 18/179 Patient Safety Alerts

PSN 042 – Risk of Death from Intravenous Administration of Solid Organ Perfusion Fluids

The Patient Safety Notice has been circulated for information but is not applicable to this Clinical Board.

CDTQSE 18/180 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 18/181 Medical Device Risks

MDA 2018/015 Gambro Ultrafilter U9000 Microbial Water Filter for Haemodialysis – Risk of Hypovolemia due to Filter Leaks During Use

MDA 2018/017 Cook Vacuum Pump for IVF – Risk of Electric Shock or Burn to Operator

The Medical Device Alert has been circulated for information but is not relevant to this Clinical Board.

MDA 2018/018 Various Arrow Critical Care Devices – Recall due to Incomplete Packaging Seals

The Medical Device Alert has been circulated for information but is not relevant to this Clinical Board.

CDTQSE 18/182 IP&C/Decontamination Issues

Information to Support WHC 2018/020

Additional background information has been received for WHC 2018/020 which was noted at the last meeting.

WHC 2018/023 National Influenza Programme 2018/19

The WHC providing information on the National Influenza Programme for 2018/19 has been circulated. It was noted that the target for uptake by frontline staff will remain at 60%.

CDTQSE 18/183 Key Patient Safety Risks

Safeguarding

Maria Jones provided feedback from the UHB Safeguarding Group. The Health and Care Standard self-assessment for safeguarding has been well received by the Nurse Director.

New safeguarding training for staff is being released and patient facing staff are encouraged to undertake level 2 when this becomes available.

The police were in attendance at the Safeguarding Group to speak on human trafficking. They noted that 80% of referrals made relate to the Cardiff area.

Maria Jones emphasised that any staff with suspicions relating to safeguarding should contact the Clinical Board Safeguarding Leads or the Safeguarding Office.

CDTQSE 18/184 Health and Safety Issues

Rachael Daniel advised that problems are being reported with items being thrown from windows in A, B and C Blocks. Items such as syringes, incontinence pads, ID badges and bibles have been identified. The Health and Safety Team have visited all wards on the 3 blocks to raise awareness. It was acknowledged that whilst some items can fall off window sills some items have been thrown at force. Staff are encouraged to report any fallen items.

There are 2 policies out to consultation; the Fire Safety Policy and the Asbestos policy.

Judyth Jenkins reported an issue with the door mechanism of the Service Accommodation Centre jamming This is a concern for staff who are unable to get

out of the building or unable to lock the door. The issue has been reported to the Estates team.

CDTQSE 18/185 Regulatory Compliance and Accreditation

The first meeting of the Clinical Board Regulatory Compliance Group has been held. This was well attended. The meeting will move forward in 2 directions:

1) A mechanism for assurance, escalation of issues and monitoring of performance with senior manager oversight.
2) Opportunity for shared learning and challenge.

CDTQSE 18/186 Policies, Procedures and Guidance

It was noted that a Policy on Pet Therapy and Assistance Dogs is to be submitted to the next UHB IP&C Group.

EFFECTIVE CARE

CDTQSE 18/187 Clinical Audit

The Clinical Audit department has asked for an update on compliance against NICE guidelines. Sue Bailey will circulate to the identified leads**.**

Action: Sue Bailey

CDTQSE 18/188 Research and Development

The Clinical Board R&D Group has not met since the last QSE meeting.

CDTQSE 18/189 Service Improvement Initiatives

Nothing to report.

CDTQSE 18/190 NICE Guidance

Nothing further to report.

CDTQSE 18/191 Information Governance

Judyth Jenkins to ask Sion O'Keefe if there is an update on the requirement to discontinue the use of fax machines in departments. It was noted that Paul Rothwell is providing an Information Governance session to dietetics and she will also raise the issue at the session.

Action: Judyth Jenkins

CDTQSE 18/192 Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 18/193 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 18/194 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Sue Bailey reported that the UHB Sensory Loss Group is focusing its work in 3 streams:

- Environment including wayfinding, paint colours, lighting etc.
- Communication with patients
- Staff awareness. Discussion was held of how a campaign can raise awareness across the Health Board rather than implementing another mandatory training module.

It was noted that the Dental Health Board has a braille embosser that they are happy to share with other services. Sue Bailey will send Judyth Jenkins the contact details.

The Pulmonary team have won a hearing loss award for their service improvement work in making their group training accessible to staff with hearing loss using a tool called a Roger Pen. Judyth Jenkins noted that dietetics work with patients with sensory loss and Sue Bailey will send her the details.

Action: Sue Bailey

CDTQSE 18/195 Equality and Diversity

An email has been circulated to directorates from the UHB Equality Adviser to request for volunteers to provide support during Pride Week.

TIMELY CARE

CDTQSE 18/196 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 18/197 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

There is concern in Radiology that the predicted end of June waiting time position is a gap of around 300 patients due to a significant increase in demand and also downtime of machines.

It is also predicted that Womens Health Physiotherapy will experience waiting time issues until September.

There is an ongoing issue with diabetes waiting times.

INDIVIDUAL CARE

CDTQSE 18/198 National User Experience Framework

92% of patients rated their experience of a score of 8 or above.

A lot of negative comments were received around car parking. Whilst car parking does not fall in the remit of this Clinical Board, it will be interesting to note if there are fewer comments relating to car parking next month following the implementation of the new car parking arrangements.

STAFF AND RESOURCES

CDTQSE 18/199 Staff Awards and Recognition

Sue Bailey encouraged staff in directorates to put forward nominations for the Clinical Board Staff Recognition Scheme**.**

CDTQSE 18/200 Monitoring of Mandatory Training and PADRs

No further update.

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

Nothing to report.

ANY OTHER BUSINESS

The Laboratory Medicine department met with the PCIC Quality lead as a large number of patient ID errors are being received. The meeting identified a way forward for communicating with PCIC and the future relationship around the transporting of samples was also discussed.

As part of the accreditation process, the Laboratory Medicine department are setting up a User Engagement Day. Lisa Griffiths asked if any other directorates would like to participate in this event. Lisa Griffiths will set a date and send out an invite to directorates. Matt Temby encouraged all directorates to participate as this is an opportunity to showcase the breadth of work undertaken across the Clinical Board.

DATE AND TIME OF NEXT MEETING

11th July 2018 at 2pm in the Council Room UGF, UHW

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

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

MINUTES OF THE MEETING HELD ON 11TH JULY 2018

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Sarah Jones	Quality Lead, Pharmacy
Kathleen Morris	Clinical Audit Coordinator
Bolette Jones	Head of Media Resources
Carly Podger	Assistant Head of Finance
Maria Jones	Senior Nurse, Outpatients
Robert Bracchi	Consultant, AWTTC
Alun Morgan	Assistant Director of Therapies and Health Sciences
Suzie Cheesman	Patient Safety Facilitator
Holly Williams	Quality and Safety Facilitator for Specialist Services
Claire Constantinou	Dietetics

Apologies:

Matthew Temby	Clinical Board Director of Operations
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Ceri-Ann Hughes	Head of Workforce and OD
Lisa Griffiths	Quality Manager, Laboratory Medicine

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 18/201 Welcome and Introductions

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

CDTQSE 18/202 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 18/203 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 13th June 2018 were **APPROVED.**

CDTQSE 18/204 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 18/160 Attendance from Laboratory Medicine

Lisa Griffiths to ask the Laboratory Heads of Service if they feel her attendance appropriately covers the different departments within Laboratory Medicine.

Action: Lisa Griffiths

CDTQSE 18/160 Attendance from Therapies Directorate

Judyth Jenkins to ask the Therapies directorate to consider the appropriate level of representation required for the breadth of Therapies.

Action: Judyth Jenkins

CDTQSE 18/023 Safeguarding Case

Alun Morgan to present the safeguarding case as a patient story to a future meeting when confirmation is received that the case is closed. The case is currently open and a meeting is being scheduled with the police.

Action: Alun Morgan

CDTQSE 18/056 All Wales RCA Template

Advice has been received from the Patient Safety Team that Cardiff University are expected to follow the All Wales RCA template but there is little the UHB can do to enforce this. Mike Bourne requested that Suzie Cheesman send him the template and he will ask Chris Marshall in PET to ensure that it is completed for RCAs going forward.

Action: Suzie Cheesman/Mike Bourne

CDTQSE 18/101 IPC Meeting

It was agreed in the IP&C Group that a meeting would be held between Radiology and Urology departments on the bacteraemia incident to close this off. Rebecca Vaughan-Roberts has now determined who should be in attendance and will arrange for the meeting to be set up.

Action: Rebecca Vaughan-Roberts

CDTQSE 18/146 Clinical Audit Information

Matt Temby and Alun Morgan to send out communication to directorates to remind them of the process for informing the Clinical Board of clinical audit information.

Action: Matt Temby/Alun Morgan

CDTQSE 18/159 Role Profile for Health and Wellbeing Champion

Ceri-Ann Hughes is trying to obtain a copy of the role profile.

Action: Ceri-Ann Hughes

CDTQSE 18/164 Directorate Presentations to the Sub-Committee

At the last meeting it was agreed that all directorates will present a QSE report and Patient Story to this Group on an annual basis. Sue Bailey has produced a schedule for attendance and a reporting template for directorates to complete when it is their turn to attend and she will circulate these to the Group. It was noted that good attendance will be required from directorates when it is their turn to present including attendance from the Clinical Director/Laboratory Director, Directorate Manager/Head of Service and QSE Lead.

Action: Sue Bailey

CDTQSE 18/168 Speech and Language Therapy Staffing Issues

It was noted that a meeting has been arranged to discuss the staffing issues at St Davids and Barry Hospital.

CDTQSE 18/168 Business Continuity Workshop

The workshop has been arranged for 23rd August. Bolette Jones has volunteered to take on the role as Clinical Board Business Continuity Lead. Mike Bourne stated that he would like the Clinical Board to host 2 major incident/crises test exercises per year.

CDTQSE 18/191 Fax Machines

Sion O'Keefe has been advised that fax machines may be permissible but services would need to justify their use. A proforma will be sent out to all services in order to ascertain if faxes are still being used, where and the justification/need.

Dietetics would prefer to use an email solution to communicate with GP practices going forward. Mike Bourne suggested that the team write to Lisa Dunsford, the Director of Operations for PCIC Clinical Board to request the implementation of an email solution and ask how they would like this to be operationalised.

Action: Claire Constantinou

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 18/205 Patient Story

Daniel Crossland was welcomed to the meeting to present outcome measures from Occupational Therapy in Mental Health. He noted that licences were purchased to measure clinical outcomes. This reduced the need to provide manual statistical data and allow the team to collect the outcomes that matter. It was emphasised to staff that they were responsible for the data and not the outcomes.

He advised that 3 years' worth of data has been collated which equates to 3,816 referrals. Implementation of outcome measures has led to large scale improvements in Adult CMHT. The team have been able to use data effectively to highlight the areas that were underperforming and drive improvements.

Focus was placed on the following key areas:

- Improvement of DNA and CNA rates. The data identified that CNA rates are now showing a downward trajectory and DNA rates have almost halved.

- New to follow up ratios. The aim was to see fewer follow up appointments and over the last 9 months the ratio is 9 follow ups to 1 new assessment, which is efficient for Community Mental Health.

- Reduce time in non-value adding activities.

- Reduce variation.

- Reduce duplication. The majority of referrals over the 3 years were accepted and the team have been able to identify duplicates. The data identified that post assessment, the vast majority of patients are accepted for treatment and the team are seeing the patients that need to be seen. Post treatment outcomes indicate that in the majority of cases, all goals were met.

- Better use of technology. Information is being captured on:
  - Demographics, age, gender and diagnosis.
  - Teams and individuals
  - Referral, assessment and treatment times
  - Treatment outcomes
  - Reasons for poor outcomes

Daniel Crossland presented a case study which involved a patient with a diagnosis of delusional disorder and complex PTSD. The patient was granted asylum following a traumatic experience in its country of origin. At interview, the patient spent most of the day in bed, had no routine no self-care and eats food prepared by friends. He was unemployed (previously a skilled worker in country of origin) and viewed his role as less as a friend and more as a dependent. The patient previously enjoyed social activities, walking and visiting the gym. He was not pursuing interests and was unable to predict his long and short term goals.

Collaborative intervention was put in place and the patient was able to identify his strengths i.e. belief in his skills and ability to change, that he had a good support network and opportunities in a social environment. Goals were set that within 4 weeks a daily routine of self-care would be established with domestic tasks performed without support. By an agreed date his physical fitness would be

improved by visiting a gym and community walking group and also by an agreed date he would explore local voluntary work opportunities. Along with friends engaging him in a social environment due to the interventions he was able to be discharged. His score at time of discharge compared to interview stage showed a significant difference.

The key learning since the implementation of outcome measures has been:

- To define professional roles
- Commit to a decision about outcome measures
- Measure what is important, not just what can be measured
- Accept that outcomes will not always be positive and ensure staff and managers understand this.
- Design data collection systems to gather what information is needed.

CDTQSE 18/206 Feedback from UHB QSE Committee 17th April 2018

The minutes of the meeting are not yet available. It was noted that this Clinical Board attended the UHB Committee on 17th April to present its annual report.

CDTQSE 18/207 Health and Care Standards

Suzie Cheesman agreed to ask Alexandra Scott if there has been any feedback on the corporate response to the health and care standards.

Action: Suzie Cheesman

CDTQSE 18/208 Risk Register

It was reported that the new UHB format template is being finalised.

CDTQSE 18/209 Exception Reports

There have been a number of issues with the LIMS system particularly around unplanned downtime and therefore concerns have been raised with go live in the Cellular Pathology and Blood Transfusion modules.

A blocks and slides audit being undertaken within Cellular Pathology has identified a historical case where tissue was used for a scheduled purpose where there was no consent. An investigating as to why this occurred is being undertaken.

A failure of the air conditioning unit in the Stem Cell Processing Unit was reported. Although the unit is now fixed, there is a requirement to look at business continuity options.

A Serious Incident attributable to Pharmacy has been reported involving a patient who was admitted to MEAU by their GP. It emerged that the patient had been taking a weekly dose of Methotrexate as a daily dose since 21st June. The correct dosage was clearly labelled on the medication and the instructions were clear. An investigation is being undertaken to explore why the patient did not understand the instructions. The patient had received the medication following an outpatient appointment.

Antisocial behaviour outside of the Field Way building was reported to the Clinical Board Health and Safety Group. Sue Bailey has escalated the issues to the Head of Security who will add the building to their walk rounds.

A veteran has made an enquiry to the UHB on his priority rights to diagnostics. A WHC describes the process and this will be circulated to the Group for information following the meeting.

Action: Helen Jenkins

Temperature control difficulties have been reported with the MRI scanner in the Children's Hospital.

Pressure on staffing levels in Haematology have been escalated to the Clinical Board and mitigating actions are being worked through.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 18/210 Initiatives to promote Health and Wellbeing

The National Long Term Plan was **RECEIVED** and **NOTED**. The document was used earlier this week to help inform a Clinical Board Workshop focusing on transformation.

It was noted that the patient story presented at today's meeting is a good example of the strategy and direction of travel outlined in the document

CDTQSE 18/211 Falls Prevention

No new updates to report.

SAFE CARE

CDT QSE 18/212 Concerns and Compliments Report

In June 2018, the Clinical Board received 5 formal concerns. This compares to 5 concerns received in the same period as last year. 3 of the concerns received were related to Radiology and 2 were related to Outpatients/Patient Administration.

The Clinical Board is reporting 10 breaches since 1st April 2018. There were no breaches in response times for concerns received in June; however there are 2 responses to concerns received in March and May that are still outstanding.

Since 1st April 2018 there has been 1 AM concern received. There were no AM concerns received in June.

12 compliments were received in June 2018. This compares to 12 compliments received in June 2017.

Since 1st April 2018 the Clinical Board is reporting 25 compliments and 19 concerns.

The key theme for formal concerns is communication between staff and patients.

- 40% of the concerns in this category relate to difficulties in cancelling or changing appointments.
- 30% relate to staff attitude
- 30% relate to other communication issues.

CDTQSE 18/213 Ombudsman Reports

Nothing to report.

CDTQSE 18/214 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 18/215 Patient Safety Incidents

SI Report

The Clinical Board is reporting 1 SI, Incident No In69239 which relates to blocks and slides that should have been returned to a family in a timely manner. The family have been contacted and an investigation is underway.

CDTQSE 18/216 New SI's

As discussed earlier, a new incident has been reported that is attributable to Pharmacy.

CDTQSE 18/217 RCA/Improvement Plans

Nothing to report.

CDTQSE 18/218 WG Closure Forms – Sign Off

There are no WG closure forms to be reviewed for sign off.

CDTQSE 18/219 Regulation 28 Reports

There are no Regulation 28 reports.

CDTQSE 18/220 Patient Safety Alerts

MHRA Drug Alert

Glass particles were detected within a batch of Bleo-Medac and instructions were issued to UHBs on the additional measures that need to be adopted.

ISN 2018/003 Inpatient Medication Administration Record

It has been identified that some wards are using an old version of the medication chart and departments are instructed to ensure that the correct version is in use.

Patient Safety Alert from Hywel Dda – Electronic High/Low Chairs

Hywel Dda Health Board sent in a patient safety alert around reclining chairs warning of the risk of patient falls if the electronic controller is accidently activated by an individual leaning or sitting on the button of the handset.

CDTQSE 18/221 Addressing Compliance Issues with Historical Alerts

PSN043 Letter from Welsh Government

In May 2018 Patient Safety Notice 043 concerning the introduction of tracheostomy guidelines was circulated. Since publication there have been concerns raised that the guidance is inappropriate for treating and managing children with a tracheostomy. The letter from Welsh Government states that all relevant teams should be aware that the guidelines are to be followed in the adult setting only.

CDTQSE 18/222 Medical Device Risks

MDA 2018/019 – JM103 and JM105 Jaundice Meters Risk of Interpretation of Measurement in Hyperbilirubinemia Cases

Not applicable to this Clinical Board.

CDTQSE 18/223 IP&C/Decontamination Issues

Sue Bailey attended the UHB IP&C Group that was held earlier this week and provided feedback.

Clinical Board are required to produce an IPC delivery plan for the coming year.

A discussion was held around how best to communicate messages around IPC to staff and patients.

Gavin Forbes is replacing Eleri Davies in terms of her role for IPC outbreaks at UHW and Rishi Dhillon has taken on the role for UHL. It was noted that they are invited to attend the Clinical Board IP&C Group.

During hot weather managers are asked to:
- Encourage hydration of staff and patients.
- Staff and patients are encouraged to be vigilant with personal hygiene and skin care.
- Departments to ensure fans are clean and not blowing out dust.

ANTT training was discussed. This Clinical Board has a strategy and will continue with this.

Sue Bailey raised the issue around changes to the usage of rooms from non-clinical to clinical activities and the need for cleaning standards to reflect the new usage of the room.

CDTQSE 18/224 Key Patient Safety Risks

Safeguarding

There was no update to report.

CDTQSE 18/225 Health and Safety Issues

The Clinical Board is reporting 72% compliance against fire training. This needs to be improved. Managers to ensure their staff are up to date with their training. Extra mandatory training sessions are being provided during September and October.

It was also noted that there are COSHH assessments requiring review within the Clinical Board.

CDTQSE 18/226 Regulatory Compliance and Accreditation

The new Clinical Board Regulatory Compliance and Accreditation Group has been implemented and is developing.

This month a service story was presented by Clinical Board Senior Managers and the Cellular Pathology Service Manager on their experiences of working within the HTA Gold Command structure.

CDTQSE 18/227 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 18/228 Clinical Audit

The Clinical Audit Department is in the process of proof reading the Annual Clinical Audit Report.

It was suggested that it would be useful if a presentation could be provided to the Clinical Board from the Clinical Audit team and Kathleen Morris will feed this back.

Action: Kathleen Morris

CDTQSE 18/229 Research and Development

The Clinical Board R&D Group has not met since the last QSE meeting.

It was noted that the UHB Annual Research and Development Report has been circulated to Clinical Boards.

CDTQSE 18/230 Service Improvement Initiatives

A Clinical Board Transformation Workshop was held on Monday. 3 interesting ideas were put forward linked to the strategy highlighted in the National Long Term Plan document.

Staff in the Clinical Board will be asked to come up with ideas for improvements that can be made within services and a prize will be awarded for the best idea. Details of how to apply will be issued shortly.

CDTQSE 18/231 NICE Guidance

Nothing to report.

CDTQSE 18/232 Information Governance

Details and tips around the new GDPR guidelines have been made available for managers and staff from the Information Governance Team.

CDTQSE 18/233 Data Quality

There are plans in IT to conduct work which will determine the flags and alerts required on systems in order to enable staff to better identify patient requirements e.g. sensory loss and allergies.

DIGNIFIED CARE

CDTQSE 18/234 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 18/235 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing further to report.

CDTQSE 18/236 Equality and Diversity

Alun Morgan attended the UHB Welsh Language Workshop. Clinical Boards will be measured on how they comply against the Welsh Language Standards. At the workshop there was a general will to comply with the standards but more understanding is needed on the financial implications that this will involve.

It was noted that transgender services are being hosted on an All Wales basis.

The Eisteddfod is coming to Cardiff in August and it was noted that a number of staff from within this Clinical Board have volunteered to be involved.

TIMELY CARE

CDTQSE 18/237 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 18/238 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Increased demand and some difficult service constraints, particularly relating to recruitment delays to specialist roles, has seen waiting times increase from the end of the last financial year. There are several comprehensive short, medium and long-term plans to address the issues. The waiting time position for June is still to be verified but is in the order of:

Radiology - 560 patients waiting 8 weeks and over.
Therapies - 70 patients waiting 14 weeks and over.

INDIVIDUAL CARE

CDTQSE 18/239 National User Experience Framework

The report for June in not yet available.

STAFF AND RESOURCES

CDTQSE 18/240 Staff Awards and Recognition

Directorates were encouraged to put forward nominations for the Clinical Board Staff Recognition Scheme. The category for July is Values into Action Award.

CDTQSE 18/241 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting 85% compliance with mandatory training.

The fire safety module is of concern which is below target at 72%. All staff are instructed to ensure they are compliant.

The Clinical Board is reporting 56% compliance against PADRs. This is disappointing given the time and investment that has been put into improving the quality of PADRs. The Head of Workforce is interested in hearing managers' views and suggestions on how to improve compliance.

As of 25th June 2018, Ceri-Ann Hughes has been appointed as the Head of Workforce for the Surgery Clinical Board in addition to this Clinical Board. The HR operational team in the Workforce and OD structure is now currently being redesigned.

The Clinical Board sickness rate is 3.06%, which is below the sickness target of 3.68%. There has been a month on month decrease in both short term and long term sickness absence. Long term sickness is currently at 2% and short term sickness is currently at 1.06%.

In terms of the reasons for absence:

12 long term sickness cases are attributed to anxiety/stress/depression/other psychiatric illnesses.
4 long term sickness cases attributed to MSK issues.
3 long term sickness cases attributed to benign and malignant tumours, cancers.

All of the above are being proactively managed along with the relevant signposting to support services including Occupational Health, Employee Wellbeing Service and Physio MSK service.

It was requested that managers complete the staff survey and also encourage their staff to complete the survey.

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

The following minutes were **RECEIVED:**

Draft Clinical Board Regulatory Compliance Group Minutes 28.6.18
Draft Health and Safety Group Minutes 3.7.18

ANY OTHER BUSINESS

It was noted that the Public Health Team have been undertaking work around sustainable travel and active travel plans. It was suggested that Tom Porter is invited to a future meeting to present the travel plans.

Action: Helen Jenkins

DATE AND TIME OF NEXT MEETING

8th August 2018 at 2pm in Classroom 1, UGF, UHW

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

MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE
11th April 2018
SEMINAR ROOM, LLANDOUGH HOSPITAL

Present: Jayne Tottle, Director of Nursing Mental Health (Chair)
Owen Baglow, Quality, Safety & Governance Lead
Ann-Marie Dunsby, ST6 South Crisis Team
Catherine Evans, Patient Safety Facilitator
Katie Fergus, Interim Clinical Director Adult MH
Mark Jones, Directorate Manager Adult MH
Steve Moore, Team Lead Physiotherapist
Bala Oruganti, Consultant Psychiatrist Crisis Team

Apologies: Jayne Bell, Lead Nurse Adult Mental Health
Jane Boyd, Clinical Director Psychology & Psychological Therapies
Arpita Chakrabarti, Assistant Clinical Director MHSOP & Neuro
Mark Doherty, Lead Nurse MHSOP/Neuro
Carol Evans, Assistant Director of Patient Safety & Quality
Robert Kidd, Consultant Psychologist
Mick McGeoch, Clinical Audit Co-ordinator
Annie Procter, Clinical Board Director, Mental Health
Ian Wile, Head of Operations & Delivery Mental Health
Joanne Wilson, Directorate Manager MHSOP

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting.

1.2 Apologies for Absence

Apologies for absence were noted.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on14th February 2018 were accepted as an accurate record.

1.4 ACTION LOG/MATTERS ARISING

The Committee received the Action Log and noted the actions that had been completed; these would be removed from the Log:

Clozapine

Recommendation for mechanisms so that GP's have a "red flag" on patient's electronic records indicating they are CMHT prescribed Clozapine.

No update at this meeting – on-going.

Action: Annie Procter to ask Avkash Jain, Community Director, if he is able to help with this recommendation.

It was noted that Owen Baglow is carrying out an audit on patients who have died whilst on Clozapine.

Manual Handling

Jayne Tottle to add "Manual Handling whilst resuscitating risk" to the Risk Register.

Action: Jayne Tottle

Access to Global Link

Issue of access to Global Link. Access was difficult. There was no receptionist or waiting area. Various Clinical Boards accommodated Global Link. There had been a suggestion that service managers contribute towards a receptionist post.

No resolution to date. On-going discussions in Clinical Board. **Action: Clinical Board**

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 UHB Quality, Safety and Experience Committee

The Chair noted the Minutes of the UHB Quality, Safety and Experience Committee meeting dated 13th February 2018:

QSE 18/013 Wales Audit Office Report on Discharge Planning

It was noted that the number of delayed transfers of care (DTOC) had reduced considerably from 157 in 2016 to 43. Weekly meetings were held with patients/families and each case was carefully scrutinized. A new clinical dashboard had recently been shared with staff to help them monitor the situation and ensure patients were allocated to the correct pathway. The Chair thanked Judith Hill for all her work and commented that the Council was working closely with the UHB to ensure a seamless service for patients. The DTOC position was the best it had been in 12 years.

2.2 Health and Care Standards

A meeting had been held in March to look for evidence. The deadline for submission of Health and Care standards self assessments is 27th April 2018. An update will be given at the next MHCB Q&SE meeting in June 2018.

2.3 Regulatory compliance and external accreditation - No report.

2.4 Risk Register

On-going.

2.5 Directorate QSE Groups

The **ADULT DIRECTORATE QUALITY & SAFETY** Minutes dated 22nd March 2018 were noted:

Primary Care Mental Health Specialist Practitioner – GP North East Cluster

Emily Boobyer, GP Mental Health Nurse, gave a summary of her role in the north east Cardiff GP cluster. The one year pilot began in October 2017 as a result of GPs discovering that much of their time was taken up with repeat patients with mental health disorders. GPs over 6 surgeries now signpost these patients to a GP Mental Health Nurse who reviews emergency and routine cases to include a medication review in
20 minute slots inclusive of admin time.

Mark Jones, Directorate Manager, said that the pilot is going very well.

Feedback from inspections on wards

The HIW feedback from their visit to Pine Ward was positive and the Clinical Board had sent their thanks to the clinical team.

Smoking Cessation

Reported that mixed response from patients have been received on the smoking ban. The HIW were understanding of the situation and appreciate that it is being monitored. Jayne Bell commented on the unpleasant experience on entering the Hafan y Coed main reception with the smell of cigarettes and the resulting littering of cigarette ends. Mary Morgan reported that on each shift a member of staff is needed to answer the ward doors as patients are exiting wards every 15 minutes to go outside to smoke.

Risk Register

Jayne Bell explained to the group that all Welsh in-patient settings were awarded funding to improve ligature risks. The work is ongoing. Due to two successful suicides and one unsuccessful suicide attempt where patients have used the en-suite bathroom doors as ligatures, the doors will be replaced with saloon design models which are made of a mould resistant, strong, bendy plastic. We are assured by the manufacturers that they are ligature-safe. The bathroom smoke detectors are over-sensitive so estates are moving these. Door top alarms on bedroom doors will be piloted and when one has been installed Jayne will inform the teams.

In-patients

The Delivery Unit's review on Care & Treatment Plans (CTP) has revealed that there is an issue with CTPs, and the recording of 1:1s is of poor quality.

The Rapid Tranquilisation policy is proving problematic for staff, notably the timeliness of the delivery of anti-psychotics. Mary Morgan is carrying out an audit on Rapid Tranquilisation.

Addictions

Neil Jones raised the issue that dual diagnosis is an ongoing challenge.

Ian Wile is discussing the dual diagnosis collaboration.

Psychiatric Intensive Care Unit (PICU) Operational Policy

A robust discussion took place regarding the PICU Policy, resulting in many discrepancies being found. Jayne Bell recommended the policy be taken to the Clinical Body for discussion*:*

MHCB QS&E discussed medical cover to patients on PICU. It was suggested that Consultants want a Lead Consultant for support. Jayne Tottle queried whether a third Band 6 was a reasonable idea.

The **MHSOP/NEUROPSYCHIATRY QUALITY & SAFETY –** No Minutes as next meeting on 23rd April 2018.

The **MHSOP/NEUROPSYCHIATRY DIRECTORATE PERFORMANCE MEETING –** Minutes dated 12th February 2018 were noted:

IMTP Update/Issues

Turnbull Day Unit, St David's - discussion regarding a move to Grand Avenue is on-going.

The REACT review is on-going.

The PSYCHOLOGY & COUNSELLING QUALITY & SAFETY – no report.

PHARMACY - No report

MENTAL HEALTH ACT - Nothing to report.

INFECTION, PREVENTION & CONTROL

The Clinical Board has performed well in relation to IP&C targets in year April 2017 to March 2018:

One case of C.difficile in Llanfair Unit, Llandough Hospital
One case of MSSA
Two cases of E-Coli

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

3.1 Initiatives to promote health and wellbeing

Smoking Cessation

Jayne Tottle reported that the UHBs Health & Safety Committee had agreed that patients may use e-cigarettes within the Ward. It would be for the Ward team to decide whether this is confined to a designated area. This is to assist in the reduction of littering outside Hafan y Coed entrance and also to support patients to utilise their leave for recovery purposes rather than to smoke. It was also agreed that the e-cigarettes could be charged on the ward with the usual risk assessments being carried out.

The availability of purchasing e-cigarettes at Llandough Hospital continues to be looked into.

It was noted that UHW had the support of a No Smoking Enforcement Officer (employed by Cardiff Local Authority) and it was hoped that the service would be extended to include Llandough Hospital.

Out of Hours Access to Hafan y Coed Gym

The Out of Hours Access to Hafan y Coed Gym SBAR, Procedure, and Risk Assessment Form had been circulated to members. This will be piloted for 3 months with Healthcare Support Workers who have attained the Level 2 fitness training qualification providing support to inpatients in Hafan y Coed to access the gym facility outside of care hours (8.30-4.30). There are three Level 2 trained staff members: one from the Activity Team and two from the SIMA Team.

The pilot between nursing and physiotherapy will enable patients to access the gym under supervision from 2 staff, one of whom will be Level 2 trained.

Patients will have undergone an assessment by a physiotherapist prior to support workers supporting them to maintain or increase their physical health fitness. Steve Moore, Team Lead Physiotherapist, explained the Risk Assessment form:

- Patients only accessing the gym under supervision from 2 staff (one Level 2 trained).
- Staff have pinpoint alarms with them to alert in an emergency in addition to strip alarms and button alarms in the environment.
- Staff alerted to the environment and the location of these alarms
- Full induction provided for these staff members
- Procedure provided to staff members
- Verbal handover to physiotherapy staff at the earliest opportunity regarding any incidents or changes to patients presentation
- Between the hours of 8.00-5.00 there are physiotherapy staff present to address any issues, after this time there is the nurse in charge of the ward or the shift coordinator

Jayne Tottle thanked Steve for presenting the Pilot Out of Hours Access to Hafan y Coed Gym and said it was very well thought out.

SAFE CARE

4.1 WG Closure Forms

Closure forms and Summary Sheet February and March 2018 had been circulated.

Catherine Evans informed the Group that there was a new Never Events Guidance from 1 April 2018. This would be circulated.

4.2 Patient Safety Alerts

None

4.3 Key Patient Safety Risks

Establishment Review Standard Operating procedures. Quality indicators.

Acute, Medicine and Surgery Clinical Boards are required to have Boards inside their wards for the purpose of displaying information relating to that ward area, this includes the names of staff on shift. Sheila Harrison is looking at a template to see if it can be adapted for other areas. Mental Health has Hot Boards outside the ward.

There is a Mental Health Workstream meeting with Jean White¸ Chief Nursing Officer Welsh Government on 27th April 2018.

EFFECTIVE CARE

5.1 Audits

Bala Oruganti is the Lead for the National Clinical Audit of Psychosis (NCAP).

Neil Jones, Consultant Psychiatrist, Addiction Services, and Bala Oruganti are undertaking an audit on Clozapine incidents.

Bala Oruganti stated that Dr Mohammed was involved in the Resuscitation audit with Owen Baglow.

5.2 NICE Eating Disorder Review

The Cardiff and Vale Eating Disorders Services considered the NICE for Eating Disorders Review (2017) at the end of last year and were then part of a Wales wide meeting at the beginning of 2018. A strategy for mapping services against NICE has been instigated to establish a baseline, and suitable training initiated at a Wales wide level. Once this is complete this information will be shared.

DIGNIFIED CARE

6.1 DECI (Dignity & Essential Care Inspections)

Senior Nurses undertake Dignity & Essential Care Inspections outside of their own area. Such an inspection was undertaken on Cedar Ward on 23 March 2018 and an Action Plan has been completed. One recommendation was to consider the use of patient initials and full surname on PSAG Board rather than patient initials, however, HIW will not permit any names in full unless the Board is covered or has doors.

TIMELY CARE

No report.

INDIVIDUAL CARE

8.1 Feedback from Surveys

Service User Feedback

Bespoke Service User and Carer questionnaires have been developed for Adult Mental Health In-patient, Adult Mental Health Community, Mental Health Older People's In-patient and Mental Health Older People's Community Services. A Service User survey will commence on 1st May 2018 for one year. Consideration is being given to commissioning CAVAMH to assist in the distribution and completion of the questionnaires on a monthly basis.

It was suggested that physical health be incorporated in the in-patient survey. **Action Jayne Tottle/ Jayne Bell**

8.2 Compliments

Compliments received for:

Judith Cooper and Alex Gazi – for covering Hafan y Coed Reception during the snow disruption

MHSOP SHOs – for providing cover during the snow disruption

East 10 - Thank you letter from a carer.

CAU - Thank you letter from a Liaison Nurse.

Complaints are on-going.

STAFF AND RESOURCES

9.1 Disciplinary Trends

Inappropriate access of medical records

Jayne Tottle informed members that some staff members had accessed medical records without the need to do so. Jayne has reminded staff that it is a breach of the staff member's contract of employment if they access medical records without the need to do so and as such could result in Disciplinary Action.

Dr Graham Shortland, Medical Director had also circulated a letter to staff reminding all staff that inappropriate access is NOT permissible irrespective of the role of the staff member. Such unauthorised access is not only a breach of the Data Protection Act 1998 (Section 55) it is also a breach of the staff member's contract of employment. It should be noted that deliberate unauthorised access to personal/sensitive information may be reported to the Information Commissioners Office (ICO). The ICO then may wish to take action to respond to any cases reported to them. Section 55 breaches are treated as criminal offences and could result in prosecution and/or fines and in severe cases lose registration to continue to practise.

Social media

Another Disciplinary trend is inappropriate actions on Social media.

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

Policies and Procedures

The Group were asked to receive and ratify the following:

10.0 Hospital Managers' Power of Discharge Handbook
10.1 Power of Discharge Hospital Managers Hearing Conduct Protocol

The Handbook and Protocol had been circulated to the MHCB QS&E members.

It was noted that the Handbook and Protocol had been circulated to the Power of Discharge Group.

THE HANDBOOK AND PROTOCOL WERE APPROVED

10.2 Suicide and Homicide in Young People

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Safer Care for Patients with Personality Disorder was published on 8 February.

As part of the National Clinical Audit & Outcome Review Programme, Owen Baglow was completing the relevant assurance proforma. It was suggested that Owen contact Jayne Bell, who had completed a Masters Dissertation regarding Suicides and Young People; Miranda Barber, who was a member of the National Steering Group for Self Harm; and Robert Stamatakis who had an interest in this subject.

10.3 Referral of Deaths to HM Coroner Guidance

The Referral of Deaths to HM Coroner Guidance had been circulated to members and was noted.

DATE OF NEXT MEETING

20th June 2018 at 9.30am in The Seminar Room, Hafan y Coed. (moved from 13th June).

(next Clinical Board Q&S Lessons Learned Meeting is on 10th May 2018 in the Seminar Room, Hafan y Coed)

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

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING
19th July 2018
Seminar Room, Hafan y Coed, Llandough Hospital

Present: Owen Baglow, Clinical Lead for Quality, Safety & Governance (Chair)
Will Adams, Crisis & Liaison Services
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Philip Ball, Senior Nurse Manager CMHTs
Aline Beveridge, Deputy Ward Manager Alder Ward
Natalie Coombs, Deputy Senior Nurse Manager CMHTs
Lisa Crump, ANP Adult In-patient
Catherine Evans, Patient Safety Facilitator
Steve Ford, Lead CPN Pentwyn CMHT
Rachel Gibbons, Staff Nurse Cedar Ward
Martin Harper, Integrated Manager Links CMHT
Stephanie James, Interim Senior Nurse Manager, MHSOP In-Patient
Robert Kidd, Consultant Psychologist
Lisa Lane, Senior Nurse Manager, MHSOP Community
Mike Lewis, SIMA Co-Ordinator
Jane Morena, Links OTT
Noel Martinez-Walsh, Integrated Manager Pentwyn CMHT
Peter Murray, Integrated Manager Gabalfa CMHT
Alex Nute, Mental Health Lecturer, Cardiff University
Darren Shore, Team Lead North CRHTT
Mark Warren, Senior Nurse Manager Criminal Justice & Forensic
Holly Williams, Quality & Safety Facilitator, Specialist Services
Justin Williams, Team Lead South CRHTT
Lowri Wyn, Ward Manager Cedar Ward

Apologies: Jayne Tottle, Director of Nursing Mental Health
Jayne Bell, Lead Nurse Adult Mental Health
Adeline Cutinha, Consultant Psychiatrist, Gabalfa CMHT
Mark Doherty, Lead Nurse MHSOP/Neuro
Alison Edmunds, Concerns Co-ordinator
Ruth Evans, Lead CPN Links CMHT
Katie Fergus, Clinical Director Adult MH
Mike Ivenso, Clinical Director MHSOP
Jayne Jennings, Ward Manager Willow Ward
Annie Procter, Director Mental Health
Natalie Prosser, Professional Practice Development Nurse
Jayne Strong, ANP Rehab & Recovery
Andrea Sullivan, Concerns Co-ordinator
Ian Wile, Director of Operations MH
Jo Wilson, Directorate Manager MHSOP

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

Chair welcomed all to the meeting and introductions were made. Owen Baglow explained that this meeting was to enable open discussions and views and to highlight good practice and lessons learned.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

No Actions.

PART 3 : CLOSURES

3.1 KE

KE was 61 year old gentleman not previously known to Mental Health Services until he attempted to take his own life by hanging. He went to his garden shed in the early hours of the morning where he had prepared a noose; his partner followed him and attempted to stop him. KE assaulted his partner when she tried to stop him. She called on a neighbour for help, and when he was 'cut-down' he required CPR and emergency services were called. Police later charged KE with the assault on his partner although she did not want to press charges.

KE was admitted to Hafan y Coed, Llandough Hospital for assessment on Cedar Ward then moved to Oak Ward (a treatment ward) and a few days later was transferred to Willow Ward (another treatment ward). KE was discharged home under the care and supervision of the North Cardiff Crisis Resolution and Home Treatment Team. South Wales Police were unhappy that he was home given the pending court case for common assault so KE was admitted to the Crisis House.

KE was due in Magistrates Court for trial for the assault on his partner. KE left the Crisis House on the morning of the court case stating he wished to walk home to get ready for Court, but he failed to arrive home.

KE was very sadly found hanging a few days later.

Issues Identified:

- No previous convictions. KE assaulted his partner when she tried to stop him from committing suicide but did the Police think there was a domestic violence issue? KE's partner said that he had never hit her.

Action: Mental Health to discuss with Police re domestic violence.

- It is not clear from the notes whether he was directly questioned about his feelings regarding his suicide attempt or his anxiety about the court appearance. It is also not clear if he attended his pre-sentencing appointment, or if he was asked how this made him feel on return to the ward.

The nurse on the treatment ward, who saw him on the day before his discharge, clearly spent time trying to get to know him and offered useful suggestions such as OT and physiotherapy, which had not been offered previously.

- KE walked home to get ready for Court

Noted that the Crisis House is for informal admissions, there is no locked door. Also, KE was assessed before he left and staff were re-assured by KE that he would be alright.

Recommendations and Actions:

- Senior Nurse for Crisis Services to reinforce to crisis teams the importance of recording a new assessment on discharge, along with intervention plans. As in this case, the Crisis Team's assessment form was predominantly a duplicate of the one completed in A&E and there was no evidence of what had changed since the day of attempt.

Action: It was noted that a different case had also highlighted the use of copying and pasting resulting in inaccurate information being forwarded to documents. Staff have been told not to copy and paste and the PARIS team were looking at stopping the copy and paste facility for Form 4 and the outcome box on Form 1A

- The policy for staying at the Crisis House is 7 days but may stay longer if necessary. In this case, KE had been told initially that he would have to leave after 7 days which may have caused him anxiety.

Action: Although the Crisis House staff were following the Crisis House Policy. This issue was perceived to be the way that it was said, not what was said. Senior Nurse for Crisis Services to remind Crisis House staff of the unintended consequences of casual comments.

- All inpatient staff to be reminded of the importance of gathering the views of families.

Action: Senior Nurse Manager reminded staff.

- Lead Psychologist for Treatment wards to consider how to support ward staff with the formulation of risk.

Action: Lead Psychologist for Treatment wards to undertake refresher training on the Inpatient Suicide Manual to encourage staff to ask direct questions

Alex Nute, Mental Health Lecturer Cardiff University confirmed that the students' programme does cover suicide

It was noted that a team of ADP nurses have completed a project on male suicide which includes asking difficult questions and are taking this forward.

The Coroner reported that KE had suffered with a condition called Superior Semi-circular Canal Dehiscence Syndrome which involved the thinning, or absence, of a portion of the temporal bone overlying the superior semi-circular canal of the inner ear. The condition made KE hypersensitive to sound.

TO CLOSE.

3.2 JB

JB had an argument with his partner and subsequently hung himself with a bed sheet in the stairwell of the home he shared with his partner and children. His partner was able to release him and called on neighbours to assist. A Social Worker, who works for Cardiff and Vale UHB and who lived in the same street, went to assist and undertook resuscitation at the scene whilst awaiting emergency services. Sadly, this was unsuccessful.

JB had been under the care of the Community Mental Health Team (CMHT) since 2015, following a referral with depression and Attention Deficit Hyperactivity Disorder (ADHD). Interventions had been limited as JB declined medication and was reluctant to engage with the CMHT.

JB had a diagnosis of ADHD and suffered from anxiety and personality traits as a result of a difficult upbringing where he suffered losses and bereavement resulting in attachment difficulties. JB would often express wanting to end his life in times of crisis but on reflection would always express that he wanted to live for his children and family, that they were strong protective factors.

The Coroner concluded that cause of death was 1a) hanging. Conclusion: died from the effects of hanging in circumstances in which his intention was unclear.

It was felt by persons who knew him that he would not have intended to take his own life.

Issues Identified:

JB refused to take his ADHD medication as he felt the medication changed his personality therefore he was offered psychological interventions for his attachment fears and it was hoped that a medication would be found that would not change his character but control the ADHD.

JB was a good parent and partner but his attachment difficulties made him anxious about being a parent and his partner leaving him.

The ADHD prevented JB using talking therapies

JB had impulsive, self harming behaviour.

Recommendations:

A reason for JB's disengagement from the CMHT could possibly be the fact that when he finished work the CMHT would be shut. Suggestions were to extend the working hours of CMHT's or introduce shift work, i.e. 11.00am -7.00pm a couple of times a week and Saturday mornings so that patients could attend before or after work and at weekends.

Action: The current community mental health services review will be addressing capacity issues.

Good Practice

Links CMHT went above and beyond the call of duty. Although there was no longer a clear role for CPN involvement, the CPN continued to develop a good therapeutic relationship with both JB and his partner and it was felt appropriate for JB to remain on the CPN caseload despite minimal involvement.

TO CLOSE.

3.3 SA

SA hung himself from his bathroom door using a bed sheet whilst an inpatient in Hafan y Coed, University Hospital, Llandough. Very sadly, SA suffered a hypoxic brain injury.

SA had been known to Mental Health Services since 2012. There were common themes through each assessment which included experiencing suicidal ideation or thoughts to harm himself and thoughts of wanting to harm other people. Substance misuse was a factor in his mental health difficulties; each assessment concluded there was no evidence that SA was suffering from a serious mental illness. There was acknowledgement that thoughts and experiences of low mood were rooted in continued substance misuse. Appropriate advice was provided to SA in how he could address substance mis-use. A copy of the assessment was sent to the GP with advice that SA start on antidepressant medication. SA was signposted to the Community Addictions Unit for advice regarding his cannabis use, but he declined this service.

During the assessments that took place in 2016 the assessors commented that SA displayed aspects of anger, irritability and intimidation. SA was advised to access support services such as ACT-ion for Living (a community package that helps people deal with stress in their lives) and also to enrol in an anger management group, but he was reluctant to engage in these types of therapy. Following discussion, SA was closed to secondary services and referred back to primary services due to there being no evidence of serious mental illness and a lack of willingness to engage in the offered support services. SA was advised to seek support from services such as MIND.

At the end of 2016, Mental Health Services received a referral from Kingston Crisis Services and SA was admitted to Hafan y Coed, Llandough Hospital as an informal patient for a period of assessment as SA had taken an overdose. SA was placed on 15 minute observations.

Issues Identified:

- Interface with Kingston Crisis Response Home Treatment Team and Cardiff & Vale was poor, in that referral information was not forth coming prior to the assessment for admission taking place. The referral information from Kingston Crisis Response Home Treatment Team shows that the recent overdose was viewed as more important than a recent attempted hanging with shower curtains.

- *Use of the Reassurance Observation System (ROS) in bedrooms*

  The Reassurance Observation System (ROS) is an observation tool specifically designed to unobtrusively observe inpatients in their bedroom areas. It comprises of an infrared camera and microphone system connected to a LCD observation panel which is situated just outside each bedroom; this is the only location where the images can be viewed and there is no facility to access it elsewhere. This panel can be accessed by the observing staff member to check on the patient's safety and well being. The system does not record video/images or sound, only allowing real-time observation.

  It is the opinion of the review team that ROS was not a factor in the incident.

- *Why was the assessment by the Crisis Team undertaken by nursing staff rather than a Consultant Psychiatrist?*

  The Operational Policy for the Crisis Service states that the Crisis Resolution Home Treatment Team (CRHTT) will participate in all assessments when admission to inpatient care is a possibility. This assessment will be multi-disciplinary wherever possible and will identify needs and levels of risk. The staff who conduct the assessment will be determined by the availability and workload of the Crisis Team at that particular time.

  The fact that the assessment of SA on was carried out by two Crisis Team nurses is seen as standard and routine practice. SA was also clerked in by the ward doctor. During the interactions with the Crisis Team and the ward doctor, if the advice of a senior doctor was deemed necessary, then it would have been sought. In this particular case it was the belief of the assessing team that this was not necessary.

- *Why didn't staff act on the information provided by SA's mother?*

  Contention of the family that a phone call was made by SA's mother to ward staff to warn them of SA's distress and the fact that he had texted her to state that he was suicidal. The member of staff who took the phone call recalls the telephone conversation in a different way. She acknowledges that SA's mother contacted the ward just prior to the incident and she states that general concerns about his physical health were expressed by his mother. The nurse stated that SA's mother said that she was concerned about SA's welfare and as his diet was poor she asked if the ward staff could encourage him to eat properly rather than issues of immediate wellbeing. The nurse states that these concerns were not of the nature that warranted immediate action and if she thought that they were or that SA was in danger, then she would have acted straight away; she did made a note to speak to SA as soon as her workload allowed.

  Discussion questioned whether this was cultural issue. Some people are unable to talk about mental health issues.

Lessons Learned:

Levels of Observations

SA was placed on observations at intervals of every fifteen minutes.

Rob Kidd stated that 15 minute observations cannot guarantee patient safety despite Hafan y Coed being a modern environment with limited ligature points but stressed that we will always try to keep people safe.

There was much discussion regarding levels of observation. The rationale of observations in this case was for overdose risk also close observations may have heightened aggression.

Further discussion would be required regarding level of observations and it was recommended that this should be carried out at the Adult Quality & Safety meeting with a possible Task & Finish group being developed.

Resuscitation Process

With regard to equipment factors, the review team noted the issue of non-rebreathe and pocket masks which were at the time on the resuscitation trolleys at Hafan Y Coed. With regard to the task factors, and the very low number of such incidents which staff have to response to, the review team considered that a task familiarity factor was a contributory factor in the resuscitation. The review team found that training in Basic Life Support was adequate. There was an issue with the provision of rescue breaths and the use of the non-rebreathe mask during the resuscitation process. The implications of this are not known

Following the incident, the resuscitation team recommended the removal of Non-Rebreathe masks from oxygen cylinders and pocket masks be placed on top of the crash trolley with spares in the drawer of the trolley. This recommendation had been completed across the Clinical Board, and all qualified staff were trained to ILS standard.

Present day – there are 3 masks in the drawer of the trolley and a poster saying which mask to is to be used is cited by the trolley

Ligature Risk Assessment

Rachel Sykes, Health & Safety Advisor, prepared a Ligature Risk Assessment Protocol for Hafan y Coed and the doors have been removed from bathrooms in the wards.

Good Practice

There was a lengthy nursing 1:1 which was recorded in detail on the PARIS electronic notes system. This was a 90 minute investment of nursing time with the explicit aim of reducing the risks on the first night of admission. In addition to discussion of recent over dose, attempts to hang himself and a variety of other means were explicitly acknowledged.

TO CLOSE.

4.0 DATE OF NEXT MEETING

13th September 2018 at 9.30am in the Seminar Room, Hafan y Coed.

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

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE held at 1.30 pm, 8th May, 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 Mogie (AM)	Lead Nurse, North and West Cardiff
Ceinwen Frost (CF)	Lead Nurse Vale Locality
Danielle Hewings (DH)	Operational Manager, GP Out of Hours
Denise Shanahan (DS)	Nurse Consultant
Helen O'Sullivan (HO'S)	Quality and Safety Manager
Karen May (KM)	Head of Medicines Management
Lisa Dunsford (LD)	Director of Operations
Maria Dyban (MD)	Community Director
Matthew McCarthy (MM)	Patient Safety Facilitator
Nicky Hughes (NH)	Lead Nurse S&E Locality
Rhian Bond (RB)	Head of Primary Care Services
Yvonne Hyde (YH)	CNS in Infection Prevention and Control
Rachel Armitage (RA) (Minutes)	PCIC Quality and Safety Officer

Apologies

Nicola Evans (NE)	Head of Workforce and OD
Lynne Topham (LT)	Locality Manager, North and West Cardiff
Anna Kuczynska (AK)	Acting Clinical Board Director
Helen Earland (HE)	Senior Nurse PC

Preliminaries		Action
05/18/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Chair.	
05/18/002	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
05/18/003	**DECLARATIONS OF INTEREST** GH asked for any declarations of interest – none noted.	

05/18/ 004	**MINUTES OF THE PREVIOUS MEETING HELD ON 13TH MARCH, 2018** The minutes of the previous meeting were recorded as an accurate record. **Matters Arising** There were no matters arising.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
05/18/ 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: **Update on service model and staffing for CHAP**: A new Community Director and Senior Nurse have been appointed; agreed workforce plan awaited. **AMR Plan:** See agenda item 16. **01/18/008 Risk Register S&E 06.01.17 HMP Mental Health Provision:** Lisa Dunsford agreed to take the lead for this work; a meeting with Ian Wile, Director of Operations and Delivery for Mental Health Clinical Board, is planned for week commencing 14th May. **01/08/009 Interface Incidents – Datix Report**: KJ has received a report from HO'S and will forward reviewed. Action completed. **01/08/010 Risk Escalation Report – EMIS:** Anna Mogie confirmed that this remains an issue and has been escalated to Allan Wardhaugh, Assistant Medical Director for Information Management and Technology. Risk is tolerated. Item to be removed from Action Log. **01/18/012 Business Unit QS&E minutes:** Primary Care meetings are not yet being minuted. Process is under development and action is ongoing to ensure this is undertaken. **01/18/015 Health and Care Standards:** Action completed. **01/18/027 Mandatory Training Update – Dementia:** Dementia Action Plan is in the process of being updated with smart indicators. To be brought back to next meeting of QSE. **03/18/007 Risk Register – call recording at CRI:** Feedback awaited from finance team. CPET has been temporarily relocated to the Communications Hub. DH to follow up with Lynne Aston. **03/18/007 Out of Hours Service Delivery:** Action plan under development; to be brought back to the next QSE meeting.	**LD** **DS** **DH** **DH**

05/18/006	**PATIENT STORY – PHARMACY – STOMA WORK** It had not been possible to identify a patient story due to staff sickness.	
05/18/007	**QUALITY DASHBOARD** KJ summarised the dashboard. The following points were highlighted. The Director of Nursing had welcomed the development of a Clinical Board Quality and Safety Dashboard and has requested that the latest iteration should be shared with the Assistant Director Patient Safety and Quality for final review and authorisation. KJ confirmed that the Dashboard is linked to agreed targets to ensure an accurate reflection of Clinical Board performance. Colleagues were asked to provide any feedback on the Dashboard to Rachel Armitage by 22nd May, to inform the Dashboard version that will be sent to the Assistant Director Patient Safety and Quality. **Current SIs:** HO'S confirmed that one SI remains open. This had been originally reported as a "no surprises" event but had been upgraded by WG to a SI. It is being investigated by the Police so no further action is permissible until that work is completed. **Formal Concerns:** It was noted that a weekly tracker is maintained and the Concerns team are able to provide information about specific cases if required. KJ can request a high level report from concern's if that is helpful to the business units? It was highlighted that the response times do not reflect the variety of issues which delay responses. **Medication Errors:** Numbers are low, no particular trends or issues of concern to note **Vacancy Rates:** KJ and RA will meet to discuss vacancy rate figures**.** **Interface Incidents:** interface themes and lessons learnt will be brought to the next meeting. MM confirmed that work is under way to develop a different indicator for the time taken to transfer interface incidents to the appropriate manager. **C. diff:** It was noted that 2 C. diff RCA tools that had been returned indicating that there had been no antibiotic prescribing. YH advised that a research proposal has been submitted regarding asymptomatic carriage rates. **MRSA:** KJ and RA will meet to discuss data sources. **E. coli:** KJ confirmed that E. coli rates are being tracked and significant work is under way to revise the UTI pathway with particular emphasis for community and Nursing Home staff regarding catheter management and the promotion of prevention work. **District Nurse (DN) average escalation levels:** there was discussion on the measure for DN escalation. AM highlighted that two North and West DN teams have been consistently at red (Level 4) since January,	**KJ/RA** **RA/MM** **KJ/RA**

	the senior nurses are in the process of reviewing the Escalation guidance for staff). **GP OOH performance:** note was made of the impact of shift fill rates on OOH performance. **OOH average escalation levels:** DH confirmed that some of the current bundles will be reviewed. **GP Sustainability:** the data will be cross-checked with RB and Lee Virgo as there was some discrepancy noted.	**RA**
05/18/ 008	**RISK REGISTER (RR)** **QS&E 000214 OOH** Risk level remains under review. GH noted that the bundles have been beneficial. LD confirmed that further work on the scope of bundles is under way. **QS&E 000113 Independent Sector** Nursing Home capacity re nurse assessor availability to meet standards for patients reviews continues to be tolerated. Business Cases have been submitted but none have been agreed to be taken forward due to financila constraints. **QS&E 020714 CHAP** Work is under way to appoint substantive GPs, following which this risk will be consdiered for removal from the Risk Register. **QS&E 160714 Patient Flow** KJ noted that the system currently requires more capacity than is available. Business Cases for community services to support increased capacity have been submitted but have not as yet been successful. Risk to remain at current level. **PCIC 110914 Complex Packages of Care** AM confirmed that current risk is associated with sustainability of packages. Procurement framework is required supported by a sustainability process for commissioning decisions. KJ confirmed that she has discussed with the Executive Nurse Director a method for making the UHB Board aware of significantly costly cases, the CHC protocol is being reviewed to reflect the process changes. **PCIC 160614 Primary Care Estates Development** RB confirmed that work is ongoing. Improvement grant funding has been secured and plans are in place to appoint third party developers. **PCIC 0814 Local Development Plan** Update is awaited. **PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainabilty** No change.	

	PCIC 10.03.16 Pressure Ulcer (PU) Prevalence Agenda item 18 was taken. MM introduced the guidance documents he has developed with PCIC Lead Nurses to support the reporting of pressure ulcers on Datix, emphasising that all pressure damage at stages 3 or 4, or unstageable, must be reported to Welsh Government (WG) as a SI. It was noted that the SI reporting definition remains under discussion with WG. MM confirmed that he will support a series of meetings with DN teams to roll out the guidance. There was discussion on the challenge of learning from incidents on the background of the increased workload brought about by extended reporting, noting its relationship with safeguarding discussions. KJ confirmed that clarity will be sought from the Assistant Director Patient Safety and Quality on appropriate and sustainable reporting. RA agreed to provide Localities with a monthly SI report from the Datix system. **PCIC18.05.16 Domiciliary Care Provision** AM confirmed that the market remains fragile although there has been improvement. KJ confirmed that removal of this item from the CB Risk Register will mean that the risk will become shared by all the Localities. Tranfer to the Localities Risk Registers agreed. **S&E 05.12.16 HMP Cardiff – Prescribing, Staff Stress, Environment** NH confirmed that senior staff remain on sick leave and other staff continue to report stress. The Locality is adopting a treat approach by supporting staff and altering the work and medication regimes in the Prison. **S&E 06.01.17 HMP Mental Health Provision** LD will lead on this work (see Action Log above 01/18/008 Risk Register S&E 06.01.17 HMP Mental Health Provision). **N&E 10.01.17 Cardiff CRT Medication Administration Procedure** AM reported that her planned meeting with Local Authority (LA) colleagues was cancelled but she will continue to pursue this issue. LD confirmed that she has a meeting scheduled with LA colleagues and recommended that any outstanding issues should be escalated to her. **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** KJ confirmed that she is working through a process with Procurement colleagues and that there is significant work under way regarding care home commissioning. **PC141117 GP OOH IT issues** An action plan for management of the issues has been developed. LD and DH will review separately to escalate ongoing issues.	**RA** **LD/DH**

	Further discussion: • AM raised the matter of the Park View Clinic flood and consequent relocation of the teams and clinics based there. It was highlighted that formal notification is required from the Planning and Estates team that the clinic will permanently close before longer term arrangements can be put in place. • CF highlighted the archiving of patient records, noting that the space previously allocated to the South and East and Vale Localities is already full, noting the new responsibilities imposed by the EU General Data Protection Regulations. CF agreed to take this matter to the Information Governance Group on 17th May, 2018. •	**CF**
05/18/ 009	**STANDARDS OF DOCUMENTATION: LETTER OF ADVICE – MR DK-V-CARDIFF AND VALE UNIVERSITY HEALTH BOARD** CF summarised the above case highlighting in particular that Mr DK's claim was successful owing to poor documentation which could not provide evidence that the community clinical staff knew all the appropriate information about the procedure carried out. It was confirmed that there had been extensive subsequent discussion with the ward and safeguarding teams and that the case had been shared with the District Nurse team. The claim had amounted to £5,000 and the legal advice had been that the UHB would be unable to recoup its costs if it had undertaken an appeal, on the grounds of the inadequate documentation. DS highlighted that the root cause of this case was the ward move and recommended that this learning should be shared with the Head of Integrated Care and the Integrated Discharge Service. AM confirmed that a pathway for patients with cognitive impairment is under development.	**CF**
05/18/ 010	**MANAGEMENT AND CONTROL OF PRESCRIPTION FORMS** This item was presented for noting and has been distributed.	
05/18/ 011	**PROCEDURAL RESPONSE TO UNEXPECTED DEATHS IN CHILDHOOD (PRUDiC)** KJ highlighted that this document represents revised guidance and recommendations for undertaking a child practice review. It was noted that an adult practice review relating to a patient with leg ulcers being cared for by the District Nurses is under way.	
05/18/ 012	**AUDIT** KJ highlighted the current audit plan, noting that other audits are also undertaken within the board but not all captured. Colleagues were invited to provide feedback. The sexual health audits were highlighted as examples of very good work.	

05/18/ 013	**HEALTH AND CARE STANDARDS SUBMISSION** KJ highlighted that the Concerns team have undertaken an audit of "Putting Things Right" compliance with all independent contractors, and have provided the results to WG. RB recommended that the information should be provided by Practice to enable identification of individual issues. LD highlighted the types of concerns received and the need to identify matters which need to be addressed and common themes. KJ suggested that it would also be useful to align these results with Practice visits. RB agreed to set up a meeting with the Concerns Team to discuss the findings. KJ agreed to link with the Complaints Manager regarding PCIC concerns.	**RB** **KJ**
05/18/ 014	**INFORMATION GOVERNANCE** KJ highlighted the imminent introduction of the EU General Data Protection Regulations. It was confirmed that this would be discussed at the Information Governance Group on 17th May. Information has been widely shared with teams and departments.	
05/18/ 015	**BUSINESS UNITS QS&E MINUTES** KJ agreed to feedback to individual business units on matters recorded in their minutes, all three Localities have been received. Primary Care returns were still outstanding.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
SAFE CARE		**Action**
05/18/ 016	**HCAI REPORT AND ANTIMICROBIAL DELIVERY PLAN** HCAI had been discussed above as part of the Dashboard review. KJ highlighted that a HCAI improvement group is working on a plan to reduce the numbers of E. coli, C. diff, MSSA and MRSA. KJ summarised her presentation recently given nationally at the All Wales HCAI collaborative event in North Wales , highlighting the learning drawn from root cause analysis (RCA) of C. diff cases, including the use of the Medicines Management Incentive Scheme and ScriptSwitch. Future work was planned on appropriate prescribing and prevention of infection in community settings, utilising the learning from C.diff with the introduction of a MSSA bacteraemia RCA tool as part of the medicines incentive scheme for 2018/19, promotion of NICE guidance and raising awareness of the responsibilities shared by members of the public. The support of Infection Prevention and Control colleagues was formally recognised. YH confirmed that, since receiving KJ's presentation, Abertawe Bro Morgannwg, Aneurin Bevin, Hywel Dda and Betsi Cadwaladr Health Boards have asked to share the UHB RCA tools.	

05/18/ 017	**NATIONAL POINT PREVALENCE SURVEY OF HEALTHCARE ASSOCIATED INFECTIONS, DEVICE USAGE AND ANTIMICROBIAL USE IN LONG TERM CARE FACILITIES 2017 (HALT-3) – EXECUTIVE SUMMARY AND KEY POINTS** KJ introduced the document noting the emphasis on preventative measures. KJ confirmed that she has linked with Cardiff Care Homes and the Care Home Integrated Support Team (CHIST) to emphasise the need to improve oral care and hydration to prevent the development of infections.	
05/18/ 018	**PRESSURE ULCER REPORTING** This item was taken above, under Risk Register PCIC 10.03.16 Pressure Ulcer (PU) Prevalence.	
05/18/ 019	**PRESSURE ULCERS – NUMBER AND GRADES OF PRESSURE ULCERS BY HEALTH BOARD 2013 – 2018** KJ confirmed that pressure ulcer data is reported to WG and that Cardiff and Vale UHB had been identified as an outlier in not reporting SIs. These discussions were ongoing with the Exec Nurse Director and Asst Director of Patient safety.	
05/18/ 020	**POCT MEETING SUMMARY** KJ summarised the work ongoing regarding point of care blood glucose and anticoagulant testing. It was highlighted that there must be a business case to support all applications for new point of care meters and that the agreed escalation should be via the Point of Care Manager, Seetal Sall (SS) and through the clinical board QS&E committee. Work is under way to determine which meters should be used within Primary Care, based on the best evidence and guidance available; SS will feedback following her meetings with Novo Nordisk and dialogue with WG. Following this work, arrangements for calibrating meters will be necessary to ensure that statutory responsibilities are met. Audits of District Nurses POCT compliance is underway at present. Outcomes are being fed back directly to staff.	
05/18/ 021	**MEDICAL EQUIPMENT ISSUES** No medical equipment issues had been identified.	
05/18/ 022	**PATIENT SAFETY VISIT, STANWELL HEALTH CENTRE, PENARTH** This report was submitted for information. No issues had been identified.	
EFFECTIVE CARE		**Action**
05/18/ 023	**ASEPTIC NON-TOUCH TECHNIQUE (ANTT) UPDATE** KJ confirmed that Jane Britten, Professional Practice Development Nurse, has met Lead Nurses and highlighted the need for increased uptake on	

	this methodology in particular areas. Generally there has been excellent uptake led by Jane, YH supported the excellent roll out in PCIC.	
DIGNIFIED CARE		**Actions**
05/18/ 024	**NCEPOD REPORT "EACH AND EVERY NEED" SUMMARY AND ACTION PLAN** KJ highlighted the action plan points relevant to Primary Care and GPs, and the need to note the requirements set out in the action plan and respond to the recommendation checklist.	
TIMELY CARE		**Action**
05/18/ 025	**SAFEGUARDING** **25.1 Safeguarding update** HO'S confirmed that the Safeguarding Team is experiencing more reporting from GPs and that the Governance Team will meet with the Head of Safeguarding on 12th June to develop clear guidance and enable consistency of approach. **25.2 Annual Self-Assessment Health and Care Standards – Safeguarding Children and Safeguarding Adults at Risk KJ** confirmed that the safeguarding element of the Health and Care Standards return had been positively received. **25.3 Cardiff and Vale of Glamorgan Violence against Women, Domestic Abuse and Sexual Violence Strategy 2018-2023 and 25.4 Strategy on a page Colleagues** were advised to provide feedback to the Safeguarding Team. **25.5 The Progress and Development of the Role of the Health Independent Domestic Violence Advisor – Year 1 This** document was submitted for information. DS highlighted that a post has been funded which only to cover the Emergency Unit, hence there was no support available in the community. **25.6 Agenda Safeguarding Steering Group March 2018** **25.7 Safeguarding Steering Group Minutes 25 January 2018** These documents were presented for information.	
INDIVIDUAL CARE		**Action**
05/18/ 026	**26.1 Dementia Action Plan** DS confirmed that the plan had been drafted and would be circulated for consultation to ensure that it reflects the Dementia Strategy. The final Action Plan will be brought to the next meeting. **26.2 Mental Capacity Assessment to Consent Treatment Audit, Vale Locality** CF highlighted that the audit had identified that many District Nurses forget to formally document capacity. The findings and guidance are being disseminated through Sisters of Nursing meetings. A re-audit will be carried out in approximately one year. GH highlighted the interface of this issue with the legal advice on documentation case discussed above.	**DS**
STAFF AND RESOURCES		**Action**

05/18/ 027	**NURSE STAFFING LEVELS (WALES) ACT – NURSING ESTABLISHMENT SIGN-OFF** KJ confirmed that the establishments had been signed off with the Executive Nurse Director, noting that the All Wales District Nursing principles are not yet aligned to the Act. A Business Case has been developed noting that, because it was a statutory requirement to meet the principles of the Act; it had been necessary to sign-off the establishments as sufficient and safe without additional investment. KJ will continue to work with the Nurse Director to progress optimal levels of staffing to meet the future requirements of transferring care to the community. KJ confirmed that there will be a fourth All Wales PDSA cycle to audit quality and compliance with the Nurse Staffing Act undertaken in Cardiff and Vale Community as part of the All Wales work on Acuity and Dependency.	
SUB-GROUP REPORTS		**Action**
05/18/ 028	**28.1 GP OOH Business Unit** It was noted that there had been one safeguarding referral; the team is working through the associated actions. **28.2 Vale Locality** CF highlighted that one complex concern involving safeguarding was absorbing a significant amount of time and human resource. **28.3 Cardiff South and East Locality** NH confirmed that • a band 8a Nurse has been appointed to the HMP Cardiff team • a very violent man has been transferred to HMP Cardiff from Swansea; a risk assessment had been put in place but NH will meet with the Swansea team to share learning from the very poor transfer arrangements • An incident had occurred involving the Butetown DN team which had led to two members of staff being on sick leave; multi-agency and safeguarding work is under way, ensuring that the patient is cared for going forward in the most appropriate environment. A court of protection application is being made. • work is under way to address a professional concerns issue • there is a residential home in provider performance measures • A meeting will be held with the Safeguarding Team and CHAP regarding the management of child referrals and the proper alignment of accountabilities. **28.4 Cardiff North and West Locality** AM confirmed that • disciplinary proceedings are under way regarding an IG breach • A care home is entering the escalating concerns process. **28.5 Pharmacy and Medicines Management** KM confirmed that	

	• notification has been received that a Pharmacist has been convicted of a criminal offence and imprisoned; contingencies are in place to ensure that patients will be safe and continue to receive provision • A prescriber has resigned, while a full-time pharmacist will return on a part-time basis from maternity leave. **28.6 Palliative care** No further update.	
PART 2:	**Items to be recorded as Received and Noted for Information by the Committee**	**Action**
05/18/029	**<u>CMO UPDATES</u>** CEM/CMO/2018/2 — Shortage of Hepatitis B Vaccine - update CEM/CPhA/2018/3 & 4 — Drug Alerts Class 2, Glaxo Wellcome UK Ltd., Ventolin Accuhaler 2001 mcg and Seretide Accuhaler 60 mcg/250 mcg CEM/CPhA/2018/5 — Drug Alert Class 4: Kyowa Kirin, Bleo-Kyowa Powder for Solution for Injection, 15,000 iu, Pl 16508/0046 CEM/CPhA/2108/6 — Drug AlertClass 3 (Action within 5 days): AstraZeneca; Lynparza Capsule 50 mg (Olaparib); EU/1/14/959/001 *(NB – also alerted by MHRA and AstraZeneca)* CEM/CPhA/2018/7 — Drug Alert Class 4 – Techdow Europe Ab, Inhixa Solution for Injection in Pre-filled Syringe, Product Licence EU/1/16/1132/012; EU/1/16/1132/014; EU/1/16/1132/016; EU/1/16/1132/018/ EU/1/16/1132/020 **<u>MHRA MEDICAL DEVICE AND MEDICINES ALERTS</u>** EL(18)A/06 — Drug AlertClass 3 (Action within 5 days): AstraZeneca; Lynparza Capsule 50 mg (Olaparib); Eu/1/14/959/001 (also see above CMO alert) MDA/2018/009 — Bag valve mask (BVM) manual resuscitation system – risk of damage to lungs by delivery of excessive pressure **<u>WELSH HEALTH CIRCULARS</u>** WHC 2018 015 — 'Ordering Adjuvanted Flu Vaccine for the 2018-19 Season' (All Wales HB Primary Care Managers) **<u>WELSH GOVERNMENT ADVISORY</u>** **<u>NICE GUIDANCE</u>**	

	PATIENT SAFETY NOTICES PSN041/March 2018 — Risk of Death and Severe Harm from Failure to Obtain and Continue Flow for Oxygen Cylinders harm **INTERNAL SAFETY NOTICE AND GUIDANCE** ISN: 2018/001 — The Nurse Staffing Levels (Wales) Act 2016 **UPDATES FROM OTHER GROUPS** Minutes from the UHB Nutrition and Catering Steering Group Public Health Update March 2018	
	ANY OTHER BUSINESS	
05/18/030	Nil Noted	
DATE OF NEXT MEETING		
Tuesday, 10th July, 2018, 1.30 pm – 3.30 pm, PCIC meeting room 1, CRI		

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
8am, 27th April 2018
Critical Care Resource Room

In Attendance:

Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board (Chair)
Navroz Masani (NM), Clinical Board Director, Specialist Services
Hywel Pullen (HP), Director of Finance, Specialist Services Clinical Board
Hywel Roberts (HR), Consultant Intensivist, Medical QSPE Lead Clinical Board
Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
John Martin (JM), Clinical Director, Neurosurgery
Dale Charlotte-Moore (DCM), Directorate Manager, Critical Care
Mathew Price (MP), Assistant Service Manager, Neurosciences
Maurice Wentworth (MW), ALAS
Gareth Jenkins (GJ), Service Manager, Haematology, Immunology and Medical Genetics
Mary Harness (MH), Senior Nurse, Haematology, TCT, Immunology and Medical Genetics
Keith Wilson (KW), Consultant, Haematology
Steve Gage (SG), CB Lead Pharmacist Martyn Read, Consultant, Critical Care
Sarah Matthews (SM), Senior Nurse, Nephrology & Transplant
Orla Morgan (OM), Lead Nurse, Critical Care
Beverley Oughton (BO), Senior Nurse, Critical Care
Sian Williams (SW), Senior Nurse, Cardiothoracics
Vince Saunders (VS), IP&C

PART 1: PRELIMINARIES		**Lead**
1.1	Welcome & Introductions	
1.2	Apologies for absence Received from; Gemma Ellis, Colin Gibson, Jennifer Proctor, Alex Murray, Anne-Marie Morgan, Fiona Kear and Ceri Phillips.	
1.3	To review the Minutes of the previous meetings 22nd February 2018 and 16th March 2018 Both minutes were agreed as an accurate record, subject to an amendment required to the 22nd February minutes; HR noted that under Critical Care MCA results it should note that 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 so that he can collate them and discuss further with Julia Barrell, Mental Capacity Act Manager. Also delete the original last sentence. Matters Arising Not discussed.	**HR**
1.4	Patient Story – N&T, Live Donation Team Rhian Cook introduced herself as one of the Live Donor Co-ordinators at UHW who works with incompatible kidney transplantation patients. Rhian presented on "A Journey to Live Donor Transplant." The patient was diagnosed with renal impairment as a result of FSGS in her 30's and attended renal OPs for monitoring over the last 20 years.	

	Kidney function declined between 2011 and 2012 suddenly and by 2014 it had dropped further. The patient's preferred treatment option was a live donor transplant with CAPD as backup treatment. Auto deceased donor list was activated. Commenced CAPD. Entered the UK's Living Kidney Sharing Scheme. 4 unsuccessful matches before a successful match. Long altruistic donor chain – x 3 transplants came from this. The transplant was successful and the patient was discharged a few days post transplant. It was agreed that this was a very positive story. RC informed the group that it was "Live Donor Awareness week" last week and that 10 potential donors had come forward.	
PART 2: SAFE CARE		
2.1	<u>Open Inquests</u> INQ/IN44394 – Patient JO in N&T - this case now has an inquest date of the 31st May 2018. The report will be going to Carol Evans, Asst Director Patient Safety And Quality, shortly. <u>Open Serious Incidents</u> In26753 and In33464 both in Cardiothoracics – related to chest drains being inserted and inadvertently puncturing the patient's ventricles. SC noted that Maria Roberts is awaiting a response to a question before these can be closed. Investigation being led by the Respiratory team in UHL. In47040 in N&T – MSSA Bacteraemia is listed on part 2 of the death certificate – with Maria Roberts as needs more information. In46388 in Neurosciences – Perforator (drill) punctured into the patient's brain – nothing wrong with the drill. JM noted that the patient has made a significant recovery. The surgeon has changed his clinical practice and no longer uses the drill. Any junior doctors are also not allowed to use the drill. Mr Bhattis is undertaking the investigation which is considerably delayed despite reminders. JM will prompt. In56779 in Neurosciences – patient died unexpectedly on B4 – statement from registrar not detailed enough. HR is IO, MRR is arranging a meeting around this. InIn59723 in Critical Care – device related pressure damage whilst on the intensive Care Unit at UHW – being closed today. OM noted that the RCA is nearly complete. In61137 Cardiac Surgery – patient choked – SC noted that a closure form should be completed soon. In61828 in N&T – patient developed grade 3 device related (urinary catheter) pressure damage to his penis. CF requested that this is completed and the closure form is sent to Carol Evans by Monday. In61929 in Neurosciences – concern raised regarding the length of time that a patient had to wait to have neurosurgery for a tumour. Patient has now had the surgery and was discharged shortly after. Colin Gibson is investigating the delay and the patient's deterioration during this time. <u>New incidents</u> In66884 #NOF in CC – a patient fell off the commode resulting in an injurious fall. In67673 Patient fell on B1 and fractured their metatarsal. As it required surgical intervention it will most probably need reporting. With Carol Evans for decision. <u>Closure Form</u> In58668 – patient developed grade 2-3 pressure damage between T5 and Critical Care. Patient couldn't have pressure areas assessment before she went to Critical	**MRR** **SM** **JM** **SC** **SM** **CE**

	Care as she was too sick. It was found that the patient was very unwell with sepsis. It was noted that there are issues with different gradings of pressure sores between different areas. CF requested that this case is closed before the end of April.	**SM**
2.2	Patient Safety Alerts Internal Safety Notice ISN: 2018/001 – the nurse staffing levels (Wales) Act 2016 is now in place for certain clinical areas. The act requires the UHB to report on the impact on care of not maintaining nurse staffing levels in certain circumstances to the Board and Welsh Government. The main points of the Act are that there must be a supernummery sister/shift co-ordinators and 26.9% add on to cover leave etc. Based on triangulation of KPIs, acuity data and professional judgement. CF noted that she has been working through the establishments with each Directorate and that they have now all been signed off. Now working towards putting the staff in place. Establishments now must be displayed outside of each ward area. 26.9% agreed for Rookwood as it will be moving to UHL – this doesn't apply to Primary Care, Rehabilitation and Mental Health. It was noted that amendments have been made to various template documents in use to support the investigation of patient safety incidents, in line with the Nurse Staffing Act. This will assist the Health Board to be able to collate information required for the annual report to Board and Welsh Government. GW will check that the documents have been circulated. Patient Safety Notice – PSN041/March 2018 – "Risk of Death and Severe Harm from Failure to Obtain and Continue Flow from Oxygen Cylinders harm". All Directorates confirmed that staff in their areas are aware of how to use the cylinders. CF requested that Directorates ask Practice Educators to check that this is the case and documentation is kept to that effect.	**GW** **LNs**
2.3	Emergency hydrocortisone for neuro-endocrine patients SG updated the group. A patient who had undergone neurosurgery for pituitary tumour was discharged without the pack of hydrocortisone injections for use in an emergency. The correct practice is that the patient should be counselled on the ward and told that they will receive this pack with a list of instructions given. On this occasion the injection was not added to the Discharge Advice Letter (DAL). The patient was re-admitted with a chest infection. Patient was admitted to the EU. Patient was treated appropriately and responded well. Need to ensure that patients receive the injection. Neuro have been taking steps to ensure that this doesn't happen again. SG requested that Directorates encourage nurses to check that patients are going home with the correct drugs etc. Potentially a gap in unplanned and weekend discharges. Risk it could be missed again. Discussion took place around the importance of reading something before it is signed off. The incident will be picked up and discussed in Neuro Q&S. JM raised concern that there are still 4 SHOs short – which contributes to the wider picture. KW will send the Haematology checklist to GW to circulate to see if this could be applied elsewhere. NM noted that Drs/Consultants should be encouraged to write the discharge letter during the day and not just at discharge.	**JM/RN** **KW**
2.4	RTT Backlog clearance Neurosurgery, Neurology and Neuropsychology MP noted that Neuro were now in a much better position – with only 42 patients now waiting over 36 weeks. It was noted that a lot of work has been carried out around this.	
2.5	Healthcare Associated Infections Clinical Board HCAI Review to end of March 2018 Reductions in year of C.Difficile, MSSA and e-Coli cases. Same number of MRSA as last year = 5 cases. C&V was one of only two Health Boards that met the C.Difficile target. This year there are two additional targets that will need to be	

	measured and reported on; Klebsiella and P.aeruginosa. This year's target is 10% reduction on last year. CF congratulated renal on managing 200+ days without any cases of C.Difficile and SM recent presentation at 1000Lives conference. Specialist Services Clinical Board HCAI meetings This meeting is now being chaired by Orla Morgan. The format of the meeting has been reviewed. Representatives are required to attend from all clinical areas to present x 2 RCAs each month in order to share learning. Looking at voice activated "wash your hands" on wards. OM will ring around to other hospitals to see what is available. The expectation is that a Nurse and Medic attend from each area. The meeting will take place every 6 weeks. GW to send dates to HR. Programme Team – Update for Nurse Directors CF referred to the presentation given by Eleri at the last Nurse Directors meeting - "HCAI and AMR Programme Team PHW – Update for Nurse Directors". GW will circulate the presentation to the group along with the Nurse Directors Forum Meeting minutes, held on Friday 23rd March 2018. C.Jeikium Cases in Haematology Concern was raised regarding the number of C/Jeikium cases within Haematology. Haematology – 30 cases over the last few months. All cases are being reviewed as no reason found as yet.	**GW** **GW**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee Not discussed.	
3.2	Health and Care Standards (HCS) CF noted that the Health Care Standards were due back in today. CF noted that she was aware that not everyone has been receiving information back from other areas. CF noted that a QSE Facilitator will be starting within the Board from June who will be able to pick this up and monitor throughout the year in future. Completed HCS to be uploaded onto the S-Drive. CF will then review them later on today.	
3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups Chest Infections – Renal RC noted that they have had a small cluster of chest infections within CTU. Currently looking into this. 4 cases in April. Concern has been raised regarding the ward infrastructure. A meeting will take place next week in order to discuss the issues and Estates have been invited to attend. CF raised concern that on T5 there are no doors on the bays which means that proper cleaning cannot take place using HPV/Ultraviolet cleaning methods. CF requested that Estates are asked if doors can be added. Renal/VS to feed back. Critical Care Capacity CC continues to operate at way over 100% capacity. There have been incidents associated with this which need to be reported. An incident occurred where a potential organ donor couldn't be admitted into Critical Care and therefore neither the patient's or family's wishes could be met and other patients were not able to receive organs.	**Renal/VS**
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business World Health Hygiene Day Taking place on the 25th May 2018. Stands will be in the concourse. Parking and Concourse Changes Parking and concourse are being handed back to the hospital from the start of June 2018.	

PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR IFNROMATION BY THE COMMITTEE		
5.1	Received and noted for information: Traceability Non-Compliance March 2018 – figures for information.	
PART 6: DATE OF NEXT MEETING		
6.1	Thursday 17th May 2018, 8am, in the Critical Care Resource room, UHW.	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
17th May 2018
Critical Care Resource Room

In Attendance:
Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board (Chair)
Hywel Roberts (HR), Consultant Intensivist, Medical QSPE Lead Clinical Board
Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
Mathew Price (MP), Service Manager, Neurosciences
Maurice Wentworth (MW), ALAS
Keith Wilson (KW), Consultant, Haematology
Sarah Matthews (SM), Senior Nurse, Nephrology & Transplant
Orla Morgan (OM), Lead Nurse, Critical Care
Beverley Oughton (BO), Senior Nurse, Critical Care
Lisa Higginson (Morgan) (LH), Senior Nurse, Nephrology & Transplant
Kevin Nicholls (KN), Service Manager, Cardiothoracics and Critical Care
Mary Harness (MH), Senior Nurse, Haematology
Sarah Lloyd (SL), Directorate Manager, Neurosciences
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Maria Roberts (MR), Patient Safety
Gemma Ellis (GE), Nurse Consultant, Critical Care
Vince Saunders (VS), Infection, Prevention and Control
Paula Goode (PG) Interim Director of Operations, Specialist Services Clinical Board

Present:
Wendy Ingram (WI), Consultant, Haematology
Gemma Williams (GW), PA to the Specialist Services Clinical Board (Note taker)

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome and Introductions	
1.2	Apologies for absence Navroz Masani, Suzie Cheesman, Dale Charlotte Moore, Ravindra Nannapaneni, Catherine Wood and Orla Morgan.	
1.3	To review the minutes of the previous meeting 27th April 2018 The minutes were agreed as an accurate record. Matters Arising • 1.3 – GW has amended the sentence in relation to MCA and Critical Care as requested by HR. HR and Julia Barrell to meet and discuss the Directorate's responses. • 2.1 – Open Serious Incidents In26753 and In33464 in relation to chest drain insertions and punctured ventricles. MRR confirmed that she is awaiting responses to a couple of queries before this can be closed. MRR and Helen Davies to update where they with regards to combining protocols. **Action:** CF to email Helen Davies and Melissa Rossiter. • In47040 in N&T MSSA bacteraemia listed on part 2 of the death certificate – SM confirmed that this was now closed.	**CF**

	• In46388 in Neurosciences – Perforator (drill) punctured into the patient's brain. CF confirmed that she has spoken to John Martin this week. John Martin is now leading on this. • In61137 Cardiac Surgery patient choked. Closure form should now be complete. • In61828 in N&T – grade 3 device related pressure damage. This should now be closed. • In67673 in Cardiac – patient fell on B1. Carol Evans has decided that this should be reported as an SI. MRR will look into this one. • Closure Form In58668 – grade 2-3 pressure damage between T5 and Critical Care. SM to feedback on this one. • Item 2.2 Internal Safety Notice ISN: 2018/001 – nurse staffing levels (Wales) Act 2016. GW confirmed that the documents associated with the Nurse Staffing Act and the investigating of patient safety incidents have both been circulated. • Patient Safety Notice PSN041/March 2018 – "Risk of Death and Severe Harm from Failure to obtain and continue flow from oxygen cylinders harm". Directorates confirmed that all of their areas know how to use the cylinders correctly and training records are being kept. • Emergency hydrocortisone for neuro-endocrine patients – SL/MP were not aware if the issue had been discussed in the Neurosciences QSE meeting. **Action:** MP will check with John Martin. • GW confirmed that KW had sent her the Haematology checklist and that she had circulated it to the group. • Item 2.5 HCAI Meetings – GW confirmed that Orla Morgan had sent the new HCAI dates out to the group **Action:** that she would ask her to send them onto HR. • Public Health IP&C Programme Team – Update for Nurse Directors. GW confirmed that she had circulated the presentation to the group along with the Nurse Director Forum minutes from 23rd March 2018. • Item 3.3 Exception reports – Chest Infections in Renal. On agenda to be discussed.	**SC/OM** **SM** **MP** **GW**
1.4	<u>Patient Story – Haematology</u> Wendy Ingram introduced herself as a Haematology Consultant who works on the BMT programme. Wendy presented on "Respiratory Infection in Haematology patients". Wendy noted that they report around 200 adverse events every year and provided a summary of where they are currently. The following was discussed: - Part A – BMT Incident Trending and findings - Part B – Dep. E-Datix findings Concern was raised that the reporting system isn't capturing all risk and the lack of isolation facilities is a significant issue. MRR noted that e-Datix was rolled out in 2015 and didn't then meet the needs of BMT, now as a Health Board there is much better understanding of it. MRR noted that it is now possible to cluster reporting which could help. **Action:** MRR to meet with Wendy, CF and KW to discuss further. Discussion took place around JACIE and what their findings will mean. PG noted that she met with Len Richards and Abi Harris this week, and that there is a plan in place for BMT provision, Likely build time is 2020/21. PG noted that the Board/Directorate will need to look if there is anything more that can be done in the short term in relation to isolating patients. Decisions need to be made on priorities and risks.	**MRR**
PART 2: SAFE CARE		

2.1	Open Inquests • B5 RCA – MRR needs to do some work on this. The inquest is due to take place on the 31st May 2018; MRR is going to discuss with Mat Davies. • MRR referred to a case where a neurosurgery patient from Cwm Taf had to be transferred to Bristol. EMERTS were transferring the patient and felt that he was waiting here too long to intubate etc so they intubated the patient themselves. The family have raised concerns regarding the delay. **Action:** MRR will speak to Tony Turley and feedback. Serious Incidents (SIs) • Major Trauma SI from 2016 – HR noted that today was the last day for comments from the authors. **Action:** MRR will look for an update on this. Cath Evans in Patient Safety is leading on this one. HR will copy CF into the communication. CF noted that all of the SIs were discussed in the last meeting. The only new one to date was a pressure damage incident in Critical Care. To be discussed at the next meeting.	**MRR** **HR/MRR**
2.2	Patient Safety Alerts • ISN: 2018/002 – the terminology used to describe the thickness of texture modified food and drink is changing from the UK National Descriptors to the new IDDSI framework. Directorates to disseminate. • Medical Device Alert MHRA MDA/2018/012 – BD Vacutainer EDTA and BD Vacutainer Lithium Heparin Tubes – risk of incorrect results for lead testing or other assays using ASV methodology. MR noted that this could be an issue within our Clinical Board. **Action:** Directorates to review the alert. • Medical Device Alert MDA/2018/013 – manufactured by Roche Diagnostics GmbH – under specific circumstances scheduled automatic QC measurements may no longer be performed and erroneous patient results may remain undetected. **Not an issue for our Clinical Board.** • Medical Device Alert MDA/2018/014 - Infinity Acute Care System and M540 Patient Monitors software versions VG2.2 – VG6.0 risk of alarms are not activated. **Not applicable for our areas.** • Safe Practice Reminder – for all staff who use portable oxygen cylinders. Discussed earlier on the agenda. • Safeguarding Team Newsletter – for information. MRR noted that the MDA alerts should be going through procurement first and that not all of the MDAs were relevant to our Health Board. **Action:** MRR will pick this up.	**Dirs** **MRR**
2.3	RTT Backlog Clearance Neurosurgery, Neurology, and Neuropsychology Discussed at the last meeting. MP detailed the improvements and holding static for now. CF noted that this was a good news story with regards to the progress made in this area over the last few months. There is a long way to go but huge improvement. CF noted that Neurophysiology was a particular concern in relation to medical staffing and waiting list reporting. Working on an action plan to reduce wait to 7 weeks. **Action:** Provisional plans around outsourcing, update required at next meeting. PG has revised the risk rating for neurosurgery to level 20. **Action:** SL will submit the information to CF to update the Clinical Board Risk Register.	**HS** **SL**

2.4	Healthcare Associated Infections VS referred to the Clinical Board HCAI Review to end of March 2018. The Clinical Board did meet its C.Difficile reduction target which was good, however didn't meet its MRSA/MSSA/E-coli targets. Neither did other Health Boards in Wales. Pseudomonas and Klebsiella have been added to targets this year. April 2018: MSSA - 2 cases E-Coli - 3 cases Klebsiella - 1 case May 2018 to date: C.Difficile - 1 case in Critical Care MSSA - 2 cases E-Coli - 1 case CF raised concern that she isn't being sent the lessons learnt and actions that are going to be taken from Directorates as a result of the RCAs. **Action:** Directorates to ensure that this information is sent back to CF. Carbapenemase carrying Enterobacter aerogenes outbreak in Critical Care has now been closed. VRE on C5 and CITU has now also been closed. Ongoing actions around this. Continuing increased audits. CF raised concern that we cannot sustainably ensure clean commodes in all our areas. Individual training with staff is now taking place. Stickers have also been introduced to say "now clean". Stickers on unclean commodes will be picked up with the individual who has signed the sticker. This is an ongoing issue across the Health Board. CF noted that this will also be picked up at Nursing Board. CF noted increased incidence of PcP on T5. Meeting taking place this afternoon which WHSSC are attending. 6 cases to date in April. Environmental problems with ongoing leaks etc are one factor contributing to this but there are many other factors to take into account. Another 2 cases on B5, IP&C are monitoring the situation. LS/SM confirmed that they did manage to HPV a 4 bedded area yesterday. CF noted that a second letter to staff in relation to bare below the elbow and hand hygiene has been written by Dr Masani. It has been sent to Ruth Walker and Graham Shortland for approval. Staff will be told that they will be informally counselled and then formally counselled if they do not comply with file notes. Some Directorates haven't met the 95% target for over 12 months. **Action:** Directorates need to put plans in place to address non-compliance. For information: Welsh Health Circular WHC/2018/020 issued 4th May 2018 – AMR Improvement goals and HCAI reduction expectations by March 2019; Primary & Secondary care antimicrobial prescribing goals, C.Difficile, S.Aureus Bacteraemias and Gram Negative Bacteraemias.	**Dirs** **Dirs**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee Not discussed.	
3.2	Exception reports and escalation of key QSE issues from Directorate QSE Groups.	

	Paul Twose will be presenting at a future QSE on Tracheostomy care. This will link in with a Tracheostomy patient safety alert that will also be discussed.	
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	Received and noted for information: • 2 minutes of your time • Traceability April 2018 • Root Cause Analysis Training	
PART 6: DATE OF NEXT MEETING		
6.1	Friday 8th June 2018, 8-9am, in the Critical Care Resource room, UHW.	

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

Minutes
8th June 2018

PART 1: PRELIMINARIES		Actions
1.1	Welcome & Introductions Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board- *chair* Hattie Cox (HC), Graduate Management Trainee, Neurosciences Fiona Kear (FK), Assistant Service Manager, Haematology, Immunology & Medical Genetics Mary Harness, Senior Nurse, Haematology, Immunology & Medical Genetics Steve Gage (SG), Clinical Board Lead Pharmacist Paula Goode (PG), Head of Operations and Delivery, Specialist Services Clinical Board Lisa Higginson (LH), Senior Nurse, Nephrology & Transplant Claire Main (CM), Lead Nurse, Nephrology & Transplant Sarah Matthews (SM), Senior Nurse, Nephrology & Transplant Dale-Charlotte Moore (DCM), Directorate Manager, Critical Care Bev Oughton (BO), Senior Nurse, Critical Care Ceri Phillips (CP), Lead Nurse, Cardiac Sian Pring (SP), PA, Haematology, Clinical Immunology & Medical Genetics- *minutes* Hywel Pullen (HP), Assistant Director of Finance, Specialist Services Clinical Board Martyn Read (MR), Consultant Intensivist, Critical Care Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead, Critical Care Maria Roberts (MRo), Patient Safety Manager, Patient Safety Lisa Simm (LS), Service Manager, Neurosciences Maurice Wentworth (MW), Response Desk Manager, ALAS	
1.2	Apologies for absence Suzie Cheeseman (SC), Patient Safety Facilitator, Patient Safety Colin Gibson (CG), Clinical Engineer, Neurosciences & ALAS Tom Hughes (TH), Consultant, Neurosciences Gareth Jenkins (GJ), Service Manager, Haematology, Immunology & Medical Genetics Anne- Marie Morgan (AMM), Directorate Manager, Haematology, Immunology & Medical Genetics Orla Morgan (OM), Lead Nurse, Critical Care Alex Murray (AM), Consultant, Medical Genetics Jennifer Proctor (JP), Lead Nurse, Haematology, TCT, Immunology & Medical Genetics Vince Saunders (VS), IP&C Helen Scanlan (HS), Service Manager, Neurosciences	
1.3	Minutes of the previous meeting- 17th May 2018 The minutes were agreed to be an accurate record. Matters Arising • 1.3- Actions for item 2.1 has been completed. The matter remains ongoing, • 1.3- Feedback for closure form In58668 has been received. • 1.3- The dates have been circulated. • 1.4- The meeting has yet to be held. • 2.1- MRR reported that the matter is escalating. Tony Turley is to send information to MRR. The inquest will reconvene on 20/07/2018. • 2.1- Reported regarding the major trauma SI from 2016 has been circulated. • 2.2- Directorate have reviewed the PSN at their departmental QSPE meetings.	

	• 2.2- MDA alerts. Work with procurement in ongoing. • 2.3- risk registers are to be sent to CF by the end of June • 2.4- new posters for "bare below the elbow" and hand hygiene have been put up in Critical Care. An email has also been circulated on the consultants.	**ALL**
1.4	<u>Patient Story – Cardiothoracics ACHD Nurses</u> Sarah Finch and Beth Shires Clinical Nurse Specialists from the ACHD service discussed a female patient who had undergone 2 heart surgeries for her condition. Her care was shared between CAV and Bristol. The patient was very complimentary of the ACHD service in CAV, stating that staff were very supportive and always available should she need them. She also highlight possible breakdowns in communication between Bristol and CAV, particularly as the latter did not seem to be aware of postponements to her operations. The patient also stated that the care she received post-operatively at Bristol was less personal than the care she receives at CAV, recalling occasions where she was referred to as her bed number or surname only. The ACHD team have provided feedback to Bristol regarding the patient's comments on her care. The ACHD team are working on building bridges with Bristol to improve communication and a mechanism for feedback is under development. The possibility of counselling services is also being explored. Ceri Phillips is meeting Richard Cuddihy, CB Lead Psychologist to discuss	
PART 2: SAFE CARE		
2.1	<u>Open Inquests</u> Feedback is outstanding from inquests held on 09/05/2018 (INQ/UHW/3208) and 23/05/2018 (INQ/UHW/3078). INQ/IN44394, held on 31/05/2018, was adjourned by the coroner to give the patient's family opportunity to review the report. MRo stated that this case was a difficult one, and highlighted the lack of documentation of overnight observations in the patient's notes (the nurse taking care of the patient has written them down on her handover sheet intending to write them in the patient's notes retrospectively, unfortunately the latter did not happen). The patient had been reasonable overnight, but deteriorated rapidly the following day. <u>Open Serious Incidents</u> These were discussed in great detail at the previous meeting. One nephrology case is to be closed by the end of the month. <u>Closure Forms</u> The following cases have been closed: • Pressure damage patient on Critical Care • G3 pressure damage in N&T • Patient who fell and fractured their metatarsal in Cardiology	MRo SM
2.2	<u>Patient Safety Alerts</u> *Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids* N&T confirmed they have dedicated transfusion fridges in order to keep such fluids separate. It was suggested that a lock be added to the perfusion fluid fridge as an extra safety measure. *Supporting the introduction of the Tracheostomy Guidelines for Wales* Physio will be attending the next meeting to discuss the Health Board plan.	**LH**

2.3	RTT Backlog clearance in Neurophysiology The possibilities of outsourcing to other sites is being investigated and sites willing to help have been identified. IT is the biggest obstacle, Gareth Bulpin is conducting a walk- around soon. WG input is awaited.	
2.4	Sodium Valproate in women of child bearing age: PSN037 / April 2017 The notice was discussed at a previous QSPE meeting. 400 patients have been identified (250 are CAV patients, the remainder AB/Cwm Taf). Discussions with Cwm Taf regarding funding contributions are ongoing. AB manage their own patients Specialist review is required to continue use of sodium valproate and the patient must sign an acknowledgment for the risk of continued use. Furthermore the patient's will be subject to regular review and monthly pregnancy testing. Pharmacy are also providing advice as the medication is dispensed. This will place a huge strain on epilepsy services which is already having capacity issues. Services are reviewing where else parts of this service could be provided e.g. Community Pharmacists. GPs won't contribute	
2.5	Surveillance of patients awaiting Cardiac Surgery The matter is being discussed at the next consultant meeting (being held on 28/06/2018) and has been deferred.	
2.6	Healthcare Associated Infections Deferred to next meeting.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee None.	
3.2	Flu Planning The Clinical Board exhibited a 60% compliance last flu season. To improve on last year's figures flu champions are to be identified in each directorate and more flu clinics will be held once the vaccine becomes available in October. MH requested a list of staff who are qualified to administer the vaccine from each directorate.	ALL
3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups Critical Care MR highlighted their lack of secretarial support. Haematology The preliminary declaration for JACIE has been submitted. A visit is expected in September/ October. The unit is still under escalation with WHSSC due to lack of facilities and infection plans. Nephrology & Transplant PCP outbreak on T5 has closed. Refurbishment work on T5 yet to be confirmed A meeting to discuss the Suite 9 refurbishment is to be held next week.	
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business Neurosciences CF mentioned a patient on neuro who has been medically fit for discharge since October 2017, but due to severe behavioural issues no suitable discharge setting has yet been found. The patient has been difficult to manage during his time on the ward which has affected staff morale greatly. Staff	

	have also been injured by the patient, Carl Ball is supporting. Patient has had at least one special nurses with him for all that time. <u>Nephrology</u> The department has received a letter from the Renal Registry regarding their mortality rates for 2012- 2015. CM pointed out these figures refer to the incident population, not prevalent population. The new data cohort has already exhibited an improvement. CM stated that incident patient cohort is increasing over time and patients are getting younger. A plan is needed to account for these changes.	N&T
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	<u>Received and noted for information:</u> Commercial Medicines Unit: Diamorphine supply issue (circulated 22nd May 2018)	
PART 6: DATE OF NEXT MEETING		
6.1	Thursday 28th June 2018, 8am, in the Critical Care Resource room, UHW.	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 28th June 2018
Venue: Critical Care Resource Room

In Attendance:

Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board (Chair)
Navroz Masani (NM), Clinical Board Director, Specialist Services Clinical Board
Hywel Roberts (HR), Consultant Intensivist, Medical QSPE Lead Clinical Board
Paula Goode (PG) Interim Director of Operations, Specialist Services Clinical Board
Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
Maurice Wentworth (MW), ALAS
Beverley Oughton (BO), Senior Nurse, Critical Care
Kevin Nicholls (KN), Service Manager, Cardiothoracics and Critical Care
Mary Harness (MH), Senior Nurse, Haematology
Gareth Jenkins (GJ), Service Manager, Haematology, Immunology & Medical Genetics
Sian Williams (SW), Senior Nurse, Cardiothoracics
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Rachel Barry (RB), Lead Nurse, Neurosciences
Tom Hughes (TH), Clinical Director, Neurology
Richard Wheeler (RW), Consultant Cardiologist
Claire Main (CM), Lead Nurse, N&T
Martyn Read (MR), Consultant, Critical Care

Present:

Paul Twose (PT), Physiotherapist, Critical Care
Gemma Williams (GW), PA to the Specialist Services Clinical Board (Note taker)

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome & Introductions CF welcomed RB back.	
1.2	Apologies for absence Maria Roberts, Keith Wilson, Ravindra Nannapaneni, Jennifer Proctor, Anne-Marie Morgan, Colin Gibson and Fiona Kear.	
1.3	To review the Minutes of the previous meetings 8th June 2018 The minutes were as an accurate record. Matters Arising Item 1.3 Directorate Risk Registers to be sent to CF by the end of June – all Directorates confirmed that they would send CF their Registers as soon as possible.	**Dirs**

	Item 2.1 Open Inquests feedback is outstanding on 09/05/2018 INQ/UHW/3208) and 23/05/2018 INQ/UHW/3078. Inquest outcomes still awaited. Open Serious Incidents – Nephrology case to be closed by the end of the month. This will be picked up at the next meeting. Need confirmation of which SI this is and update. Item 2.2 Patient Safety Alert in relation to Soltran – CM confirmed that the perfusion fluid fridge in N&T doesn't lock but that they will move it to T5 to the NORs locked fridge temporarily and look for a new fridge in the long term. Item 3.2 Flu Planning – MH confirmed that she had received all of the flu champion lists from Directorates. MH will send out a list of those nominated to administer the vaccine to Lead Nurses. Item 4.1 Renal Registry letter regarding mortality rates for 2012 -2015. Plan required to account for increase in incident patient cohort in that patients are getting younger. Kieron Donovan, Nephrology Consultant, is analysing the data locally.	
1.4	<u>Patient Story – Paul Twose</u> Paul Twose, Physiotherapist in Critical Care, presented to the group on a project entitled "Improving Tracheotomy Care at University Hospital of Wales". The results showed significant improvements including a reduction of adverse events from 21.8% (2017) to 6.2% (2018). Bed days released per year: Critical Care = 319 Ward = 744 The group felt that it was an excellent presentation and congratulated Paul and his colleagues on the work that had taken place. GW will circulate the presentation to the group. RB, TH and Paul will meet up to discuss how this relates to Neurosciences. To discuss in the Neurosciences QSE meeting as well. The project is due to end in October (9 month duration). Could go into phase 2 of the business case. The project will be picked up in core team to decide how to take it forward.	**GW** **RB/TH** **CF**
PART 2: SAFE CARE		
2.1	<u>Open Inquests</u> <u>INQ/UHW/3373 – dialysis patient</u> CM noted that the Dialysis Unit are supposed to be sending the final copy back this week. Some issues can be picked up within the unit. Issues due to snow. Pneumonia was listed as cause of death. Charlotte Lloyd, Nurse Practitioner is investigating the case. <u>INQ/IN44394 – Nephrology patient with sepsis</u> Inquest adjourned last month as the family wanted a copy of the report and the Coroner wasn't aware. Inquest now 4th October. Humbling report received from the family – not blaming the patients care.	

	INQ/IN65611 – B5 patient who took an overdose Meeting next Monday. Inquest is 1st October 2018. Open Serious Incidents (SI's) CF referred to the drill incident patient – where the drill was used to drill into the patients head but it didn't stop drilling when it should have. John Martin has taken over the investigation. Gentleman had altered anatomy. Another case yesterday. CF and SC will discuss all of the Open SI's in their 1-1. Closure Forms In61137 – a gentleman with a medical history of Spina Bifida with hydrocephalus started to choke on his evening meal. Patient went into cardiac arrest and sadly passed away. Coroner returned accidental death. There were no actions to be addressed. The correct procedures were followed. In64902 – three cases of infection/colonisation with Vancomycin-resistant enterococci (VRE) have been identified in the Cardiothoracic Directorate. It has been agreed that the cases were linked in time and place and therefore constitutes an outbreak. This has now been closed down. Closed down with Welsh Government as well. Discussion took place on how likely patients would be to get VRE if in Critical Care. Not normally an outbreak. Another case has occurred in Cardiac ITU. Patient was on the ward for 74 days. BO will check whether the patient was on Critical Care during the outbreak. CF noted that hand hygiene has improved on CITU and C5 but commode cleaning has not. Met with the Sister on C5 and they are now scoring 100%. CITU have not had 100% during the outbreak. BO is going to change practice. Video training on how to do it, along with spot checks. In64537 – grade 2 pressure damage to patient's occiput – whilst concluded that the pressure damage was unavoidable the following actions will be undertaken for continued learning; Teaching sessions and teaching boards available to all staff Continuous updating of teaching boards and utilisation of the Critical Care wound team staff for advice and information.	**BO**
2.2	Patient Safety Alerts Public Health Link CEM/CPhA/2018/9 Drug Alert – Bleo-Kyowa, powder for solution for injection. Haematology confirmed that they do not use the drug. FGM Clinical Pathway – for information. PSN043 Tracheostomy Guidelines for Wales – for information.	
2.3	Surveillance of patients awaiting Cardiac Surgery RW presented to the group. Concern regarding a large number of patients with severe disease awaiting Cardiac Surgery who are therefore a significant risk cohort. RW referred to the case of a patient who died suddenly on C5 the night before their scheduled surgery. Over the previous 4/5 months the patient had a number of contacts with Specialities and it was felt that there were missed opportunities to expedite surgery and change his outcome. No. of proposals suggested: - Clinic Review - Patient information letter when patient goes on list for cardiac surgery to	

	educate patient if they get worst. - Elective Warning System – flagged if patient admitted to another speciality to notify original Cardiologist. - Nursing team to moniter i.e. Specialist Nurses. PG noted that all patients in Cardiac Surgery need to be looked at. KN noted that the patient letter could be amended to say "if your clinic is cancelled please ring to rebook etc...." as concern if the clinic is cancelled the patient may be lost as will be booked into the next clinic which could be 3 months time. GW will circulate the presentation to the group.	**GW**
2.4	<u>Healthcare Associated Infections</u> Not discussed.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u> Not discussed.	
3.2	<u>Exception reports and escalation of key QSE issues from Directorate QSE Groups</u> <u>Haematology office accommodation</u> GJ raised concern that Haematology were struggling to secure additional office accommodation. Some of the team have expanded and therefore the department cannot accommodate them. Trying to get one of the Universities to loan some space. <u>T5 Move</u> CM has had confirmation of where T5 is moving to – in relation to the outbreak of 6 cases of pneumonia. Increased PCP prophylaxis from 6-12 months. Help line for concerns has been set up. Actions in place regarding patients arriving for dialysis. Environmentally tested and the environment needs refurbishing. Incident can be closed down. Form has been started. <u>Cardiac</u> NM noted that he had received an incident form from another Health Board. NM queried whether the Health Board is made aware of across Health Board incidents. CF confirmed that we do. <u>Neurosciences</u> RB referred to a disturbed patient on B4 who has been difficult to manage. A number of staff have been injured by the patient. The patient will be reviewed by a Specialist Friday or Monday. Environment is making it very difficult to transport him. Will access Mental health again for support.	
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u> <u>New Safety Notice</u> SC referred to a new safety notice which wasn't circulated in time to be included on the Agenda regarding staff using the correct medication charts. Directorates confirmed that all old charts had been destroyed however concern was raised that the print room is still printing the old version. CF requested that wards keep checking that the correct chart is being used. SC to follow up with the distributor of the medication charts to ensure that the correct version is being supplied. <u>Clinical Board H&S Representatives</u>	**Dirs** **SC**

	Representatives for the Clinical Board H&S Group: Cardiac – KN Critical Care – DCM N&T – Sarah Matthews GJ to send H&S group dates to GW to circulate. <u>Haematology Risk</u> PG referred to the risk to patients in the Haematology Day Unit with regards to cross infection as patients cannot be isolated properly. The Directorate has been asked to produce a plan to reduce the risk to patients while awaiting the new facilities to be built. This is the second time of requesting. GJ and MH to follow this up. Directorate to also produce a plan for the BMT Quality Manager post.	**GJ/GW** **GJ/MH** **GJ/MH**
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information: • Medical Device Alert -MDA/2018/018- various arrow critical care devices – recall due to incomplete packaging seals. For information. Discussed previously. • National Report – May 2018 for information.	
PART 6: DATE OF NEXT MEETING		
6.1	Friday 20th July 2018, 8am, in the Critical Care Resource room, UHW.	

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

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 20th July 2018
Venue: Critical Care Resource Room

In Attendance:
Hywel Roberts (HR), Consultant Intensivist, Medical QSPE Lead Clinical Board (Chair)
Holly Williams (HW), QSE Facilitator
Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Mathew Price (MP), Service Manager, Neurosciences
Colin Gibson (CG), Rehab Engineering. ALAS
Martyn Read (MR), Consultant, Critical Care
Fiona Kear (FK), Assistant Service Manager, Haematology, Immunology & Medical Genetics
Jennifer Proctor (JP), Lead Nurse, Haematology, Immunology and Medical Genetics
Sian Williams (SW), Senior Nurse, Cardiothoracics
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Sarah Lloyd (SL), Directorate Manager, Neurosciences
Sarah Matthews (SM), Senior Nurse, N&T
Vince Saunders (VS), Infection, Prevention and Control
Claire Main (CM), Lead Nurse, N&T

Present:
Emma Jones (EJ), Neuro Vascular Nurse Specialist, Neurosciences
Gemma Williams (GW), PA to the Specialist Services Clinical Board (Note taker)

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome and Introductions HR introduced Holly Williams, QSE Facilitator for the Board to the group. The group introduced themselves one by one.	
1.2	Apologies Mary Harness, Dale-Charlotte Moore, Catherine Wood, Keith Wilson, Steve Gage, Maria Roberts, Carys Fox, Navroz Masani and Gemma Ellis.	
1.3	To review the minutes of the previous meeting 28th June 2018 The minutes were agreed as an accurate record, subject to Martyn Read needing to be taken off of the apologies list. Matters Arising: • Item 1.3 Directorate Risk Registers - All Directorates confirmed they had sent their Registers to CF.	

	• Item 1.4 Patient Story Paul Twose – GW has circulated the patient story to the group. RB/TH to discuss in the Neuro QSE meeting. The project will be discussed in core team in relation to taking it forward. • Item 2.1 Closure Forms – In64902 3 cases of VRE identified in Cardiothoracics. Another case in Cardiac ITU. BO will check if the patient was on the ward during the outbreak. • Item 2.3 Surveillance of patients awaiting Cardiac Surgery – GW is awaiting the presentation from Richard Wheeler and will circulate once received. • Item 4.1 Medication Charts - Directorates confirmed that they have removed all out of date versions. SC noted that she had spoken to the print room and it is an external company through oracle that are still printing the old charts. Procurement are going back to the company to address the issue. It was noted that you have to enter exact wording into Oracle in order to find the correct chart. SC will feed back. • Clinical Board H&S representatives – GJ to send the H&S group dates to GW to circulate. • Haematology Risk – the Directorate has been asked to produce a plan to reduce the risk to patients while awaiting the new facilities to be built. Conversations have taken place with Geoff Walsh and consideration is being given to identifying a space in the Day Unit. There will be a plan going forward. Haematology to update at the next meeting.	**RB/TH** **CF** **BO** **GW** **SC** **GJ** **Haem**
1.4	<u>Patient Story – Neurosciences</u> Emma Jones presented to the group. It was noted that Neurosciences lost the interventional service between May and October last year (2017), which had a significant impact in a number of areas. Since then changes have been made, such as more structure to MDT and referral process. Outcomes uploaded to clinical portal. A positive patient story was presented that spanned the previous service and the current service. Patient presented with a subarachnoid haemorrhage due to ruptured small middle cerebral artery aneurism. GW will circulate the presentation to the group. New service is up and running. Only one interventional radiologist which is a concern. If on leave referring emergency patients out.	**GW**
PART 2: SAFE CARE		
2.1	<u>Open Serious Incidents (SIs)</u> SC updated the group. There are currently 18 open SIs - 10 of which are reaching closure date. Last month 3 closures. New SI in relation to a man on B5 Nephrology (complex renal patient). The patient had a massive bleed and there were issues around the management of low haemoglobin. The patient had a cardiac arrest and sadly died. Maria Roberts, Patient Safety, to speak to Gemma Ellis to take it to the resuscitation committee. <u>Open Inquests</u>	**MRR**

	One Inquest is going ahead today (initials SW) involving EMERTS. Another Inquest on Monday. SC needs to speak to Claire Main, Lead Nurse, N&T as family not attending therefore the inquest is likely not to be held. <u>Closure Forms</u> No closure forms to present. <u>Public Health Wales Briefing</u> 13 July 18: CBRN reminder and Public Health England Briefing Notes for Emergency Departments – documents for information.	**SC**
2.2	<u>Patient Safety Alerts</u> For information: ISN: 2018/003 Medication charts – discussed at the last meeting but too late to include in last month's papers.	
2.3	<u>Healthcare Associated Infections</u> <u>Clinical Board HCAI Review to end of June 2018</u> • No C.Difficile cases in July. • No MRSA since April. • 1 case of MSSA on B5. • No e-coli. HR noted that he had attended the last Clinical Board HCAI meeting which was 2 weeks ago. It was a positive meeting. Hand washing, Bare Below the Elbow (BBE) and commode cleaning were the main issues discussed. There will be sterner measures taken if compliance doesn't improve with regards to BBE. Discussed ways to improve hand washing. VS will be shadowing ward rounds and there will be coaching as well. VS noted that IP&C are looking to produce a newsletter to present the HCAI data in a different more meaningful format. Figures will be broken down by ward. Updates provided for the link nurses. The information included will be based around infection control and what works well in other areas in order to share practice. Information needs to be cascaded down to the wards.	
2.4	<u>Consent – BMT/Haematology doctors</u> Keith Wilson, Haematology Consultant, requested that this item is discussed (Agenda Item from the 11th July Haematology QSE meeting). Unfortunately Keith was not available to attend. The issue pertains to the practice of other teams (who perform invasive procedures on Haematology/BMT patients) insisting that consent for these procedures be obtained from the patient by the Haematology/BMT doctors. This happens most frequently with respect to the insertion of Hickman lines in Radiology and upper or lower GI endoscopy. The most recent example pertained to the endoscopy service refusing to perform a sigmoidoscopy procedure unless the ward doctor had obtained consent. Concern raised as the Junior doctors are not experienced or knowledgable enough to obtain informed consent. HR referred to the 2 documents that he	

	circulated ahead of the meeting; GMC consent guidance (responsibility for consent point 26) and the UHB consent policy (8.2.6). HR noted that final responsibility for consent does lie with the person carrying out the procedure. There is however a process for delegation of consent. EJ noted that their Junior Doctors have also raised concern regarding this issue. They therefore carried out an audit and linked in with the standards the radiologists use. The risks were shared with numerical value and a leaflet was developed for patients. When the patient comes for their induction an email is then sent to them including the leaflet, which details a clear list of complications etc. HR to speak to Keith Wilson in relation to Haematology specific problems and link in with Navroz Masani, Clinical Board Director and Carys Fox, Director of Nursing for the Clinical Board.	**HR**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee Nothing to feedback.	
3.2	Exception reports and escalation of key QSE issues from Directorate QSE Groups Critical Care Secretarial Support MR raised concern that the Critical Care QSE meeting has had no secretarial support for the last 5 months. MR to email HR who will then contact Matt Wise, Clinical Director, Critical Care regarding support for these meetings. Posture Mobility Centre CG raised concern that there has been no hot water at the posture mobility centre for the last 2 weeks. CG to link in with Geoff Walsh. Thoracic Surgery Public Consultation CP referred to the Thoracic Surgery Public Consultation which is taking place between the 3rd July and the 27th August. WHSSC came to Health Board last Friday and the consultation for all staff was well attended. A good debate took place. Concern raised from clinicians with regards to the service moving to a single centre in Swansea. If anyone has any comments really need to encourage all staff to submit them. Link below: Welsh Health Specialised Services Committee (WHSSC) | Public Consultation on the Future Provision of Adult Thoracic Surgery Services in South Wales	**MR/HR** **CG** **All Dirs**
3.3	PMS Accuracy HW referred to an email that she had received from Steve Gage in Pharmacy which gives an example of a lady who rang the hospital to say that her GP had not received a follow up letter and needed this to get her medication reissued. The GP address on the DAL was different to the GP address provided by the enquirer. Discussion took place around PMS and ensuring the details are accurate. Along with the risk factors associated with incorrect patient details. It was agreed that patient demographics should be checked on admission and that	

	the next step was actually updating it on the system which may not always be happening. Checking patient details needs to be reinforced in clinical areas. Details should also be checked on discharge. Nurse talking to the receptionist to change the address on the system is the final step. Need to check GPs address as routine practice. Welsh clinical portal could also be used to check that the letter has been sent to the correct GP address. However it was noted that not all GPs currently can access it but that it is being rolled out.	**Dirs**
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u> <u>Overdue Datix Reports</u> HW noted that there were currently 261 overdue datix reports; 29 awaiting review with no harm, in progress 82, catastrophic 0 waiting review. It should be possible to bring these to a close. Concern raised that the reports are not being sent to the correct people. The list of names from the drop down list is not necessarily accurate. Not all those listed deal with the reports. It was agreed that each Directorate needs an agreed person to circulate the incidents so that none are missed. People need to know how to use the system properly. Names can be hidden from the drop down list for those that need to be. It was suggested that staff listed as an option to send the report to, log in to check when they can if there is anything in their to-do list however there is a 90 day log out period. <u>C.Difficile Testing</u> VS informed the group that testing for C.Difficile is changing from next week. PCR tests will be used which is a more accurate test than GDH.	**Dirs**
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information	
PART 6: DATE OF NEXT MEETING		
6.1	Thursday 9th August 2018 8am in the Critical Care resource room, UHW. HR apologies on leave.	

Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 17th May 2018 09:00-11:30
Venue: Pathology Right Hand Side Seminar Room

Attendees:	Rebecca Aylward	Jane Murphy	Sian Brookes
Delyth Jones	Emma Mitchell	David Pitchforth	Barbara Davies
Lisa Waters	Ben Durham	Jeff Turner	Derek King
Alison Hayes	Gill Spinola	Lisa Graham	Angela Jones
Ian Dovaston	Frank Wilcox	Sarah Cornes-Payne	

A1	Welcome & Introductions Rebecca Aylward welcomed everyone to the meeting.	**Actions**
A2	Apologies for absence Kath Prosser, Richard Evans, Sarah Follows, Sharon Parkhouse, Mudassir Pasha, Sharon O'Brien, Suzie Cheeseman	
A4	To receive the Minutes of the previous meeting **Matters Arising** Update on staff training b/f to next meeting	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	**Patient Story (Clinical Gerontology)** Patient story Clinical Gerontology good practice Patient was admitted to East 8 after 4 years with mental health, patient was at end stage dementia and transferred as part of the Iowarth Jones closure. After transfer the patient became unwell with medical treatment and required transfer to UHL and was admitted to East 8. Mental Health services must have had a hard time with this patient, there were many concerns raised from the wife about the care of her husband, she wanted him to be discharged home whilst in Iowarth Jones. At point of transfer the communication between the wife and the team had broken down. Whilst on East 8 treatment was provided with the aim of getting him medically fit using good evidence-based practice. Patient's wife has been managed extremely well, 2 discharge meetings were held with the aim of the patient going home noting that the patient had been institutionalised for the last 5 years. We are looking forward to supporting him and his wife to discharge him home, and the staff have built up a good relationship. This patient has been able to have 1:1 care to aid relaxation with playing music and reading to have proved beneficial for the patient. He has become medically stable we are waiting to discharge patient. This is a good story for the patient, wife and team and he will hopefully spend the remainder of his life at home with his wife.	SB to send patient story to Ruth Walker
1.2	**Feedback from UHB QSE Committee** This has been shared with all staff.	http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee-
1.3	**Directorate QSE minutes – exception reporting**	

	Directorate Reports – Directorate QSE reports noted and shared for Emergency Medicine, and Internal Medicine	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	Major Trauma Centre up date – b/f to next meeting	
2.2	**Code Stroke Book** Code Stroke Book – There has been a change to the swallow tool, previously the swallow assessment was the HEAD assessment but a significant amount of research has been done by the speech and language therapists. This is the standard for going forward. AU/EU staff – CNS in stroke has had training so they will support additional training. The booklet is ready to be implemented but need training in place, 62%- /64% completed in April. In March this was around 40% so there has been an improvement.	
SAFE CARE		
3.1	**New SIs** SIs – overall we had a peak in SI reporting mainly in February this year when we had 18 which is the highest we have reported since 2015. On average the highest we have been reporting is around 10. In some ways this is attributed to an increase in the number of healthcare acquired pressure damage and the new reporting/grading measures. WG closure forms for discussion and shared learning In63513 – Grade 3 healthcare acquired pressure damage: All Wales Pressure Damage Tool noted that the patient had a pre-existing grade 2 pressure ulcer which evolved into grade 3. The patient had several co-morbidities which increased the potential risk of deterioration. All risk assessments were updated and skin bundle completed in line with best practice with the correct mattress used. The Pressure Damage Tool noted that there was no handover of the initial pressure damage on admission and going forward there continues to be shared learning around safer patient handover. Deterioration to Grade 3 was noted to be unavoidable. In65751 – Grade 3 healthcare acquired pressure damage: All Wales Pressure Damage Tool noted that the patient had pre-existing Grade 2 pressure damage on transfer to St Davids which evolved into grade 3. There was evidence to support all risk assessments were completed in line with UHB best practice and timely referrals to tissue viability and dietician. There was a fault identified with the Duo 2 mattress which resulted in a new mattress being order, it was also noted that the patient kept repositioning on to the right side (non-compliant). Deterioration to Grade 3 noted to be unavoidable. In65855 – Injurious injury: Injurious assessment found that the patient had a witnessed fall and sustained a fractured NOF. The patient was identified as a potential falls risk with all risk assessments completed and updated in line with best practice. Sensor mats were being used recognising the patients falls risk, however, staff were not able to get to the patient in time to prevent the fall. The investigation found that post falls procedures were not followed in line with NICE 2015 guidelines where the Hover jack was not used to safely manoeuvre the patient from the floor back onto the bed. Ongoing education and training continues throughout the Clinical Board for all pre and post falls procedures and best practice. In66245 – Injurious injury: Injurious assessment found that the patient was mobilizing to the bathroom with a Zimmer frame and tripped sustaining a fracture to the neck of femur. The patient was identified as having several risk factors for falls including Parkinsons Disease. Post falls procedures were completed in line with NICE guidance with the exception of the Hover jack not being used. It has been discussed that there are not enough Hover jacks	

available within the UHB with only one being available on UHW site. This has been raised at the UHB Falls Task and Finish Group in June. All staff have been reminded of the importance of using the Hover jack for any unwitnessed fall with a potential long bone or spinal injury. Education and training continues for all areas within the Clinical Board.

In64366 – Injurious injury: The injurious assessment investigation noted that the patient had an unwitnessed fall which resulted in a fracture to the neck of femur. The patient had known cognitive impairment and would require regular reminding and prompting to use the Zimmer frame. The investigation found that post fall the Hover jack was not used in line with NICE 2015 post falls procedures and UHB best practice, continued education and training in place. The investigation also found that there was a delay in the patient being transferred from UHL to UHW secondary to pressures experienced with WAST services. Staff have been reminded to escalate any delay concerns in hours to the Senior Nurse or out of hours the Site Manager.

In64471 – Grade 3 healthcare acquired pressure damage measuring 0.6cm: All Wales Pressure Damage Tool highlighted that the patient had pre-existing pressure damage on admission and was nutritionally compromised which increased the risk of further deterioration. The tool identified that the patient had spent 5 hours sat in a chair within the acute footprint secondary to overall UHB bed pressures, with no evidence of a skin assessment being completed. On admission the tool identified that the patients skin bundle was not completed as per best practice and the patient would often decline to be repositioned regularly. This pressure damage has been deemed as avoidable.

In64473 – Grade 3 healthcare acquired pressure damage: All Wales Pressure Damage Tool identified that the patient had several pre-existing co-morbidities which would increase the risk of potential pressure damage including diabetes, IHD and COPD. The patient had a superficial pressure area on admission which deteriorated into a 1cm grade 3 pressure ulcer.Patient admitted to medical ward in February with Type 1 diabetes, ischaemic heart disease & COPD. There was a small superficial area on the left upper buttock this was previous to admission and reported as 1cm categorised grade 3. The patient was noted to be reluctant to reposition on their sides secondary to their COPD despite encouragement from nursing staff. The tool identified that generic care plans had been completed but the patient did not have a wound care plan in place. This pressure damage has been deemed as unavoidable.

In64440 – Grade 3 healthcare acquired pressure damage: All Wales Pressure Damage Tool identified that the patient developed grade 3 pressure damage measuring 0.5 x 0.5 cms. The tool identified that the patient was non-weight bearing secondary to a fractured ankle with a background history of diabetes and kidney disease. It was found that the patients skin was not re-evaluated in line with best practice, no individualised care plans in place, and risk assessments not reviewed or updated. The patient was transferred onto the correct mattress when changes to skin integrity were noted. This pressure damage has been deemed as avoidable.

In64873 – Grade 3 healthcare acquired pressure damage: All Wales Pressure Damage Tool identified that the patient developed grade 3 damage to the inner aspect of the right elbow. Admitted with an extensive history of advanced dementia and low BMI. There was evidence of extensive documentation around the patients skin integrity with early referrals to Tissue Viability and Dieticians. It was noted that the patient was on 2 hourly repositioning but during a period of severe weather (snow) this impacted on the frequency of the repositioning secondary to staffing levels. The nursing staff were commended on the level of detail around the patients skin integrity and documentation. This pressure damage has been deemed unavoidable.

In64912 – Grade 3 healthcare acquired pressure damage: All Wales pressure damage noted that the patient had pre-existing grade 2 pressure damage to the sacrum which evolved into grade 3. The patient had several risk factors which increased the risk of further deterioration including admission for sepsis, poor mobility with a background history of diabetes and cellulitis. The tool identified that all risk assessments were completed in line with best practice, the correct mattress used and changes to the patients skin integrity acted upon in line with best practice. This pressure damage has been deemed as unavoidable.

In62813 – Injurious injury: Following the completion of an injurious assessment the patient had an un-witnessed fall and sustained a fracture to the neck of femur. Risk assessments were completed on admission in line with best practice. Post falls procedures completed including the use of the Hover jack and neurological observations in line with UHB and NICE 2015 best practice.

In63231 – Grade 3 healthcare acquired pressure damage: The All Wales Pressure Damage Tool identified that the patient was admitted to the UHB with pre-existing grade 2 pressure area which evolved into grade 3. The patient had several risk factors which increased the potential risk of deterioration including poor mobility, admission for a chest infection, dementia, incontinence and kidney disease. All risk assessments, care plans and skin bundles were completed on admission with evidence of re-evaluation in line with best practice. The tool however identified that on admission there was evidence that the patients sacrum and heels were checked but not the spinal area. Evidence of timely referrals to tissue viability and dieticians with the correct mattress selection being used. This pressure damage has been deemed as unavoidable.

In63229 – Grade 3 healthcare acquired pressure damage: The All Wales Pressure Damage Tool identified that the patient was admitted to the UHB with pre-existing grade 2 pressure damage which evolved into grade 3. The patient had several risk factors which would potentially increase the risk of further deterioration including poor mobility and decreased dietary intake. All risk assessments and care plans were completed and updated in line with best practice to reflect changes in the patients skin integrity. The patient was initially nursed on an Aerospacer mattress which was changed to a Duo 2 mattress in line with UHB procedure. This pressure damage has been deemed as unavoidable.

In65879 – Grade 3 healthcare acquired pressure damage: The All Wales Pressure Damage Tool identified that the patient was admitted to the UHB with pre-existing grade 2 pressure damage to the sacrum. Whilst an inpatient they developed a new unstageable 3 – 4 pressure area to the left buttock and a grade 3 pressure area to the right buttock. During the patients stay they were noted to have medically deteriorated noting a background history of a low haemoglobin and diabetes. It was noted that the patient preferred to sit out in the chair secondary to chest problems but when the patients condition deteriorated they remained bed bound. The tool identified that risk assessments were completed on admission but the Waterlow score was incorrectly calculated and did not include the patients pre-existing pressure damage. Whilst this would have resulted in a higher score the patient had already been identified as high risk. Skin bundles and care plans were completed with evidence of re-evaluation in line with best practice. There is evidence within the skin bundle that the patient was uncooperative with frequent repositioning despite the risks being explained and documented. The patient was initially nursed on an Aerospacer mattress and changed to a Duo 2 and upgraded to a Dolphin. When the patient was being nursed in the chair a repose cushion was being used.

	Clinical Board update pressure damage: The Clinical Board recognises the significant increase in the number of Serious Incidents reported for healthcare acquired pressure damage. Whilst in some part this is secondary to changes in the level of reporting the board is aware that further actions are required to ensure that wherever possible all healthcare acquired pressure damage is minimised. The Board are fully engaged with the UHB Tissue Viability Task and Finish Group. The new pressure damage passports and patient information leaflets have been widely disseminated. Datix stickers are being used to promote early reporting and description of the areas. In addition, the practice development nurses have completed educational workbooks for all staff to complete which detail the accurate grading and reporting guidelines with educational posters being developed to use throughout the board to ensure consistency of information is being provided. All Aerospacer mattresses have been removed from the UHB. A pressure damage workshop is also being arranged. Clinical Board update injurious injuries: The Clinical Board are engaged with the UHB Fall Focus Group. Currently taking part in a LIPS project around falls which provides simulation training for pre and post falls procedures.	
3.2	Patient Safety Alert's/ ISN's and MDA's shared for circulation and dissemination PSN 040 – Confirming removal or flushing of lines and cannulae after procedures PSN 041 – Risk of Severe Harm or Death from Failure to Obtain and Continue Flow From Oxygen Cylinders harm ISN 2018 001 Nurse Staffing Levels Wales Act ISN 2018 002 – IDDSI Texture descriptors MDA-2018-013 cobas b 221 instruments with AutoQC module software limitation affecting QC measurements MDA-2018-012 BD Vacutainer EDTA & BD Vacutainer Lithium Heparin Tubes – risk of incorrect results for lead testing or other assays using ASV methodology MDA-2018-014 Infinity Acute Care System and M540 Patient Monitors software version VG 2.2-VG 6.0 – risk that alarms are not activated Contaminated Sterile Water (A7)	
3.3	Mortality Level 2 review tool shared amongst the group. Ongoing work with Joy Whitlock around mortality level 2 reviews and how this can be embedded across the clinical board to ensure that robust and reflective reviews of patients care are undertaken to ensure that best practice/standards are maintained.	

EFFECTIVE CARE		
4.1	Director of Nursing Quality & Safety reports Medicine Clinical Boards dashboard shared and areas of improvement noted	
4.2	UHB ID Wristband roll out New patient identification bands to be implemented within the UHB. Work is ongoing with the task and finish group around the installation and training required. .	
4.3	Infection Prevention and Control up date 139 days since MRSA 2 days MSSA 16 CDIF 10 E-coli bacteria No current outbreaks however it has been noted that the Clinical Board have experienced difficulties with influenza and norovirus. In 268 days it has affected 263 patients and 35 staff have been sick with 123 bed days lost. AI and MDU experienced the worst of the outbreaks. RCA – some other clinical boards are still doing 3 weeks. Medicine are leading the way with responses in 2 weeks but unfortunately very few are getting back within 2 weeks. T2 – Congratulations and well done 2 RCA came back on the same day. 126 CDIF target was 127 –We are the only health board to achieve this target 34 CDIF target was 24 27 MSSA target 24 MRSA 1 target 0 43 ecoi – target 12 April 2 CDIF cases, 0 MRS, 2 MSSA, ecoli is being attributed to areas A4 – have had a lot of issues but this has been turned around. **MDRO procedure** MDRO Risk assessment – This is supposed to be completed on every patient entering the UHB and before transfer to other areas in line with the guidelines, and was piloted 2 years ago but it is currently not used as per best practice. Downstairs in EU/AU and before transfer to areas. LW to feed back Infection control – policies – bring back to next meeting (more discussion)	LW
DIGNIFIED CARE		
5.0	**Mucolytic Mix in C&V Endoscopy Units** We have less gastric cancers than other parts of the world. New drinks are being piloted in Llandough to detect early cancers, they have been taste tested by volunteers, the cost is an extra 42p per patient so the trial is cost neutral but it is improving upper GI views. If you compare the cost of a re-book which is £400 for a GI long-term there are significant financial benefits. Endoscopy staff are keen on this, we have visiting consultants for other health boards and are leading the way.  Mucolytic mix.docx	
TIMELY CARE		
6.1	Emergency Medicine: ‘Report on monitoring: Stop Clock’	

INDIVIDUAL CARE		
7.1	National User Experience Framework Feedback from 2 minutes of your time survey – relevant improvement plans shared amongst the group	
7.2	Complaints and trends Good news – Education & Development Runner up –Congratulations and well done to Ian Dovaston Model ward nutrition and hydration – We had run a pilot on 2 sites which had fantastic benefits for patients, because of the success of the project Judith Hill has secured a further 300k investment which is being funded by charitable funds. A year project covering 4 wards across medicine A4, C6, E8 and E2. We have started in LLandough already for E8 and E2, hopefully we will start this project on the remaining wards in July. Each ward will have 7 days dietetic assistant, catering assistant for 12 hours a day – patients can eat and drink when they want, there will be an additional 2 members of staff enabling patients to go to the day room. The Blue crockery is out. This project has been shortlisted for the patient safety award. There is a 2 minutes video to be shared but it needs to go on a memory stick as the file is too large. We are hoping that after a year we can demonstrate the cost of this project will be cost neutral, less food waste, patients will hopefully be more independent and there will be less de-conditioning. **Bed pushers** – Internal Medicine Team are participating in the bed push on Sunday 9.00 20th May all money raised will be going to the Cardiff & Vale Health Charity. Liverpool – rock and roll marathon for PJ Paralysis – Rebecca Aylward is running the Liverpool Marathon for PJ Paralysis. PJ Paralysis – UHW are leading the way, however there have been a few technical issues with Llandough and some of the staff have been unable to upload on to their phones. RA advised that spreadsheets can be done.	
Staff and Resources		
8.1	Staffing levels – All Wales Staffing Act	
8.2	Staff recognition awards – Medicine Staff Recognition Awards is on Thursday 21 June at 5.00 p.m. 2nd Floor, Cochrane Building	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		

Date and time of next meeting: 21st June 2018 Pathology Right Hand Side UHW first floor

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

Medicine Clinical Board Minutes
Quality, Safety & Experience Committee
Date and time: 22nd June 2018 09:00-11:30
Venue: Council Room

Preliminaries			Action
A1	Welcome & Introductions	Present: T Cardew, L Graham, I Dovaston, E Mitchell, D King, D Jones, A Scott, R Aylward, K Prosser, O Williams, S Cheesman, M McCarthy, W Parsons	
A2	Apologies for absence	R Evans, S Follows, S O'Brien, S Brookes, D Pitchforth, G Spinola, C Evans, S Cornes-Payne, M Pasha, Dr J Turner, G Murray, J Murphy, B Davies, R Owen-Pursell	
A4	To receive the Minutes of the previous meeting Matters Arising	Minutes reviewed and agreed. CAMHS booklet shared which is operational within the Paediatric Emergency Department. To discuss with M Rossiter regarding further availability to share Major Trauma update which will affect the Clinical Board and UHB	KP
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY			
1.1	Patient Story	Emergency/Acute Medicine: WP shared a patient story regarding a 21 year old male that presented to the Emergency Department via WAST with what appeared to be 'intoxication'. The patient was conveyed via WAST and handed over that whilst at a cash machine they suddenly became vague and unable to speak. It was identified that whilst the patient and his friends had been drinking alcohol, this was thought not to be excessive. Whilst being conveyed to the Emergency Department the paramedic crews handed over to the triage nurse that the patient was unable to speak and would smile at the crews which was perceived as 'the patient being intoxicated'. On initial assessment the patient was treated as intoxicated and given intravenous fluids but continued to show no improvement. Recognising this the clinicians suspected that there may be an underlying medical cause and a CT head scan was requested which confirmed a Stroke. WP advised that a concern had been received from the patients mother around the nursing and medical approach to patients who are deemed 'intoxicated'. WP shared with the group that nursing and medical teams approach to patients who are intoxicated are treated differently in the fact that they have to be seen as being more assertive and that this concern has resulted in the department reflecting on how this may be perceived and to not take any patient with suspected 'intoxication' as a given. Following the patients diagnosis treatment was commenced and the patient fully recovered from	

		their presenting symptoms, RA stated that this must have been very distressing for the patient and advised that this would be a good opportunity to invite the patient to share their experience in the form of a 'patient story'.	WP
1.2	Feedback from UHB QSE Committee	http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee-	
1.3	Directorate QSE minutes – exception reporting	Directorate QSE papers shared – no exception reporting noted: Dermatology Gastroenterology Clinical Gerontology Internal Medicine Rheumatology	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT			
2.1	NATSSIP's – the way forward	MM provided an overview of the UHB requirements to be compliant with NaTSIPP's. To date each Directorate has completed a gap analysis based on their current processes and procedures measured against NaTTSIPP's requirements. MM shared an example of a LoCSSIP's (local procedure) for Endoscopy as an exemplar noting the focus should be on the processes of procedures and be a MDT approach. For the Clinical Board Gastroneterology are progressing well with their LoCSSIP's for endoscopy and paracentesis. Emergency Medicine NaTTSIP's lead aware of procedures required that would fit with NaTTSIP's, discussions ongoing around placing a WHO checklist within the ED documentation. WP to discuss with MR (NaTTSIP lead EU) regarding progress. Respiratory Nurses have completed a LoCSSIP's for pleural taps/effusions. EM raised that there may be a potential to complete a LoCSSIP's for the procedure room on B7 which is clinician led. KP advised that work with Rheumatology and Dermatology had just started.	WP
SAFE CARE			
3.1	LIP's Falls Simulation Training feedback	OW UHB Falls Strategy Lead presented some initial feedback of a LIP'S project for falls management which involved A4. The project will be formally presented in September 2018. As part of the new simulation suite pre and post falls procedures three different scenarios are undertaken. These are recorded so staff have the ability to discuss and reflect on the actions taken as a means of learning and improvement. Suggestion that this will form part of a UHB training package as a means of improving pre and post falls procedures. OW advised liaising with Melanie Cotter around providing wider training packages as a rolling package. The Practice Development Nurses have been asked to advance on this on behalf of the Clinical Board. OW feedback that initial findings identified that improvements were required with the utilisation of the Hover jack. KP re-	ID/GM

		iterated that this is a reoccurring theme from the lessons learnt whilst undertaking Injurious Assessment investigations. KP also shared that at the UHB Falls Delivery Group meeting concerns were raised regarding the issue of only having one Hover jack per site and the delays that this causes when required for a potential injurious injury.	
3.2	New SIs	KP advised that 6 Serious Incidents were reported in May, all of which were healthcare acquired pressure damage. For June to date there has been 12 reported Serious Incidents: 7 healthcare acquired pressure damage, 3 Injurious Injuries, one Colonoscopy surveillance delay and one medication error Paediatric EU.	
	Clinical Gerontology:	In67619 Injurious Injury: Un-witnessed fall resulting in a fracture to the right neck of femur. Identified that the patient fell whilst mobilizing to the bathroom unsupervised and without using the nurse call bell. Identified as a falls risk and all assessments completed in line with best practice. Sensor mat was in place but the patient had unplugged the alarm tag. Post falls procedures performed in line with UHB best practice and NICE 2015 guidance. At the time of the fall the acuity of the patients requiring support secondary to an IP&C outbreak and another patient requiring emergency treatment prior to the patient falling may have increased the potential risk of falling and subsequent harm. In67662 Injurious injury: An un-witnessed fall from the end of the bed and where the bed rails end, which resulted in an extension to a pre-existing Sub Dural haematoma. Identified as a falls risk with all assessments completed in line with best practice. An un-witnessed fall for a patient with an extensive history of falls. Post falls procedures completed in line with NICE 2015 guidance and UHB best practice. The decision to treat the patient conservatively following inpatient fall and injury completed in-conjunction with medical and neurosurgical teams with the agreement of the patients family noting this to be in the patients best interests. In67705 Healthcare acquired Grade 3 unavoidable pressure damage: All Wales Pressure Damage Tool identified that they patient was admitted to the UHB with pre-existing Grade 2 pressure damage to the sacrum known to Primary Care colleagues which evolved into Grade 3. Several risk factors which increased the risk of further deterioration including admission for a potential CVA and sepsis secondary to gangrenous toes and heel with a background history of poor circulation, diabetes and peripheral vascular disease. All risk assessments were completed on admission in line with best practice. Identified learning that whilst the patient had an individual care plan this did not reflect the changes to the patients skin integrity secondary to incorrect grading.	
	Internal Medicine:	In63326 Injurious injury: Unwitnessed fall from the end of the bed and where the bed rails end, resulting in an extension to a pre-existing sub dural haematoma following a fall at home. The	

		injurious assessment found that this was an un-witnessed fall for a patient who had a pre-existing head injury. A change in the patients level of alertness may have increased the potential falls risk. Evidence of good practice for the completion of neurological observations, and re-evaluation of post falls procedures. There was no documentary evidence to support that the patient was provided with consistent messages about when to ask for help when attempting to get out of the bed. In65036 Healthcare acquired Grade 3 unavoidable pressure damage. All Wales Pressure Damage Tool identified that the patient was admitted to the UHB with known Grade 2 pressure damage to the sacrum that evolved into Grade 3 measuring 0.8cm x 1.1cm. Background history noted as poor mobility secondary to COPD and cardiac failure and admission for an acute infective episode of COPD requiring acute NIV and anti-biotic therapy. Learning identified that the patients was not assessed for pressure ulcer risk within 6 hours in line with best practice. The patients weight was noted to be an approximate weight as they were too unwell to be weighed on admission. In addition, whilst there was extensive documentation noted on the patients body map, there was no specific patient centred care plan for wound care/pressure relief. In64777 Healthcare acquired Grade 3 unavoidable pressure damage. All Wales Pressure Damage Tool identified that the patient had pre-existing Grade 2 pressure damage to the natal cleft on admission which evolved into Grade 3 measuring 1.5cm x 1cm. A review of PARIS notes that patient known to District Nursing for pressure damage in two areas to the natal cleft but no grading is documented. The patient had several risk factors increasing the risk of further deterioration including an acute kidney injury, AF, poor mobility and dietary and fluid intake. Learning identified that whilst risk assessments were completed an updated in line with best practice there was no individual patient care plan for the patients pressure areas. In66800 Healthcare acquired Grade 3 avoidable pressure damage. All Wales Pressure Damage Tool identified that the patient had a pre-existing moisture lesion to the buttock which evolved into avoidable Grade 3 pressure Damage. The patient had several risk factors which would increase the potential risk of further deterioration, including diabetes, below knee amputation, incontinence and a previous history of pressure damage. Risk assessments were completed and re-evaluated in line with UHB best practice noting the patient to be reluctant to be repositioned from side to side. This pressure damage has been reported as avoidable as the patient was held on an ambulance for 5 hours secondary to the pressures experienced within the department and lack of inpatient beds. All patients with pre-existing or identified as high risk of pressure damage are escalated for timely access to an inpatient bed, or an appropriate bed is brought down to the department where available. All ambulance delays are escalated via the Medicine Clinical Board Hub with a plan to off load as soon as possible.	
	Gastroenterology/Hepatolo	In62221: Patient experiencing new symptoms of constipation and rectal bleeding referred by GP for urgent Colonoscopy.	

	gy/Endoscopy:	Referral was vetted by Consultant and listed for an urgent Colonoscopy on 01/09/2017. The patient met the NICE suspected cancer criteria for a 2 week wait referral. A colonoscopy was performed as part of the UHB insourcing work on 27/01/2018 where a malignant rectal tumour was found. The patient has undergone surgery and is continuing to have follow up. The RCA investigation noted the following in terms of learning and actions: The Quality and Governance Lead for Gastroenterology has formally written to all Consultants within the department and fellow primary care colleague to advise them of the criteria for referring against NICE guidance. Some colleagues have also presented at GP educational sessions. A new dedicated 'suspected cancer and lower GI cancer' referral is being used in WPRS (electronic referral system for Primary Care) so General Practitioners have to clearly define priority. The Directorate are also undertaking some pathways for Health Pathway implementation. The UHB continues to work towards JAG accreditation. The UHB continues to balance risk across all categories of endoscopy (urgent, routine and surveillance) and continues with implementation of its endoscopy plan to reduce waiting times. Significant inroads have been made in reducing symptomatic waiting times – with the number of patients waiting greater than 8 weeks at end of March 2018 reducing by 58% in comparison to the previous year end. However, whilst the number of patients waiting greater than 8 weeks past their agreed target date for surveillance endoscopy has reduced in recent months, there has been a deterioration in overall volumes since year end. This is, however, in the context of an increase in demand for both surveillance and symptomatic patients. The UHB has refreshed its demand and capacity plan for 2018 – 19 and in addition to core capacity – continues with additional capacity through internal and external providers to reduce overall waits. In addition, clinical validation of patients waiting for surveillance endoscopy is underway. There is Executive oversight of the service and regular monitoring of the improvement plan is in place In62114: Patient with a several month history of dysphagia and fullness referred for an urgent endoscopy by their GP 18/08/2017. The referral was vetted by a Consultant and was listed for an urgent OGD. A GP expedite letter was received and prioritised as USC due to deteriorating symptoms of dysphagia. An OGD was performed on 27/01/2018 which identified a malignant looking tumour at the Gastro-oesophageal junction. The patient has undergone pre-operative chemotherapy and is now awaiting surgery. The RCA investigation reported noted the following in terms of learning and actions: The Quality and Governance Lead for Gastroenterology has formally written to all Consultants within the department and fellow primary care colleague to advise them of the criteria for referring against NICE guidance. Some colleagues have also presented at GP educational sessions. A new dedicated 'suspected upper and lower GI cancer' referral is being used in WPRS (electronic referral system for Primary Care) so General Practitioners have to clearly define priority. The Directorate are also undertaking some pathways for Health Pathway implementation. The UHB is working towards JAG accreditation. The UHB continues to balance risk across all categories of endoscopy (urgent, routine and surveillance) and	

		continues with implementation of its endoscopy plan to reduce waiting times. Significant inroads have been made in reducing symptomatic waiting times – with the number of patients waiting greater than 8 weeks at end of March 2018 reducing by 58% in comparison to the previous year end. However, whilst the number of patients waiting greater than 8 weeks past their agreed target date for surveillance endoscopy has reduced in recent months, there has been a deterioration in overall volumes since year end. This is, however, in the context of an increase in demand for both surveillance and symptomatic patients. The UHB has refreshed its demand and capacity plan for 2018 – 19 and in addition to core capacity – continues with additional capacity through internal and external providers to reduce overall waits. In addition, clinical validation of patients waiting for surveillance endoscopy is underway. There is Executive oversight of the service and regular monitoring of the improvement plan is in place. In63274: A patient underwent a colonoscopy on 25.02.2010 for polyp surveillance, results of which were normal. A further surveillance colonoscopy was requested for 5 years time; the patient was added to the patient management system (PMS) endoscopy waiting list (13) on 01.03.2010. Meaning a follow up surveillance colonoscopy was due on 25.02.2015. An urgent suspected cancer (USC) referral was received from his GP on 10.05.2016 due to a 3 month history of change in bowel habit and weight loss. A USC colonoscopy was requested and received by endoscopy on 16.05.2016. An appointment date was agreed with the patient on 18.05.2016. He attended for his procedure on 25.05.2016, and a rectal cancer was diagnosed. Following staging the gentleman has subsequently undergone chemo-radiotherapy and surgery. The RCA investigation noted the following in terms of actions and learning: Specific staff have been protected to only dedicate their time to support clearing the backlog of surveillance and planned recall patients awaiting clerical validation. The review and monitoring of performance reports for all staff. Monitoring of sickness and absence in line with UHB policies. The existing rota has been redesigned to improve function and performance with clearly defined performance measures and expectations. The review of roles and responsibilities within the Directorate support team. The Clinical Board have requested from the Directorate a detailed trajectory for quarter 2 to include reduction profile in activity. An accurate reporting template to measure demand versus capacity is being developed, including a demand profile exercise to ascertain capacity gaps which will inform how much further support is required from insourcing. Review the way in which surveillance cases are allocated to insourcing versus outsourcing lists to maximise those allocated to insourcing. The UHB continues to balance risk across all categories of endoscopy (urgent, routine and surveillance) and continues with implementation of its endoscopy plan to reduce waiting times. Significant inroads have been made in reducing symptomatic waiting times – with the number of patients waiting greater than 8 weeks at end of March 2018 reducing by 58% in comparison to the previous year end. However, whilst the number of patients waiting greater than 8 weeks past their agreed target date for surveillance endoscopy has reduced in recent months, there has been a deterioration in overall volumes since year end. This is, however, in the context of an increase	

		in demand for both surveillance and symptomatic patients. The UHB has refreshed its demand and capacity plan for 2018 – 19 and in addition to core capacity – continues with additional capacity through internal and external providers to reduce overall waits. In addition, clinical validation of patients waiting for surveillance endoscopy is underway. There is Executive oversight of the service and regular monitoring of the improvement plan is in place. In65423 Healthcare acquired Grade 3 unavoidable pressure damage. All Wales Pressure Damage Tool identified that the patient had several risk factors which increased the risk of pressure damage evolving, including admission for sepsis. The investigation found that following the completion of risk assessments a primo mattress with a repose would have been recommended. However, at the time Aerospacer mattresses were being used as part of the mattress selection process. All of these mattresses have now been withdrawn following advice from the UHB Tissue Viability Task and Finish Group following concerns raised regarding the use of these. In66021 Healthcare acquired Grade 3 unavoidable pressure damage. All Wales Pressure Damage Tool identified that the patient had pre-existing Grade 1 pressure damage to the coccyx which evolved into unavoidable Grade 3 pressure damage. On admission the patient was admitted with confirmed flu, was noted to be extremely thin and frail and developed diarrhoea which resulted in a deterioration in the patients skin integrity. All risk assessments were completed and updated in line with UHB best practice, however the investigation did note that the patients wound care plan was not updated when the patients pre-existing grade 1 area started to deteriorate to grade 2. In relation to Pressure Damage Serious Incident: Clinical Board update The Clinical Board recognises that ongoing education and development is required to ensure that the correct grading and accurate and timely documentation is maintained around pressure damage treatment and prevention. Form part of the UHB Tissue Viability Task and Finish Group – new patient passports/leaflets/Datix recording stickers introduced. In addition educational booklets have been completed by the Practice Development Nurses. Standardised educational posters are being developed to ensure consistent education/advise is provided across the Clinical Board	
3.2	Patient Safety Alert's, WHC's and MDA's	Patient Safety Alerts, WHC's and MDA all shared for dissemination across Directorates. PSN 043 – Supporting the introduction of the Tracheostomy Guidelines for Wales - KP raised with EM that this would be relevant to B7 and to ensure that this was shared with the ward PSN – 037 Safety of Girls and Women who are being treated with Valporate WHC-2018 020 – HCAI AMR Targets 2018 – 2019	EM

		MDA/2018/017 Cook Vacuum Pump for IVF – risk of electric shock or burn to operator	
EFFECTIVE CARE			
4.1	Director of Nursing Quality & Safety reports	RA shared the Clinical Boards recent Quality Dashboard reporting positive feedback. Continued improvement with the concerns response rate. RA raised concerns regarding the number of Datix in progress between 30-60 days and >60 days and this required some effort by all incident managers and Dif 2 users to reduce the number by ensuring that all actions/recommendations are completed. KP to provide a breakdown of each Directorate and circulate for action. RA noted the increase in the number of E Coli cases reported against the reduction expectation goal. DK advised that the target is noted as being ambitious, this year's targets are yet to be circulated.	KP
4.2	Audit/NICE compliance	AS shared information to the group on NICE guidance. Some of these guidelines are sent for information where no response or action is required or where there is action required. This requires each area to clarify if the guidance is not being implemented or actions taken to provide evidence of implementation. The UHB is required to provide assurance and responses to WG around NICE compliance. AS to continue to attend Clinical Board QSE meetings as a means of re-enforcing the importance of NICE guidance. To consider whether compliance with NICE guidance should be added to the Risk Register. RA commented on that further engagement is needed and noted that it is difficult to engage clinicians at Clinical Board QSE meetings, but Directorate meetings are always well attended. RA to discuss with RE. AS shared that clinical audits results are not received back to the audit team in a timely manner. Directorates have been contacted regarding what clinical audits are being completed within the Clinical Board. AS advised that there are 3 tiers of clinical audits, Tier 1 National Audits, Tier 2 Audits around QSE themes and Tier 3 Audits undertaken for individual staffs CPD/revalidation or clinicians interest. Tier 3 audits should be given the lowest priority. AS advised that additional corporate audits for executive performance include pressure damage and falls which were welcomed from the nursing staff present.	RA
4.3	Infection Prevention and Control up date MDRO procedure	DK presented the Clinical Boards recent IP&C figures: 12 days since last MRSA – this was noted to be on East 2 and the first case since last October. The RCA has been escalated for completion to understand the source and any learning 11 days since last MSSA 17 days since last C Difficile 8 days since last E Coli 7 days post Klebsiella 0 Pseudamonas reported	

		Recent IP&C audits undertaken have highlighted areas of concern and common themes including commodes, environment and hand hygiene. Improvements were noted for bare below the elbow. Actions plans are already been undertaken with timeframes noted for improvement and to be shared with the Clinical Board. DK advised of the new terminology around 'expectation goals' for 2018 rather than expected reduction figures. Improvements noted in the return rate for RCA's to understand any potential learning, with only 6 outstanding. These have been shared with the relevant Senior Nurses for escalation. Psuedamonas and Klebsiella will be Tier 1 targets from this year with RCA's required. With the changes to E Coli RCA's no longer being required it is anticipated that the workload would not increase as the number of Pseudamonas and Klebsiella cases reported are minimal. E Coli will remain a Tier 1 performance indicator. Expectation goals for 2018 are yet to be decided. DK advised that following a review of the Bacteraemia RCA's learning was identified for the following: • Use of PVC pack stickers which does not allow for a clear audit trail • Utilisation of blood culture packs and stickers RA commented that further re-enforcement with the clinicians is required. DK asked to email concerns to RA and RE so that this can be widely cascaded across the Board.	
DIGNIFIED CARE			
5.0	East 8 project up date	ED shared a progress up date for a project being undertaken on East 8 known as 'CWDTCH'. Project has been established since February 2018 with an expected time frame of a year. There has been a slight changes in the nursing establishment with increased HCSW based on the acuity of the patients, and the introduction of activities co-ordinators based on the model ward theory. Aims and objectives are based on the prevention of deconditioning and improvement of patients who are cognitively impaired. Key performance indicators are being monitored around patient falls, healthcare acquired pressure damage, nutrition and length of stay. Meetings are held fortnightly with the nursing staff where staff are free to discuss any concerns that they may have. To date the main concerns noted have been around the acuity of the patients versus the number of registered nursing staff. Patient acuity audit being undertaken. RA recognised that this is an excellent project with the aim of improving how patients with cognitive problems are cared for. Environmental assessments are being undertaken in line with Kings Fund and how to provide care for dementia patients.	
5.1	Engagement with MHSOP – Healthcare support worker exchange programme	ID provided an overview of how UHL and Hafan Y Coed sites can improve working relationships and the care provided to patients. An exchange programme has been established for HCSW to work in clinical gerontology and older mental health wards to share learning and experiences of working in these environments. Competencies and a training package has been undertaken. RA commended this piece of work.	

5.2	HIW feedback Elizabeth Ward	EM provided feedback from the recent HIW inspection of Elizabeth ward. On the whole the feedback report was excellent. Following the report several actions were identified which included environmental decluttering, which has been completed. The provision of medical cover out of hours and access to timely social work input. GP cover is provided by CaV Primary Care during out of hours and weekends. For more urgent advice access to the H@N team based at UHW is available. Written sheets are being reviewed and will be re-issued. Discharge processes are currently being reviewed. The provision of timely speech and language therapy has been identified as a deficit with discussions ongoing with the Directorate and Clinical Board to discuss further. Pressure damage is monitored via the UHB Task and Finish Group recommendations/best practice and shared as part of the wards Tier 1 performance indicators. Bed linen remains an area of concern. KP advised the meeting that a procurement order has not been submitted for the new sheets so would not be available for the next year. RA to raise with RW. IP&C audits continue as part of the wards best practice in conjunction with IP&C colleagues. Medicines management, all staff have been reminded of their responsibility of medication storage at safety briefings. DoLS paperwork, staff have been reminded on safety briefings to ensure that referrals are keep in the front patients' notes for easy access. EM raised concerns regarding the number of documents that required access in this manner, such as DNAMR. The assessment of patients pain, PPDN in conjunction with the Senior Nurse to ensure that the ward are using the approved pain tool and the trigger for the use of the tool is via intentional rounding. Integrated assessment, discussed at safety briefing the importance of completing this assessment in a timely manner. Spot audits to be undertaken. Oral Bundle, the Clinical Board is in the process of rolling out the All Wales Oral Bundle.	RA
TIMELY CARE			
6.1	Emergency Medicine: 'Report on monitoring: Stop Clock'	No information provided. Escalated to newly appointed Directorate Manager AT. To ensure that this information is available and shared at each meeting.	AT
INDIVIDUAL CARE			
7.1	National User Experience Framework Feedback from 2 minutes of your time survey – relevant improvement plans	May's returns were discussed response rate noted to be 68%. Lots of positive feedback noted. On going negative feedback regarding how cold some of the wards are. On patient notes: 'I don't want to complain bit I do feel a little cold. I came in in a hurry so didn't bring a cardigan'.	
7.2	Complaints and trends Compliments & Good news	Continued improvement noted in concerns response rate. Currently 27 open concerns. For May, formal concerns response for 30 days 62%.	

		Lovely compliments shared with the group. Particular reference was made to a poem written by a patient following their stay on West 2 UHL.		
Staff and Resources				
8.1	Staffing levels – All Wales Staffing Act	RA deferred until next meeting in August. To discuss staffing and patient acuity.		
AOB				
'Read about me' flag is on CWS and can be used. Discussions around the fact that it needs a proper launch including the Comms team. Should be linked with the Enhanced Supervision Framework as a means of monitoring compliance.				
PART 2: Items to be recorded as Received and Noted for Information by the Committee				

Date and time of next meeting: 16th August 2018 Right Hand Side Pathology Room

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

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 8th May 2018, 08:00-10:30 hours
Seminar Room B, A Block, UGF, UHW

CONFIRMED MINUTES

Present:		
Richard Hughes	Chair, Consultant Anaesthetist	RH
Linda Walker	Director of Nursing, Surgery CB	LW
Gillian Edwards	Lead Nurse, T&O	GE
Mark Bennion	Clinical Governance Facilitator, Perioperative Services	MB
Rafal Baraz	Consultant Anaesthetist	RB
Catherine Bradshaw	Professional Practice Development Nurse, Surgery	CB
David Scott-Coombes	Quality & Safety Lead, General Surgery	DSC
Catherine Evans	Patient Safety Team	CE
Susan Mogford	Senior Nurse, SSSU, PCAC & Pain	SM
Babs Jones	Perioperative Care	BJ
Simon White	CD, Trauma & Orthopaedics	SW
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Ophthalmology	AJ
In attendance:		
Edwina Shackell	PA, Surgery Clinical Board	ES

	Actions
18/55 Patient Story: General Surgery Incident: In53668 CB provided the timeline of the incident which concerned a colorectal cancer patient admitted for laparascopic surgery. There had been no post-operative bed available on the dedicated ward, T2, resulting in transfer of the patient to ward A2. A doctor review was requested on the Saturday in question. Junior Drs were on duty, the take was busy, resulting in no review being undertaken. The next day, Sunday, the patient was still awaiting medical review. The nurse on duty phoned the duty Dr. The nurse decided to give an enema which they felt was prescribed. The Registrar saw the patient on the Sunday evening, and raised no concerns regarding the giving of the enema. On the Monday afternoon, the patient had chest pain and was reviewed and was thought to have an anastomatic leak. An emergency laparotomy was performed on the Tuesday morning, an anastomotic leak was found which resulted in the patient requiring formation of a stoma. Key findings: 1. The enema had been given without a valid prescription. An enema had been given in pre-operative period and had been signed for. The Nurse felt that the Dr had signed in the wrong place for the enema. 2. There was a clear lack of knowledge from the Nurse's perspective, and the F1 Dr could not recall the giving of the enema being discussed. 3. There was a poor knowledge of the Enhanced Recovery After Surgery (ERAS) protocol, so the notes were non-contemporaneous. Root causes:	

1. The nurse had been slightly preoccupied dealing with patients' concerns, and had lost objectivity. The nurse knew after the enema had been given, that it should not have been given and this constituted a medication error. 2. The lack of a consultant review on the Saturday probably contributed to the incident. 3. Poor understanding of ERAS documentation. 4. The F1 who reviewed the patient on the Sunday evening had been a colorectal F1, so should have known the care pathway. 5. There had been no handover by the SpR to the surgical team, who did not know about the enema. Actions: 1. Prominent posters are in place, that enemas are contraindicated. 2. The member of staff involved will be managed by the Medication Error Management Policy. 3. Teaching on post-operative care incorporated in Drs Training.		
PART 1: PRELIMINARIES *(Chair)*		
18/56	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
18/57	**Apologies for Absence** Received from Carol Evans, Ceri Chinn, Adrian Turk, Clare Wade, Sally Finlay, Graham Roblin, Chris Williams and Claire Mahoney.	
18/58	**Declarations of Interest** None declared	
18/59	**Deployment of Neuraxial ISO 80369-6 devices in the Welsh NHS** The background of this work was described. The NPSA published a series of alerts in 2009 and 2011 requiring the UK NHS to use non-Luer devices for neuraxial bolus doses and infusions. In Wales, the decision had been made to wait for the new International Standard. The group of standards for small-bore connectors for medical use is known as the ISO 80369 series and addresses connectors including Neuraxial applications and major regional anaesthesia (NRFit) (ISO 80369-6) Published March, 2016, for all neuraxial and major regional anaesthesia. Looks like a Luer connector, but is 20% smaller. Unique design features that reduce cross-connections, especially with Luer connectors. Now NRfit will be incompatible with intravenous connectors. Some key suppliers will not have devices ready until end of 2018. Spinal aspiration – needles will be relabelled Long Luer. Epidural infusion in bags/reservoirs: It is acknowledged that epidural infusions would be safer if the reservoirs (bags) could not be attached to an IV giving set, reducing the risk of IV infusion of bupivacaine. The replacement of IV ports or additive ports with neuraxial port connectors on epidural infusion bags is not anticipated in the near future. For the time being, NRFit giving sets will have the usual spike at the reservoir end, and an NRFit connector at the patient end. These bags are kept in Recovery, so still present a risk, but minimized as far as is possible. Availability of devices were summarised, 2 not yet available from current suppliers, Unresolved issues:Hanging drop technique: there is no appetite form industry to make a specific giving set for paeds - CSE NRfit needle through needle (locking) is not currently available - GBUK produces NRfit syringes but stability testing is a problem (24 hours, max 72 hours)	

	- BBraun produce NRfit syringes with good stability testing up to one month but failed on microbiological testing (using GBUK caps) - BD plastipak have not yet produced NRfit syringes Deployment of devices: Aneurin Bevan rolled out, Cwm Taf next to go, then Cardiff, probably mid 2019, in order to wait for all kit to be available and learn from others' feedback. Cardiff: • Neuraxial Task and Finish Group (appointed by the Medical Director) • Chaired by C Morley-Jacob and R Baraz • Regular meetings (multidisciplinary) • Aim to coordinate safe transition Welsh Neuraxial Connector Reference Group: The decision was taken in March 2018 to cease surveillance due to insufficient funding and poor clinician engagement (5%). It was recommended departments do audits on changeover. Discussion: It was acknowledged around the table that identifying and quarantining existing kit at changeover would be challenging. RB explained that it was likely that small discrete areas would be addressed first, e.g. CAVOC. It was agreed that the practicalities would need to be worked out. Financial implications: suppliers would exchange unopened old kit for new.	
18/60	**Approval of the minutes of meeting held 27th March 2018** Approved as an accurate record.	
18/61	**Matters Arising:** To receive Action Log from the above meeting Item 2.1.3 17, May 2011. Checking pregnancy before surgery. LW had emailed Carole Evans on behalf of the Clinical Board. The Anaesthetists had made the decision to follow the guidance and so whist it caused some noise in the system initially this appears to have reduced. This policy remains with C&W to resolve. When LW has received a response, this item will be closed, at next meeting. 17/090: Line insertion service. LW explained current situation. It was recognised that T&O patients at UHL needed a service provided at UHL. Currently patients are transferred from UHL to UHW and back. Dr Turley is working on this. The service would be solely for T&O. Currently anaesthetic colleagues do insert lines on a good will *ad hoc* basis. **Action: SW to speak to Dr Turley to gain clarity** 18/11 Perfusion Cleaning Protocol. The updated protocol had been returned to Perioperative care, BJ had sent to Infection Prevention & Control (IPC) for comment. Update next meeting. **Action: BJ** 18/12: NG77 – October 2017. Management of cataracts in adults. **Action: Chris Williams to provide a response.** 18/31: Workplan 2018-19. Updated. **CLOSED.** 18/32: Terms of Reference Annual Review. No comments received to date. All to check and send comments to ES prior to next meeting. To be signed off next meeting. **Action: ALL** 18/37: PCA Morphine stickers – discussed at Anaesthetic Q&S. **CLOSED**. 18/38: Change from Luer to non-Luer & SBAR. Agenda item. **CLOSED.**	**SW** **CW**

	18/41: NICE Guidance. AWMSG 3035, AWMSG 2224, TA460, TA486, TA467 TA369. **Action: Chris Williams to respond.** 18/41: Patient Safety Notice 040: confirming removal or flushing of lines and cannulae after procedures. New anaesthetic chart designed. **CLOSED.** **Action: MB to carry out a risk assessment and add to the Risk Register**. 18/48: Pressure Damage Report: Agenda item. **CLOSED**.	**MB**
18/62	**Work Plan 2018 – 2019 – for approval** **APPROVED**	
18/63	**Terms of Reference – for approval** Action: All to review and comment. Sign off next meeting.	**ALL**
PART 2: PATIENT SAFETY AND QUALITY		
18/64	**Standing Item: NatSIPPS Progress report** Next meeting 23rd May. All areas converting to LOCSIPPS, a significant piece of work. Link was shared, but it appears not all had access to the link. Perioperative LOCSIPPS in hand, and available to support others.	
18/65	**Director of Nursing Q&S Report March 2018** **Serious Incidents (SIs)@** Open: 15, complex Reported to WG, March: 2 Closures submitted in previous month:4 In37239: infarct of spine In42308: diagnosis of cardiac failure In61850 pressure damage In63626 pressure damage Unopened e-Datix incident forms: 114 – all to open and review as soon as possible. Clinical Audit: nil outstanding Medication errors – 9, which is average for the Board POVAs – 0 VTE assessment documented on drug chart – 80% Noted that A6S (Stroke) should not be included. National Patient Surveys – on S Drive. Concerns: 51. An improvement, 71% responded to within 30 days. Significant progress in directorates to address concerns as informal, 90% of which achieve compliance. Active redresses – 17 Active claims – 135 IPC – 1 x C Diff, B6; 5 E coli, RCAs underway HH – needs to be 100% Duthie – 35% Ward Sister challenging Doctors. General Surgery Microbiology and pharmacy review of drug charts in SAU, and post ICU, patients is which has been a success. However this has now been withdrawn due to microbiology staff shortages.	
18/66	**Healthcare Standards Audit: Actions from Directorates** **Pressure Damage.** 2.3.1 General Surgery, Urology, Head & Neck 2.3.2 Trauma and Orthopaedics	

	Reports were received. LW noted the scale of the work completed within the Clinical Board. Prevalence had improved significantly. This would be discussed at the forthcoming Nursing and Midwifery Board. **Action: LW to report back to next meeting.** The UHB had been successful in securing Hi Lo beds and Promat mattresses for all inpatient beds. Roll out was planned initially for UHL, focussed first on T&O, moving sequentially to Barry, St David's, and finally UHW.	**LW**
18/67	**Directorate Assurance Reports:** 1. General Surgery & Wound Healing – Report to follow. Nil of significance reported. 2. ENT – Report received and noted. 3. Perioperative Services – Report received and noted. Key issues: - QUAD audits currently being undertaken in every theatre. - Robotic surgery SSSU – missing specimen. There had been a 2 day delay in being notified of this due to the mechanism for transporting specimens to the Royal Gwent. Investigation underway. - HSDU is monitoring protein residue on reusable surgical instruments. - EPIPAC. Professor Torkington is working through safety issues with Anaesthetic colleagues. The SOP requires tight fit masks; relevant staff have yet to be fit tested. A start date cannot yet be identified. - Retained arterial cannula tip, main theatres. The cannula had been sent to SMTL for analysis 4. Anaesthetics. Report received and noted. Assurance was received re: - PSN040/Jan 2018 – confirming removal or flushing of lines and cannulae after procedures – circulated 4/4/18 - Letter from the Medical Director regarding staff accessing their own records – circulated 4/4/18. - SBAR "The UK is changing to safer equipment for neuraxial procedures in 2018". **APPROVED** by the Surgery Quality & Safety Sub Group. RB would now take this to Matt McCarthy, Patient Safety. 5. Trauma and Orthopaedics. Report received and noted. Key issues: - Management of Paeds fractures in the Emergency Department (ED).Significant numbers could have had fractures manipulated in the ED. Need to ensure that X-rays are reviewed there, instead of taking patients back to theatre. - One Mandatory training module is covered every month at audit. This practice was commended by LW. The directorate advised that the Safeguarding condensed session completed at last audit had been positively received by medical staff. Perioperative Care had significantly improved compliance through use of e.g. reward certificates. 6. Urology & Ophthalmology. Report to follow.	**AJ**
18/68	**Exception reports from Directorates/Working Groups** ▪ General Surgery, Vascular, Wound Healing - nil ▪ Head & Neck, Maxillo Facial and Ophthalmology- nil ▪ Urology. 2 patients, managed through SSSU, had had robotic partial nephrectomy procedures. ▪ Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: - It was reported that difficulties were being experienced by theatre stores staff in collecting kit from Lakeside stores in a timely fashion. There was a significant backlog in Lakeside stores. NWIS are involved in finding a solution. - Two reports of children with chlorhexadine burns/marks from adhesive on drapes. One had been a 6 hour procedure with the	

	requisite checks for skin integrity throughout. This currently sits with Women & Children. RCA underway. ▪ Trauma and Orthopaedics - nil ▪ Anaesthetics – reported incident in another Health Board where Oramorph had been given intravenously. The advice is always to use an oral syringe for drawing up an oral drug drug. Wards to double check that all wards have oral syringes. **Action: Lead Nurses.**	**LNs**
18/69	**Alerts and other Safety Notices** <u>NICE Guidance</u> 1. Surgery CB summary spreadsheet – see log 2. *IPG601: Dec 2017: Transcutaneous microwave ablation for severe primary axillary hyperhidrosis.* (response to Clinical Audit provided – for Dermatology) <u>Patient Safety Notice</u> 3. *PSN041 March 2018: Risk of Death and Severe Harm from Failure to Obtain and Continue Flow from Oxygen Cylinders harm.* When cylinders stored, turned off, so turn on when administering. 4. *Safe Practice reminder April 2018: for all staff who use portable oxygen cylinders* Received and noted. 5. *International Dysphagia Diet Standardisation Initiative.* To ensure the patient is assessed correctly. New descriptors, changed thickening product, lid does not look to be tamper proof which is a concern given the incidents of patient incidents occurring due to ingestion or breathing in of the powder. Nursing staff to be aware. <u>Internal Safety Notice</u> 6. *ISN: 2018/001: Nursing Staffing Levels (Wales) Act 2016* It was explained that this was in force for staff on staffing on surgical and medical wards. The biggest change was that all Ward Sisters/Charge Nurses will be supervisory, which was to be a cost pressure on the Clinical Board of £0.5m however corporate financial support has been gratefully received. The task now if for each ward to recruit 0.8wte Band 5 to backfill. <u>Other Alerts</u> 7. *Urgent POCT Communication to ALL Glucose and Urine Meter Users* The Surgery Clinical Board had not been invited to this Group. CB is attending. It was emphasised that the patient Case Number bar code must be input and not the NHS number. Any instances of staff badge sharing will be addressed. <u>Welsh Health Circular</u> 8. *WHC 2018/12, March 2018: Never Events List 2018 and Assurance Review Process* Slight changes to all of these were noted. There had been some new never events included such as wrong site blocks and injections, retained surgical devices such as swabs not classed as never events. **Action: All to read**	**ALL**
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
18/70	<u>Key Messages from Board/ Committees/ Groups</u> 1. <u>Medical Equipment Group feedback</u> RH referred to the poorly attended April meeting. All medical equipment related incidents are to be brought to this group, and thence to the MEMG. Thanks were extended to Clinical Board colleagues for their success in submitting equipment bids. 2. <u>UHB Medicines Management Group 19 April 2018</u> To note: the Chronic Pain meeting with Primary Care and colleagues had been deferred to May 16th 2018 at the request of Primary Care colleagues.	

	a. Pharmacy Report to Clinical Board 27 April 2018. Received and noted. b. Clinical Board IP&C Group 23rd April 2018. Minutes to be provided when available. c. Clinical Board H&S Group. Minutes of 7th March received and noted. Verbal update from 18th April 2018 It was noted that the refurbishment of the male changing rooms, Main Theatres, was complete; the female rooms were in progress. Work on the theatre corridor was complete including patient friendly decor; the administration team was due to move imminently. A recent flood via the ceiling in the male changing rooms had unfortunately negatively impacted the new décor. d. UHB Water Safety Group update. No meeting e. Safeguarding Steering Group update. he Group had met at the end of March. Key issues: - New procedure for responding to unexpected death in childhood. - There had been an increase in referrals to the Domestic Violence Adviser (15 referrals per month). - A decrease in DOLS applications was noted, although there was a high volume of patients. f. 12th Neuraxial Task and Finish Group Agenda & Minutes 20th March. Received and noted g. Robot Nephrectomy Operational Group Mr Narahari had submitted a pathway for partial nephrectomy procedures. The following were received and noted: 1. Minutes 27th March 2018 2. Minutes 24th April 2017 3. Minutes 22nd May 2017 4. Trust Policy for New Interventional Procedures. This should read University Health Board (and not 'Trust'). 5. Clinical Pathway for Patients Undergoing Robotic Partial Nephrectomy (RPN) in South Wales An all Wales meeting was noted to be scheduled for Friday 11th May to review M & M data regarding robotic prostate procedures. .	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
18/71	**IP&C RCA database** The following were highlighted: MRSA – 1, Duthie Ward. No evidence of cannula pack used. LW reviewed the incident. There had been poor compliance from medical staff putting stickers in patients' notes, and poor VIP scores which will be addressed. It was highlighted that several wards had been MRSA free for over a year – this would be reviewed and the achievement appropriately celebrated. E .coli - 2 cases.	
18/72	**National and UHB Audit Reports** National Audit of inpatient falls 2017 It was noted that Mr Antony Johansen had presented this at T&O Audit. For the whole of 2017-18 the CB had reported 6 injurious falls. To date the CB has reported 3 which is of significant concern. It was anticipated that the implementation of low rise beds may positively impact on reducing the number of injurious falls. A review of the RCAs will be undertaken to identify the root causes. There were occasions when patients were placed in wrong areas, where patients at risk of falls could not be cohorted. **Action: AJ to liaise with Oliver Williams, Falls Strategy Implementation Lead.**	**AJ**

	It was noted that with effect from 1/4/2018 the Clinical Board and Director of Nursing were mandated to comment if non-compliance with the Nurse Staffing Act was a contributory factor to falls and pressure damage.	
18/73	LIPS Progress Report – End of year progress report Last cohort had not presented due to adverse weather. **Action: GE liaise with Joy Whitlock to determine when this would be rescheduled.**	**GE**
18/74	**Transfusion Committee** 1. Blood Transfusion Committee Minutes of meeting 24th January 2018. Received and noted: - Massive Haemorrhage Policy. A 'dry run' is planned for staff in high risk areas. The impact on Theatres to be considered. 2. Traceability Non-Compliance for April 2018. Failure to confirm one transfusion was noted 3. Blood Transfusion Incident Report 1/12/17 – 28/2/18 Received and noted that there had been a significant improvement	
18/75	Health Care Standards Self-Assessment This had been completed and was ready for submission. Teams were thanked for the information supplied.	
18/76	All Wales Stage 2 Mortality Review Tool Developed and recommended for use. Circulated to CDs. SW and DSC would ensure that this is implemented.	
PART 5: GOVERNANCE		
18/77	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. Open SIs, No Surprises Total 19 outstanding. 2 closures. It was anticipated that the target of 5 closures should be reached for May. It was noted that longstanding SIs were complex. 2. Regulation 28 report & Open Inquests Two inquests: 1 - One date to be confirmed. 2 - Urology 24/5/18. A request had been made for support from the Legal and Risk team. 3. Serious Incidents 1. Closure forms sent to WG since 1st January 2018 – noted. 2. Ombudsman's Report: 201700813 – presentation and actions for noting. In the absence of Mr Chris Williams, a summary of this incident was described by LW which concerned an ophthalmic patient who had been referred between clinics, missed appointments, and subsequently had lost the sight in one eye. The actions required by the Ombudsman had been implemented. 3. Ombudsman's Report: 201701433. The actions required by the Ombudsman were noted. 4. A Just Culture Guide – supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents. Received and noted. 4. Falls Report. Year to date, 3 injurious falls (compared to total of 6 for the previous year). RCAs were underway. 5. Complaints, Claims and other Concerns 1. All New Clinical Negligence claims opened 23/3/18 – 26/3/18	

	2. All Clinical Negligence Claims Settled 23/3/18 – 26/4/18 Received and noted. No themes.	
18/78	**Patient Surveys:** National Survey Report for Surgery (March 2018) "2 Minutes of your Time" (March 2018) Noted.	
18/79	**Research & Development** A Policy for Research Consent and Standard Operating Practice had been circulated by LW for comment. **Action: for comment.** It was noted that this was a requirement for all involved in research trials, including a specific SOP for sponsored research.	**All**
PART 6: DATES OF NEXT MEETING **Tuesday, 3rd July 2018, 08.00 – 10.30. Seminar Room B, UGF, A Bl, UHW.**		
PART 7: URGENT BUSINESS		
18/80	Organ Retrieval. RH informed colleagues that the practice of a receiving visiting surgical transplant team was to use a personal mobile device to record an echo scan on a donor's heart to provide a receiving consultant with an up to date Echo, received in turn on their own personal device. This raised serious concerns regarding Caldicott and patient confidentiality. It was agreed that only a UHB approved device should be used; retrieval teams needed to provide a device approved by the UHB. On a separate issue, SW emphasised the need for a decision regarding the use of 'Whats App'. This had been escalated to the Medical Director. **Action: LW to raise these issues with Specialist Services.**	**LW**
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
18/81	**Recent Reports & Communications** Medical Director's Bulletin April 2018. Received and noted.	
18/82	**Directorate Q&S Minutes.** The following were received and noted for information. 1. Perioperative Care 6th April 2018 2. Anaesthetic Agenda Q&S 17th April 2018 3. Anaesthetic Minutes 17th April 2018 4. Trauma & Orthopaedics Minutes and supporting documents 17th April 2018	

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE (H&S FOCUS)
Tuesday 22 May 2018
8.30am, Council Room, A Block, Upper Ground Floor, Main Hospital UHW

Preliminaries		**ACTION**
	Welcome & Introductions Cath Heath, Director of Nursing (Chair) Meriel Jenney, Clinical Board Director Mary Glover, Lead Nurse, ACH Directorate Louise Young, Safeguarding Heather Gater, Interim Head of Therapies, Acute Child Health Matt McCarthy, Patient Safety Team Rachael Sykes, Health & Safety Advisor Rim Al-samsam, Interim Clinical Director, Acute Child Health Jane Maddison, Interim Head of Therapies, Community Child Health Paula Davies, Lead Nurse, Community Child Health Cheryl Evans, Directorate Head of Operations & Delivery, Obstetrics & Gynaecology Laura Bassett, Risk Manager, Obstetrics & Gynaecology Eirlys Ferris, Senior Midwife, Obstetrics & Gynaecology Angela Jones, Senior Nurse, Resuscitation Service Alison Jones, Health & Safety Representative, RCN Michelle Abel, Infection Prevention Control Nurse **In Attendance** Kirsty Hook, Board Secretary Linda Hughes-Jones, Safeguarding (presentation) Michelle Moseley (presentation)	
	Apologies for absence Rachel Burton, Ian Sprigmore, Sarah Evans	
	To receive a presentation on the Safeguarding Supervision Project A presentation was provided on the safeguarding supervision project. It was noted that following review of the current programme, the processes for supervision needed review and a pilot study was therefore put into place which has been taken forward over the last 18months. The study was undertaken to review options for group supervision, however acknowledging that 1:1 supervision would still be available if required. Focus groups were set up with the health visiting teams and safeguarding advisors in order to understand the needs for the supervision and evaluate the effectiveness of group supervision. The recommendations from the focus groups was that group supervision would be launched, with a re-evaluation of this in 12months time. The process has changed from 6 monthly on a 1:1 basis to 3 monthly on a group basis. 1:1 supervision is still available should there be a need. It was also noted that peer support is being received by all group members as well as shared learning. On the phone advice is also available to ensure support where required.	

	Signs of Safety Model has been introduced by Cardiff Council across all Cardiff areas and discussions are in process to review options for roll out training across all areas.	
PART 1: HEALTH & SAFETY		
1.1	**To note any specific Matters Arising from the last CB H&S Meeting dated 27th February 2018** **Memorandum of Understanding CCNS** Noted and approved at the last meeting. **Archiving at Lansdowne** This is an ongoing issue due to reduced options for alternative storage at Nant Garw. There are ongoing discussions as to the management and access of the filing facilities. Concerns were raised with regards to the length of time that it is taking to access records and the health and safety risks associated due to poor filing and storage. It was noted that any incidents should be recorded on Datix so that this can be raised appropriately with the Medical Records Department. Discussion ensued with regards to destruction of medical notes and it was acknowledged that the Destruction of Notes Policy is available on the Information Governance Section of the Intranet.	
1.2	**Feedback from UHB Health & Safety Operational Group Meeting** The summary of the points of the meeting were noted for information and a further meeting is scheduled for next week. Refresher Training for Manual Handling & violence and aggression training was discussed and the following noted: - Completion of the Awareness Sessions Module A in both subjects is only required on Induction with no requirement to refresh. - Manual Handling and Violence & Aggression Tutor led foundation courses should continue to be on an assessment basis and to progress this, work is being undertaken within LED on competency needs. - Refresher period for both Manual Handling and Violence & Aggression modules B&C should be reviewed to 2yrly which may be completed by either Classroom update training or competency assessment (undertaken by Link-workers or H&S training staff). - V&A intervention courses such as Level D mental health remain unchanged Legionella Flushing - there was discussion as to the responsibility for flushing. It was noted that the responsibility of the manager for the area to undertake the flushing however this can be delegated as appropriate. Unused outlets should be flushed x3 per week and the use of others is evaluated to ensure there are appropriate flushing mechanisms in place. **Control of Contractors Guidance** The control of contractors' guidance was shared for information to reiterate the requirements and responsibilities for all areas in relation to use of contractors for work that is being undertaken outside of the Capital Estates Department.	
1.3	**To note the latest Health & Safety Report** The report was noted for information. It was acknowledged that there have been significant improvements made in the number of open incidents and work continues to close and action appropriately.	
1.4	**C&W Clinical Board Health & Safety Report Update** The Health & Safety Improvement plan for the Clinical Board was shared for information. The group were asked to review all the information and provide updates back to HG. Reviews of the current risk registers are being undertaken with a deadline of November 2018 for completion. Work is progressing and it was acknowledged that this is a significant piece of work to ensure that the risk register is meaningful.	**ALL**

	It was agreed that the improvement plan would be brought back to the next H&S meeting for ratification.	**HG**
1.5	**COSSH Report for Noting** Noted for information. All were asked to review and ensure that COSSH assessments are carried out appropriately to ensure that all areas are compliant.	**ALL**
1.6	**H&S Alerts** **Sharps on Roof Areas** It was noted that there have been a number of needles etc found on the radiology roofs. A walk around is being undertaken to review areas and undertake some education and raise awareness of responsibility of appropriate disposal of sharps.	
1.7	**Workplace Inspections Update** Work is progressing across all areas and there were no specific issues to report for this meeting.	
1.8	**Feedback from H&S Staff Side** No items to note for this meeting.	
1.9	**Exception Reports and Escalation of key H&S issues from Directorates** Noted as part of item 2.3.	
1.10	**To note the Lone Worker Compliance** Noted for information. It was acknowledged that there has been an improvement of usage for the Clinical Board.	
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**To receive the Minutes of the previous meeting dated 24th April 2018 for approval** The minutes of the last meeting were agreed to be an accurate record.	
2.2	**QSE bring forward action log / Matters Arising** It was agreed that an update on all actions would be provided following the meeting and the action log circulated with the minutes for information.	
2.3	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **ACH** • 5 RCA's ongoing. • NATSSIPS work is ongoing. • Hand Hygiene compliance continues to be high. • There has been an increase in tenfold medication errors and information sharing and shared learning is being undertaken with staff as part of the staff forum. • Therapies RTT is currently at 4 weeks and is from date of referral received. Work is ongoing to deliver zero patients waiting 36 weeks for the end of quarter 1. • Child City Friendly Initiative work is progressing well. • Recruitment processes continue and vacancies are being progressed within nursing and also across therapies services. **O&G** • Safer Pregnancy Clinic Evaluation has been received and it was agreed that this would be shared at the next meeting for information. • Grade 2 pressure area has been reported in Gynaecology associated with a complex patient.	

	• There have been a number of falls have been reported in month, all of which have been investigated. • BFI Accreditation has been received and an action plan is in place to take forward • Formal Opening of the FGM Service has been undertaken • Perinatal Mental Health Service – reviews are being undertaken to determine what is required with regards to a Tier 4 service. • Joint working is being taken forward with Cwm Taf regarding patient safety & quality • Middle tier gaps anticipated for August/September 2018 and a business case is being produced to outline the risks associated with this. **CCH** • Ongoing risk management being undertaken with regards to the Rover Way Gypsy Traveller Site. There have been no further issues reported from Social Services however it was felt that a further meeting was required to risk assess restarting the primary birth visits on site. • Security are now on site at Global Link and a receptionist has also commenced in post which is hoped will improve access to the site. • Use of clinical portal at Ysgol y Deri is problematic and concerns have been raised with regards to access of information. Work is ongoing to resolve this issue. • All therapies waiting lists are being reported under 14 weeks • Statutory Notice for Ty Gwyn Special School has been received due to gaps in therapy services available at the school. There is no additional funding available to support the increased requirements and this will also have an impact on school nursing services. A response has been produced to the recommendations outlined within the School Nursing Framework as there will be significant risks. • 1 RCA has been completed with regards to influenza vaccination being received due to a miscommunication of consent. A full investigation was undertaken and no harm was caused to the patient. • LAC Out of County assessments being required for children placed in ABMU is progressing • Children's Rights work is progressing well and it was agreed that a presentation would be provided at a future meeting in order to provide a detailed update of the work being taken forward.	**PD**
2.4	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** No items to note for this meeting.	
2.5	**Paediatric Surgery Update** Risks continue however a positive report has been received from the Deanery and an action plan has been developed to progress the recommendations and requirements. The junior staff position is anticipated to be improved from July 2018 and further consultant appointments due to commence in July 2018.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	Initiatives to promote health and wellbeing of Patients / Staff • Resilience day held on May 4th in line with International day of the Midwife supported by the RCM Cardiff Branch	
SAFE CARE		
4.1	**Update on Serious Incidents** 7 open at present and x2 closure forms are with the Nurse Director for sign off. Good progress has been made and it was noted that all incidents prior to 2018 have now been actioned.	
4.2	**SBAR wrong route medication error Datix 259247** The case involved a patient being given the standard epidural solution through the intravenous venous cannula as opposed to the epidural catheter. The error was immediately and the	

	administration was discontinued. Maternal observations and wellbeing were assessed and the error reported to the anaesthetic registrar and the coordinator. Review of the patient was undertaken immediately and the patient informed of the error. **Root causes** • There was a delay in going to theatre due to the obstetric team being in theatre with another case resulting in the midwife administering a standard epidural top up to the patient in the room following an anaesthetic review. • The midwife did not undertake a full assessment prior to the administration of the epidural solution and due to distractions at the time this was administered intravenously. • Although human error occurred if there was an appropriate physical safety mechanism available to prevent misconnection this medication error would have been avoidable. **Lessons Learnt** • It would have been common practice for the attending anaesthetist to administer the epidural top up prior to transferring to theatre himself so that midwife 3 could focus on preparing LH for theatre. However, due to an anticipated delay in transferring LH to theatre, it was reasonable for the anaesthetist to ask midwife 3 to administer a routine 10ml epidural top up to ensure LH was comfortable prior to her transfer to theatre. • Midwives should, however, be encouraged to request help if they feel that this is required. • Clarity is required to ensure that both anaesthetists and midwives are aware of their roles when a decision has been made to transfer a patient to theatre. In times of peak activity it is important to ensure clear role distinctions and ensure any potential risk to patients are minimised through appropriate escalation if these roles cannot be fulfilled safely. The SBAR was approved and it was agreed that the closure form would be submitted to Welsh Government for sign off.	**MM**
4.3	**Infection Prevention Control Update** The report was noted for information. • New faecal testing will be introduced from July 2018 and for paediatrics under 2yrs will not be tested and will follow the current C Diff algorithm • Study Day for Infection Control has been shared for information • Assessment of infectious status for all patients should be completed and paperwork is available on the intranet pages • Antibiotic audit continues in Obstetrics & Gynaecology and feedback has been provided on the last 3 months of data which has improved significantly and continues	
4.4	**Safeguarding** Standard Operational Procedure has been produced for the Clinical Board and outlines the safeguarding programme and training being taken forward throughout the year which is available for all staff. It was agreed that this information would be circulated following the meeting. **Violence Against Women – Ask & Act Training** It was noted that this training will be required for all staff and this will be rolled out from September 2018– March 2019 for the first tranche of training as per requirements from Welsh Government. This is a significant piece of work that will be required to be taken forward, however it was acknowledged that the training resources have not yet been developed.	**LY**
4.5	**Patient Safety / MDA Alerts (internal/external)/WHC** • MDA/2018/012 - BD Vacutainer® EDTA & BD Vacutainer® Lithium Heparin Tubes – risk of incorrect results for lead testing or other assays using ASV methodology • MDA/2018/013 - cobas b 221 instruments with AutoQC module – software limitation affecting automatic QC measurements	

	• MDA/2018/014 - Infinity Acute Care System and M540 Patient Monitors software versions VG2.2-VG6.0 – risk that alarms are not activated • Internal Safety Notice 2018/002 - IDDSI Texture descriptors • Public Health Link - Valproate Contraindicated In Women Of Childbearing Potential Unless There Is A Pregnancy Prevention Programme The above patient safety and medical device alerts were shared and noted for information. There were no exceptions to report and the group were asked to ensure that all alerts are widely disseminated.	**ALL**
5.1	**Latest Cleaning Scores Report** The latest cleaning scores report was shared for information. The Clinical Board are currently reporting a position of 97%.	
6.1	**Update on latest 2 minutes of your Time feedback.** Work is progressing across all three Directorates in relation to 2 minutes of your time. There was no specific feedback to note for this meeting.	
STAFF AND RESOURCES		
7.1	Feedback on current position for PADR and Sickness was noted. With regards to PADR, figures for April have been reported by 62% and work is progressing to further improve the compliance. It was noted that within England, the pay award has been linked to PADR and further information is awaited as to whether this position will be the same within Wales. The breakdown position by Directorate was noted: ACH – 65% CCH – 63% O&G – 65% In relation to Sickness – improved sickness figure for April has been reported at 4.1%. There were no specific issues to note.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
8.1	**To note the Screening Annual Report for Public Health** Noted for information. It was noted that cervical screening has decreased slightly however there are no specific issues that need to be highlighted.	
ANY OTHER BUSINESS		
	Update on the Paediatric Resuscitation Practitioner Business Case AJ agreed to forward the business case through for comment and once agreed this would be taken to the Resuscitation Committee for final approval.	**AJ**
DATE AND TIME OF NEXT MEETING		

The next meeting is scheduled for **Tuesday 26th June, 8.30am, Meeting Room, Clinical Board Offices, Lakeside (Quality & Safety Focus)**

<u>Remaining 2018 Meeting Dates</u> (4th Tuesday of the Month, between 8.30 – 10.30am unless otherwise stated below)

Tuesday 24th July, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 28th August, Venue to be confirmed (H&S Focus)
Tuesday 25th September, Meeting Room, Clinical Board Offices, Lakeside

Tuesday 23rd October, Venue to be confirmed
Tuesday 27th November, Meeting Room, Clinical Board Offices, Lakeside (H&S Focus)
Tuesday 18th December, Meeting Room, Clinical Board Offices, Lakeside

Dental Clinical Board

Minutes of Quality, Safety & Experience Committee Group Meeting
Thursday 28 June 2018 ~ 8 – 10 am
Annexe Seminar Room, University Dental Hospital

Present:

Andrew Cronin (Chair) (AC)	Rowena Griffiths (RG)	Catherine Evans (CE)
Gurcharn Bhamra (GB)	Julia Charles (JC)	Barbara Chadwick (BC)
Caroline Sutton (CS)	Shannu Bhatia (SB)	Emma Stone (ES)
Nick Drage (ND)		

Apologies:

Eira Yassien (EY)	Ivor Chesnutt (IC)	Diana Wakefield (DW)
Dinah Jones (DJ)	Mike Lewis (MAOL)	James Gillespie (JG)

In Attendance:
Ruth Taylor (RT) - Minutes

		ACTION
PRELIMINARIES		
1.1	**Welcome & Introductions** AC welcomed everyone to the meeting of the Quality, Safety and Experience Group. AC welcomed CS, Medicine Supply Manager, to her first meeting as Pharmacy Representative following an update to the Terms of Reference. The group provided brief introductions.	
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 3 May 2018 were reviewed and confirmed to be accurate and correct. **Matters Arising** There were no matters arising.	
MONITORING & REPORTING – DENTAL CLINICAL BOARD SUB GROUPS		
2.1	**Oral Surgery, Medicine, Pathology & Radiology** **- Mr N Drage** The minutes from the OSMP Audit Group meetings held on 16 May 2018 and 14 June 2018 were received and noted. ND reported that Joelle Mort presented a completed audit on sharps incidences at the May audit. This compared the number of sharps incidences before and after the implementation of the adapted WHO checklist in Oral Surgery. This showed a marked improvement with 30 incidences occurring prior to implementation and only 10 afterwards. It was noted that there was no pattern to the injuries, but following implementation, it was noted to be the DCTs who were suffering the injuries rather than any other staff group. It was noted that there were 22 incidences of sharps being left on trays (near miss) prior to the checklist being implemented and this reduced to 7	

	afterwards. The question was raised as to whether there were any repeat offenders and AC will discuss this with Niki Wood. It has been agreed to roll out the adapted WHO checklist to all areas where extractions occur. This will include deciduous teeth. AC has agreed to compose an email to all staff informing them of the introduction of the form to all areas, and this will be circulated by RT. Phil Atkin chaired the June OSMP audit meeting where the break glass presentation was given. Melanie Wilson presented the initial findings of the antimicrobial audit and the final data should be available for presentation at the end of the year. Discussion was had over previous audit presentations and where they were stored. RT has agreed to speak with Debbie Preece/Jonathan Peck to ensure they are all stored centrally and can be easily accessed.	**AC** **AC/RT** **RT**
2.2	**Restorative Dentistry - Mr G Bhamra** The minutes from the Restorative Audit Group meeting held on 23 May 2018 and 21 June 2018 were received and noted. Emma Stone gave presentations on DATIX incident reporting and patient identification and MAOL gave a presentation on Never Events. Wayne John from Colten gave a presentation titled 'Brilliant Crios; Reinforced composite Bloc for permanent CAD CAM restorations'. Projects have been arranged with the undergraduates and DCTs for September looking at using composite rather than ceramic. This change is likely to lead to a significant cost saving. Fitzroy Hutchinson attended the June meeting to provide a presentation on Environmental Management. There was also a case presentation by Polyvios Charalambous on an 'Integrated restorative case; Holistic Approach'. Abdullah Al Telmesari presented a 'Retrospective audit on the incidence of root canal flare-up associated with patients seen in MClinDent endodontic programme by postgraduates at Cardiff University from September 2014 to July 2017. This showed that we are within the reported standards. It was suggested that we evaluate how antibiotics are being prescribed and look at the details as to how we manage these patients in future.	**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 16 May 2018 were received and noted. The first part of the meeting was used as a specialist training session. Jeni Bone from Action on Hearing Loss attended and provided a very interesting presentation on treating patients with hearing loss. MAOL attended to provide a Never Event presentation. The minutes from the meeting held on 14 June were not available due to lack of secretarial support. The handwritten notes of this meeting are however available. The meeting was split into two with paediatric staff attending paediatric BLS for the latter part of the meeting. There was one patient story presented which related to safeguarding concerns around a paediatric patient with multiple caries. The patient had been treatment planned, including requiring GA, but DNA'd multiple appointments. The father also exhibited aggressive behaviour. The main issues related to parental responsibility and the father requesting a change of address. The case is to be discussed with the social worker to see if dad should be included in correspondence, along with the social worker, to try and encourage attendance. Yvonne Jones presented a completed retrospective audit on twin blocks appliances on behalf of a final year student. This showed a 17% DNA rate with an overjet recorded in 100% of patients. It showed that girls were more successful than boys. This audit will be repeated in future as part of a final year project.	

	New guidance from WG on the prevention of dental caries in the 0 – 3 year age group was tabled and staff have been asked to ensure they are up to date with the changes. Concerns were raised with regard the recording of audits whilst JP has been away. AC has requested that each audit lead send a list of all completed audits to JP in order for the database to be updated accordingly. There had been concern that a cost was going to be incurred for the provision of mouth guards. The lab have now confirmed that patients requiring a mouth guard as part of their treatment will not be charged.	
2.4	**Community Dental Service - Mr J Gillespie** The unconfirmed minutes from the CDS Quality and Safety Meeting held on 15 March 2018 were received and noted. JG was not in attendance and no report was provided.	
2.5	**Occupational Health and Safety Advisory Group (OHSAG) – Dr M Wilson** The unconfirmed minutes from the Dental Clinical Board and School Health and Safety Advisory Group held on 6 June 2018 were received and noted. MW was not in attendance and no report was provided.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	**Health and Care Standards Monitoring data** Not discussed	
3.2	**Consent** Not discussed	
3.3	**Patient Identification Policy** ES gave an informative presentation on a patient identification audit that had recently been undertaken. This audit was undertaken on the back of an improvement plan following an investigation in to a never event relating to wrong site surgery. As part of the improvement plan, we are required to review our identification policy and how it applies to our practice and ensure it is reinforced throughout the Clinical Board. ES performed an audit whereby she observed 70 patient interactions. She was looking to see whether the clinician asked the patient to confirm their name, address and date of birth. Out of the 70 observations, there was only 3 occurrences whereby the clinician asked all three questions. This highlights a limited understanding of the patient identification policy within UDH and that staff need to be aware of these guidelines and that they are best practice. The policy is available for all staff on CAVWeb. JC confirmed that an electronic wrist band printer is due to be installed in GA Theatres shortly. SB has requested that ES present this again at the Paediatric audit.	**ES**
3.4	**Audit Plan** Not discussed	
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. This was not discussed.	
SAFE CARE		
5.1	**Risk Register- Rowena Griffiths** RG confirmed that this is being reviewed and revised.	
5.2	**Incident Reports** The incident report dated May – June 2018 was received and noted. JC stated that In69353 did not occur in GA Theatres and therefore the location needs to be amended. ES presented her investigation into the never event that occurred on the Sedation Suite on 8 November 2017. The improvement plan recommended the Dental Clinical Board should: • Consider the roll out of the adapted WHO checklist across all clinical areas that carry out extractions • Identify invasive dental procedures and develop Standard Operating Procedures. • Review the role and responsibility of the Dental Nurse in their role of assisting during dental procedures and the second person in tooth identification for dental extractions. • Review the methods used for sharing the learning from Never Events and other incidents to ensure all staff are made aware of any changes to practice to reduce the risk of a reoccurrence. In response to these recommendations, it was confirmed that Matthew Thomas and Leili Sadaghiani are taking the lead on developing a LocSSIP for root canal treatment. The GDC have confirmed that a dental nurse is able to second check a tooth prior to extraction/dental work and a presentation on never events has been added to all DCT/student inductions. An educational day is scheduled to take place in July and never events will be on the agenda to raise awareness, especially with restorative tutors.	
5.3	**Medicines Management Audit Report – Rowena Griffiths** Not discussed.	
5.4	**New Medical alerts** The following Patient Safety Notices were reviewed and noted. • **PSN042 / April 2018** Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids • **PSN043 / May 2018** Supporting the introduction of the Tracheostomy Guidelines for Wales • Tracheostomy Guidelines for NHS Wales	
5.5	**Medical devices/equipment issues**	

	The following medical device alerts were noted: • **MDA/2018/012** BD Vacutainer® EDTA & BD Vacutainer® Lithium Heparin Tubes – risk of incorrect results for lead testing or other assays using ASV methodology • **MDA/2018/013** cobas b 221 instruments with AutoQC module – software limitation affecting automatic QC measurements • **MDA/2018/014** Infinity Acute Care System and M540 Patient Monitors software versions VG2.2-VG6.0 – risk that alarms are not activated • **MDA/2018/015** Gambro Ultrafilter U9000 microbial water filter for haemodialysis – risk of hypovolemia due to filter leaks during use • **MDA/2018/019** JM103 and JM105 Jaundice Meters – risk of misinterpretation of measurement in hyperbilirubinemia cases	
5.6	**Decontamination CDS WHTM01-05** Not discussed	
5.7	**HIW Inspections and report** There was nothing to discuss.	
5.8	**Infection, Prevention & Control** **Clinic inspection reports and improvement plans** Nothing to discuss	
5.9	**NatSSIPs – Julia Charles** The LocSSIPs Tookit for Dental Extractions was circulated prior to the meeting. AC has requested that this is reviewed by the group and any comments are passed to RT for further discussion at the next meeting.	**ALL**
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**	

	Not discussed • **Mental Capacity Act** Not discussed.	
TIMELY CARE		
8.1	**RTT – Mrs E Yassien** EY sent her apologies. No report was provided.	
8.2	**LIPS Bariatric Pathway** Not discussed	
INDIVIDUAL CARE		
9.1	**Concerns** The concerns report dated February – June 2018 was received and noted. RG noted that a concern relating to an oncology patient has now been taken out of redress and will be pursued through the Claims Court. This is likely to have a larger impact on the Clinical Board.	
9.2	**Compliments** The compliments report dated May - June 2018 was received and noted.	
9.3	**Safeguarding – Professor B Chadwick** The Safeguarding Team Newsletter – Spring 2018 was circulated and noted.	
STAFF AND RESOURCES		
10.1	**Employee of the Month** May 2018 – Sheila Oliver, Consultant in Special Care Dentistry June 2018 – Julie Andrus, Dental Nurses, Peripheral Hospital Dental Service.	
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: • WHC/2018/020 - AMR improvement goals & HCAI reduction expectations by March 2019: Primary & secondary care antimicrobial prescribing goals; C.Difficile, S.Aureus bacteraemias and gram negative bacteraemias • WHC/2018/021 - Raising awareness of Lyme disease and ensuring prompt and consistent diagnosis and treatment • WHC/2018/023 - The National Influenza Immunisation Programme 2018-19 • Public Health Link from the Chief Medical Officer for Wales - Influenza Season 2017-18 – Cessation of use of antivirals now recommended • Adapted WHO Checklist It has been agreed that this will be rolled out to all areas that undertake extractions, including deciduous teeth. Official correspondence will be circulated by AC/IC.	IC/AC

Any Other Business		
	A Safety Walkaround is due to take place in OMFS on 12 July 2018. AC requested that the following documentation is reviewed prior to the next meeting: • WHC(2018)009: Dental Services - Service Standards for Conscious Sedation in a Dental Care Setting RG wished to remind the group about the DSDU repair and replace form. This follows on from an incident relating to a rubber dam clamp breaking. Staff are reminded to ensure that floss is attached to the clamp before use. Broken items should not be disposed of, but returned to DSDU with a repair/replace form. This ensures that clinics are not issued with a non-conformance for lost equipment. Carol Evans and CE are preparing a written summary of all our never events for Ruth Walker. Carol has asked for the approximate number of tooth extractions and RCTs that we do each year. It was agreed that this data should be obtainable, but it should also include figures from SSSU and CHfW.	

Date and time of next meeting:

Thursday 30 August 2018	8.00 -10.00 am	TBC

PRIVATE QUALITY SAFETY AND EXPERIENCE COMMITTEE

18th September 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 12th June 2018	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting	Oral *Chair*
7	Safeguarding Update	*Executive Nurse Director*
8	Paediatric Surgery Report Update	Oral *Executive Nurse Director*
9	Items to bring to the attention of the Board/Other Committee	Oral *Chair*
10	Review of the Meeting	Oral *Chair*
11	Date of next meeting Tuesday 16th October 2018 (Annual Special Meeting)	