Bundle Quality, Safety and Experience Committee 16 October 2018

Agenda attachments

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10	UHB Human Factors - Initiatives to Support Staff and Improve Safety and Quality
11	Items to bring to the attention of the Board or other Committees
12	Date of next meeting: 18th December 2018 @9am

SPECIAL QUALITY SAFETY AND EXPERIENCE COMMITTEE

9am on 16th October 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 Committee meeting held on 18th September	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting	*Chair*
7	Hot Topics	Oral *Executive Nurse Director*
8 8.1 8.2	Analysis of Trends and Themes in: Serious Incidents Concerns and Clinical Negligence	*Executive Nurse Director*
9	Falls Assurance Report	*Director of Therapies and Health Sciences*
10	Presentation UHB Human Factors - Initiatives to Support Staff and Improve Safety and Quality	*Dr Mark Stacey and Dr Christina Diaz-Navarro Consultant Anaesthetists*
11	Items to bring to the attention of the Board/other Committee	Oral
12	Date of next meeting 9am on Tuesday 18th December 2018	

UNCONFIRMED MINUTES OF THE MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 18 SEPTEMBER 2018 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Dawn Ward	Vice Chair QSE / Independent Member – Trade Union
Akmal Hanuk	Independent Member – Community
Maria Battle	UHB Chair

In Attendance:

Angela Hughes	Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Chris Lewis	Deputy Finance Director
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Nicola Foreman	Director of Corporate Governance
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
Dr Tony Turley	Assistant Medical Director, Patient Safety and Clinical Effectiveness
Dr Holly Williams Observer	Quality & Safety Facilitator, Specialist Clinical Board
Vince Saunders Observer	Infection Prevention & Control Clinical Nurse Specialist

Apologies:

Susan Elsmore	Independent Member, QSE Chair
Prof Gary Baxter	Independent Member – University
Michael Imperato	Independent Member – Legal
Abigail Harris	Director of Planning
Fiona Salter	Staff Representative
Dr Graham Shortland	Medical Director
Robert Chadwick	Director of Finance
Dr Sharon Hopkins	Deputy Chief Executive / Director of Public Health

Secretariat: Julia Harper

QSE 18/122 WELCOME AND INTRODUCTIONS

The new QSE Vice Chair, Ms Dawn Ward welcomed everyone to the meeting, and explained that she would Chair the meeting in the absence of the Committee Chair. Members of the Medicine Clinical Board were attending the meeting to deliver the patient story and their quality and safety report and two observers were also in attendance.

QSE 18/123 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 18/124 DECLARATIONS OF INTEREST

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

QSE 18/125 MINUTES OF THE COMMITTEE HELD ON 12th JUNE 2018

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

QSE 18/126 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:

Digitalization of Medical Records QSE 18/087 – The UHB Chair reported that a meeting had been set up for 31st October.

CHC Scrutiny Overview QSE 18/088 – Mr Allen confirmed that a meeting would be set up.

QSE 18/127 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 18/128 PATIENT STORY – MEDICINE CLINICAL BOARD

Mr Wayne Parsons, Quality and Governance Interim Lead Nurse delivered the patient story that demonstrated the importance of looking beyond the symptoms of intoxication.

A 20 year old male had been brought to the Emergency Unit following a night out with friends and suddenly lost the ability to speak. He was under the influence of alcohol but not to excess. He had no other obvious symptoms, but friends and his mother kept raising concerns and telling staff that this "wasn't him". The doctor reassessed for stroke and he was scanned. He tested positive for stroke but his symptoms had been masked by intoxication. The story was being used to raise awareness amongst staff before freshers week.

The Chair invited comments and questions:

- In the past patients with a head injury had been misdiagnosed due to intoxication.
- The story had been shared with WAST as ambulance colleagues had not considered stroke.
- Some practical improvements had been made such as faster assessments and raising awareness of staff to question underlying causes.
- If stroke was not diagnosed correctly, patients did not get onto the correct pathway. The effects of stroke on young people had the potential to be profound.
- Over 16,500 potential stroke referrals were received in a year and under 700 were found positive.
- Stroke was largely preventable and lots of preventative work on life style and alcohol was being undertaken.
- The patient's mother made a complaint to the UHB and was pleased with the remedial work undertaken.

The Chair thanked the Clinical Board for sharing this story and noted that Mrs Hughes would help staff create a powerful digital patient/relative story for staff to learn lessons.
Action – Mrs Angela Hughes

QSE 18/129 MEDICINE CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

Colleagues from the Clinical Board attended the meeting to present their comprehensive report covering both challenges and successes in the Clinical Board: Rebecca Aylward, Nurse Director, Jane Murphy, Deputy Nurse Director, Geraldine Johnstone, Director of Operations, Dr Aled Roberts, Deputy Clinical Board Director and Kath Prosser, Quality and Governance Lead.

Ms Aylward commented on the themes in the report for improvement in patient experience and clinical standards. The Medicine Clinical Board had significant risks around surveillance of cancer patients (referrals had increased to around 50-70 per day) and this was a priority. It was a challenge to meet the 8 week target for endoscopy but this was expected to be achieved by the end of September. The focus would then be put on surveillance (around 950-1000 patients). One of the biggest risks in the Clinical Board was the 25% nurse vacancy. A plan was in place and staff were looking at how they could work differently.

The Chair invited comments and questions on the comprehensive report:

- The recruitment video and learning disability bundle were commended.
- Risks were managed on a daily basis through leadership and team work.

- It was noted that staffing a winter ward would be a challenge as some areas were already working with 40% agency staff and there was a high sickness rate.
- Staff would be formally asked if weekly bank pay would be attractive / an incentive. A briefing would be provided for the Chair to share with the Minister.
  Action – Mrs Ruth Walker
- Members discussed the contentious UBH policy of assessing and leaving patients on ambulances which was being used as the UHB deemed this safer than bringing patients into a corridor. Discussions were being held with WAST but the priority was to keep patients as safe as they could be. A consultant would support assessments at the "front door" during winter. In addition, two hour "performance huddles" had been instituted and these included staff from WAST. At this huddle the risk to patients was considered. The CHC advised that good communication was needed with patients and their families when patients were kept waiting on ambulances.
- The Clinical Board was asked to consider what support was needed especially with regard to skill mix to improve care for stroke patients at Llandough.
- The UHB Chair commended the improved performance against Tier 1 targets and the improvements in response times to complaints.
- It was suggested that charitable funds may be able to support the reinstatement of a dietetic support worker.
- A request was made for the Clinical Board Director to write an impact statement to support prosecutions when staff were off work following incidents of violence and aggression.
- The sepsis 6 bundle had been introduced and patients were flagged on the work station.
- It was suggested that links into the local communities could assist with recruitment. Suggestions should be shared with the Director of Workforce and OD.

ASSURANCE was provided by:

- The sustained progress the Clinical Board had made on the range of key quality, safety and patient experience. The focus on governance arrangements, in relation to the promotion of health, the delivery of safe, effective and dignified care. The Clinical Board recognised the key areas of improvement and actions required to further improve the patient experience received.

The Committee:

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

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

QSE 18/130 COMMUNITY HEALTH COUNCIL (CHC) REPORT

The CHC had no report to present in September.

QSE 18/131 HOT TOPICS – SERIOUS INCIDENTS INVOLVING WAST (WALES AMBULANCE SERVICES TRUST)

The Executive Nurse Director, Mrs Ruth Walker gave a brief oral update. WAST had not yet completed their investigations and staff were supporting WAST by providing root cause analysis training.

QSE 18/132 POLICIES FOR APPROVAL

The Committee received two Policies that required formal approval and adoption within the UHB.

1 INTERVENTIONS NOT NORMALLY UNDERTAKEN (INNU)

Ms Fiona Kinghorn attended for this item and advised that a complete update had been undertaken during which time outliers had been considered along with the mechanism for the cost/activity run rate. In addition, the list was more frequently updated. The CHC commented on the importance of communicating this information with patients and members of the public therefore, links to the website would be provided to the CHC.
Action – Ms Fiona Kinghorn

ASSURANCE was provided by:

- The policy had been fully reviewed and the intervention list had been comprehensively updated with Clinical Boards. A full Equality Health Impact Assessment (EHIA) had 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 had been reviewed and focused on high volume and high cost interventions.

The Committee:

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

2 INCIDENT HAZARD AND NEAR MISS REORTING POLICY AND PROCEDURE POLICY AND PROCEDURE

The Executive Nurse Director, Mrs Ruth Walker advised that this well used policy had been refreshed and fully consulted on.

ASSURANCE was provided by:

- The former Policy had been in existence for a number of years within the UHB.
- It was updated in 2017 by the Head of Health and Safety.
- It had been necessary to provide a further update to the elements of the Policy that related 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 were in place to monitor incidents reported via the electronic incident reporting system.

The Quality, Safety and Experience Committee:

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

QSE 18/133 CORPORATE RISK AND ASSURANCE FRAMEWORK (CRAF)

Mrs Nikki Foreman, Director of Corporate Governance gave an oral update on progress. The former CRAF would be replaced by a comprehensive Board Assurance Framework (BAF) that would combine priorities in the UHB Strategy and identify risks with mitigating action. This would be presented to the Board in November.
Action – Mrs Nikki Foreman

The Committee **NOTED** the update.

QSE 18/134 HEALTH CARE STANDARDS ASSESSMENT

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that this item was considered annually although the system was now one of continuous self-assessment. The Independent Members and Executives were thanked for checking the evidence used in the submission.

ASSURANCE was 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:

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

QSE 18/135 PUTTING THINGS RIGHT ANNUAL REPORT

The Executive Nurse Director, Mrs Ruth Walker thanked Mr Angela Hughes and her Team for all their work and for dealing with some of the most difficult situations and for going the extra mile to support patients who were not happy with their treatment.

It was pleasing to see that the number of issues being handled through the informal process had increased and the number of follow up enquiries had gone down due to the improved quality of responses. Complaints meetings were audio recorded to ensure nothing was missed.

Referrals to the Ombudsman had increased but on the positive side a number of letters were not taken forward as the Ombudsman felt the complaint had been investigated in full by the UHB.

Internal Audit had provided substantial assurance on the process and the CHC was also thanked for their support.

It was queried whether the Ombudsman would provide some insight into why/when issues were taken further. It was noted that guidance was being refreshed and if further clarity was required it would be taken up with the Ombudsman.

ASSURANCE was provided by the annual report

The Quality, Safety and Experience Committee **NOTED** the report for information.

QSE 18/136 HTA INSPECTION AND RESPONSE TO INDEPENDENT REVIEW OF MORTUARY AND CELLULAR PATHOLOGY SERVICES AND RCA INTO TISSUE TRACEABILITY

Mrs Sue Bailey, Lead for Quality and Safety in the Diagnostics and Therapeutics Clinical Board attended the meeting to update on this report. It was recalled that a range of concerns on governance, quality, tissue traceability, premises and equipment had been raised by the inspection. In response, the UHB asked for an independent review of the service and a combined action plan was produced. Mrs Bailey reported that all actions identified by the HTA had been completed and a re-visit should be expected at some point. The remaining actions were in progress, with two outstanding: the need to identify a new DI (or the licence could be lost) and organisational work on leadership and culture.

It was noted that a recent internal inspection of systems and processes had gone well. The pathology premises were included on the capital plan as not

fit for purpose but capital had not been identified. However, small remedial works had been undertaken that had made a significant difference. It was suggested there may be an opportunity to utilise charitable funds to make further improvements. It was also reported that the HTA had been impressed with the UHB methodology and had shared it with others.

It was suggested that the UHB responded well in a crisis but was not able to sustain performance and this was where the work on organisational development could assist. As part of learning, a monthly Regulatory Compliance Group had been set up. It was a challenge, but the Clinical Board was aware of where the issues were.

ASSURANCE was provided by:

- The actions developed and progressed

The Quality, Safety and Experience Committee **NOTED:**

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

QSE 18/137 PATIENT SAFETY SOLUTIONS ALERTS AND NOTICES

The Assistant Director Patient Safety and Quality, Mrs Carol Evans advised that the UHB was now 94% complaint with safety notices, an improvement from 79% in 2016. Some issues had been non-compliant for a long time. Mrs Evans was pleased to report that after many years the new patient wristband was being rolled out across the UHB, starting at the Barry Hospital. In addition, work on naso gastric tubes was advanced and almost compliant. However, safe storage of medicines was still problematic across Wales. 98% compliance was anticipated by the next report.

ASSURANCE was provided by:

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

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

QSE 18/138 CLEANING STANDARDS

Mr Lee Wyatt, Head of Estates and Facilities attended the meeting for this item. He reported that Internal Audit had identified that credit for cleaning scores had been enhanced with higher levels of detail. A draft Strategy had

been produced and although cleaning targets were being achieved, there was a need to set up a Committee/Group to lead and monitor.

It was noted that it was the responsibility of wards to publish their cleaning scores and that the introduction of hand dryers positively impacted on the time required for cleaning.

The Chair invited comments and questions on the report:

- Improvements in cleanliness had been noticed in communal areas.
- Greater engagement and feedback with ward nursing and cleaning staff was required.
- Ward cleaning scores should be displayed/aligned with infection information.
- First impressions were very important and the level of cleanliness greatly affected these. Unfortunately the lack of ownership of equipment dumped across the UHB was negatively impacting the good work done on cleaning.
- Unison had accepted the recent pay offer. It was important to talk to all Band 1 staff and that they be given the opportunity to take up a Band 2 post with any additional support / training required.
- It was suggested that information was not always clear. The food hygiene rating system was widely understood and could, perhaps, be adapted to demonstrate cleaning scores - it was a patient's right to see these scores.
- It was vital that everyone recognised the importance and value of cleaning staff. This could be recognised through the sharing of staff and team stories and supported through the values and behaviours work - Mr Wyatt agreed to link with Rachel Gidman.
  Action – Mr Lee Wyatt

ASSURANCE was provided by:

- KPI scores on Very High and High Risk areas were meeting targets.

The Committee:

- **AGREED:** Paper update content was appropriate and proportional.

QSE 18/139 BLOOD PRODUCTS (STANDARD 2.8)

Dr Tony Turley representing the Medical Director, advised that the assessment was technical and the key was good regulatory compliance and medical involvement. Compliance was heavily monitored both by the UHB and authorities.

The Chair invited comments and questions:

- The Committee was updated on the national Infected Blood Inquiry that required the UHB to provide a great deal of information. The Executive Nurse Director thanked Mr Carol Evans for leading this work. NHS Wales had asked the UHB to share its template. The UHB had shared its Initial findings with Haemophilia Wales.
- Blood and transfusion was currently tracked through the telepath system. The UHB would be required to move to the WLIMS system but there were concerns over the national structure and blood stock. The system was only 50% complaint with the NWIS standard and therefore a resilience plan was required. Blood was one of the last modules to be included. The Chair agreed to take this up with the Chief Executive.
  Action – Miss Maria Battle

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee **AGREED** the report.

QSE 18/140 NUTRITION AND HYDRATION (STANDARD 2.5)

The Director of Therapies and Health Sciences, Dr Fiona Jenkins provided the update on the single plan and advised that the full report was available if required. If this plan was linked with the model ward work, many of the actions would be addressed and the Charitable Funds Committee was thanked for funding the pilot ward. Recent visits identified that elderly patients preferred traditional food and their wards would welcome inclusion in the pilot. Unfortunately this was not possible until the pilot concluded and had been fully evaluated.

REASONABLE ASSURANCE was provided by the status report attached.

The Quality, Safety and Experience Committee:

- **NOTED** progress on actions listed within the Patient Nutrition, Hydration and Catering experience management action plan particularly in relation to the model wards and the development work around the nutrition and dietetic service and speech and language service within the integrated team Emergency Unit.
- **WAS ASSURED** that the Nutrition and Catering steering group kept a regular review of the action plan to ensure and update on progress.

QSE 18/141 MEDICAL DEVICES, EQUIPMENT AND DIAGNOSTIC SYSTEMS (STANDARD 2.9)

The Director of Therapies and Health Sciences, Dr Fiona Jenkins stressed that this was a function of all Clinical Boards with limited capital funding available to replace broken equipment. This remained a risk as it was not possible to fund all items required. It was noted that Clinical Boards had been asked to discuss this issue as a standing item at their Quality, Safety and Experience Sub Committees but minutes demonstrated this was not being undertaken in sufficient detail and therefore it was important to secure better engagement and attendance at Medical Equipment Group meetings.

It was acknowledged that there should be a corporate responsibility for the issue and a system, process and resource was required to manage it, rather than duplicating work in 8 clinical boards. It was agreed that the Executive Directors would discuss this further outside the meeting.
Action – Dr Fiona Jenkins and Mr Steve Curry

LIMITED ASSURANCE was provided by:

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

The Quality Safety and Experience Committee:

- **NOTED** the findings of the Wales 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 required capital funding.
- **SUPPORTED** the recommended system level improvement activities.

QSE 18/142 PROTECTING PATIENTS FROM PRESSURE DAMAGE

The Executive Nurse Director, Mrs Ruth Walker presented the report and reminded Committee that the numbers would increase with the new reporting requirements. The figures were likely to climb again as reporting extended into the community. However, the prevalence survey, taken on a single day, reported a rate of 3.1% which was a significant improvement on 9.1% that was the rate for the last 5 years. Mrs Walker confirmed that the UHB was reviewing the situation carefully and taking the necessary action. In addition, work was ongoing with Welsh Government to improve the definitions.

It was noted that the foot assessment tool had not yet been implemented and this would support preventative work on pressure damage. The lead Executive Directors agreed to discuss this further outside the meeting.
Action – Dr Fiona Jenkins and Mrs Ruth Walker

ASSURANCE was provided by:

- The range of actions that were being taken to reduce the occurrence of pressure damage.

- The measures that were being taken to improve the quality and rate of reporting to establish a reliable baseline.

The Quality, Safety and Experience Committee:

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

QSE 18/143 CHILD PRACTICE REVIEW

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that they had been previously briefed on this case. This report provided an overview and identified the missed opportunities to identify harm and reiterated the importance of achieving the right route into the service for treatment. In this particular case, the child was seen by the right clinician but the pathway was wrong. The UHB continued to train T&O staff in safeguarding. Unfortunately, perceptions were influenced from the start in this case – the assumption that an adopted child was wanted and loved.

ASSURANCE was 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 **NOTED** this report.

QSE 18/144 OMBUDSMAN PUBLIC REPORT

The Executive Nurse Director, Mrs Ruth Walker presented the report. She was disappointed that it had been received as it demonstrated that the UHB had not recognized Ethan's issues. The UHB had to learn lessons noting that its initial investigation into the complaint did not reflect the issues taken to the Ombudsman by the family. The Ombudsman agreed that the UHB should investigate further but also issued a Section 16 report.

The UHB was reviewing arrangements for consultant decision making on waiting list issues. There was some conflict in this area between clinicians and managers but it was clear that ownership rested with clinicians in partnership with managers. The process was very important with 80,000 people on a waiting list.

ASSURANCE was 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:

- **NOTED** the report for information.
- **AGREED** to receive a further report on completion of the investigation.
  Action – Mrs Ruth Walker

QSE 18/145 SAFEGUARDING ANNUAL REPORT

The Executive Nurse Director, Mrs Ruth Walker presented the report of detailed activity and action taken and asked Committee to note the size and complexity of the agenda. Practice was changing and staff were proactively looking for patients who may have come to harm. The MASH in Cardiff supported multi agency working and had highlighted issues with some of the UHB's own staff - information that would not have been known without MASH.

ASSURANCE was 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:

- **CONSIDERED** this report.
- **AGREED** to signpost all Board Members to this report.

Action – Mrs Julia Harper and Ms Dawn Ward

QSE 18/146 CANCER PEER RE REVIEW – CANCER PATHWAY

Dr Tony Turley, representing the Medical Director, advised Committee that this report covered the cancer pathway process and action plan rather than an individual specialty. The issues identified included IT infrastructure and governance oversight in tertiary services. Details of the latter would be provided to the UHB Chair.
Action – Dr Tony Turley

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

- **NOTED** the report
- **AGREED** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.
- **NOTED** that the NHS Wales Peer Review Framework WHC 17 037 had been received and considered by the Committee.

QSE 18/147 MBRRACE – PERINATAL MORTALITY SURVEILLANCE REPORT

Dr Tony Turley, representing the Medical Director, also presented the report on the ongoing work and progress in this area. Measuring criteria had changed and therefore careful monitoring was required especially the action being taken in other Health Boards.

ASSURANCE was provided by:

- A reduction in baby loss since 2016
- The recommendations of the MBRRACE-UK report had been adhered to and measures taken
- Evidence of ongoing work within the Directorate to ensure that the reduction of stillbirth and early neonatal death remained a priority area for improvement

The Quality, Safety and Experience Committee:

- **NOTED** the contents of the report
- **APPROVED** assurance given for reduction of stillbirth and neonatal death within Cardiff and Vale UHB**.**
- **AGREED** to receive a report on mortality and morbidity in February or April 2019 as well as any maternity reports for learning.
  Action – Dr Graham Shortland

QSE 18/148 CARE OF THE DETERIORATING PATIENT – HOSPITAL AT NIGHT SERVICE

Dr Tony Turley, representing the Medical Director advised Committee that the current night cover system was not fit for purpose and gaps in the rota were a concern. Work was ongoing to identify the risks and what improvement measures could be taken with a number of avenues being explored. Further changes in the next year would also impact on the service. It was important that the proposed new model of care provided assurance on risk and safety.

LIMITED ASSURANCE was provided by:

- Control measures that were 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:

- **NOTED** the update
- **AGREED** to receive a further assurance report with timescales in February 2019.
  Action – Dr Graham Shortland

QSE 18/149 QUALITY IMPROVEMENT AND RESEARCH AND INNOVATION (STANDARD 3.3)

Dr Tony Turley presented the current self-assessment and highlighted the need to drive research and innovation as this would help attract and motivate high quality staff.

ASSURANCE was provided by:

- The current self –assessment for Health and Care Standard 3.3 as 'Meeting the Standard' (Appendix 1 of the report).

The Quality, Safety and Experience Committee **AGREED** the report.

QSE 18/150 NICE GUIDANCECANCER PEER RE REVIEW – CANCER PATHWAY (STANDARD 3.1)

Dr Tony Turley was pleased to report that this was an area of success and assurance was provided that the guidance was discussed locally and implemented.

ASSURANCE was 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:

- **NOTED** the compliance with the current process and the intention to disseminate NICE Quality Standards.
- **NOTED** the intention to circulate this report to the Clinical Boards for review at their Quality and Safety Meetings.

QSE 18/151 CARERS ANNUAL REPORT

Mrs Angela Hughes, Assistant Director Patient Experience introduced the report and commented on the transitional monies that were available with local authorities to support the Minister's objectives for carers. Work was

ongoing with young carers and schools that were embracing peer support. In addition, lots of work was being undertaken in hospital to support carers including staff who were also carers.

ASSURANCE was provided by the Annual Report.

The Quality, Safety and Experience Committee **NOTED** the report for information.

QSE 18/152 MONITORING OF PATIENTS ON THE WAITING LIST

Ms Caroline Bird, Deputy Chief Operating Officer attended the meeting to present the report in response to the CHC report "Our Lives on Hold" and concerns that had previously been received at Committee.

The report considered four areas:

1. Long waits – the long waiting times in paediatric surgery had been eradicated and were now good. Progress had been made in neuro and ophthalmology where long waiting times posed a risk of harm. By the end of the year no one would wait over 52 weeks. Only orthopaedics and spines would have a waiting time in excess of 36 weeks.
2. Monitoring patients on waiting lists – a stop gap process had been put in place and a paper review was conducted on a weekly basis.
3. Cardiac surgery – there was concern that other health boards continued to refer patients very late into the pathway. There was more work to do with these health boards.
4. Communications – information was provided when patients were first put onto the list but no further information was sent whilst patients were waiting which caused anxiety. The CHC was concerned that stress was compounded when people were unable to get a timely appointment with a GP. A national report was being produced in this respect after talking with over 1500 patients.

The UHB Chair was pleased with the successes achieved in referral to treatment time (RTT) and was satisfied with the backstop position.

ASSURANCE was 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 aimed to ensure that reporting arrangements and performance management acted as a catalyst to both improving waiting times and ensuring that appropriate clinical governance was in place.

The Quality, Safety and Experience Committee:

- **NOTED** 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.

QSE 18/153 ANNUAL VOLUNTEERS REPORT

Mrs Angela Hughes, Assistant Director Patient Experience was pleased to report that the UHB was now working with over 600 volunteers. Roles were diverse and linked to supporting the UHB's Strategy, but one area hard to fill was getting patient feedback. Mrs Michelle Fowler, Volunteers Manager was thanked for all her work and it was noted that she would soon be joined by a Young Volunteers Manager funded by the Pears Foundation.

ASSURANCE was provided by the Annual Report.

The Quality, Safety and Experience Committee:

- **NOTED** the report for information.
- **AGREED** to thank Volunteers at the next Board meeting.
  Action – Ms Dawn Ward

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

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

QSE 18/154 COMMITTEE DATES FOR 2019/20

Diary dates were noted.

QSE 18/155 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The following Minutes were received and noted.

1. **CLINICAL DIAGNOSTICS AND THERAPEUTICS – MAY, JUNE AND JULY**
   It was agreed to ask the Planning Director for an environmental update in the area of bone marrow transplant.
   Action – Mrs Abigail Harris

2. **MENTAL HEALTH – JULY**
   In hindsight, the medical input required in the Llanfair Unit had been underestimated and mental health nurses did not have the same basic training that general nurses received. Physical difficulties had been encountered when trying to move patients who had arrested. Nurses had been trained in resuscitation and an agreement had been reached

with the Ambulance Trust that 999 calls should be directed to the clinical desk for priority. In addition, the model of care provided by GPs needed review. However, no instances of harm had been recorded.

As the CHC had not been assured despite a more comprehensive service than previously provided at the Iorwerth Jones Unit, it was agreed that Mr Allen and Mrs Walker would discuss further outside the meeting.
Action – Mrs Ruth Walker and Mr Stephen Allen

3. **PRIMARY, COMMUNITY AND INTERMEDIATE CARE - MAY**

4. **SPECIALIST SERVICES – APRIL, MAY, JUNE x 2 AND JULY**

5. **MEDICINE – MAY AND JUNE**

6. **SURGERY – MAY**

7. **CHILDREN AND WOMEN – MAY**

8. **DENTAL – JUNE**

QSE 18/156 AGENDA FOR THE PRIVATE QSE MEETING

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

QSE 18/157 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

There following would be brought to the attention of the Board:

- Signpost all Board Members to the Annual Safeguarding Report contained in the meeting papers.
- Volunteers to be acknowledged and thanked at the Board meeting.

QSE 18/158 REVIEW OF THE MEETING

It was noted that much of the meeting had been operational so consideration would be given to more strategic assurance reports.

QSE 18/159 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 16th October 2018 (Annual Special Meeting).

ACTION LOG FOLLOWING QSE COMMITTEE SEPTEMBER 2018 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 18/087 QSE 18/126	12.6.18 18.9.18	CD&T QSE Report		Discuss digitalization of medical records with the ITG Sub Committee Chair to ensure no duplication.	M Battle	Meeting set up for 31st October 2018.
QSE 18/088 QSE 18/126	12.6.18 18.9.18	CHC Reports Scrutiny Overview		"Unable to take personal responsibility" to be discussed with END.	S Allen, CHC	A meeting would be set up.
QSE 18/128	18.9.18	Medicine CB QSE Assurance Report		Support CB to get their patient/relative story digitalized and shared. Provide Chair with a briefing on the possibility of weekly pay to Bank staff to share with Minister.	A Hughes R Walker	
QSE 18/138.1	18.9.18	INNU Policy		Provide CHC with links to information on website.	F Kinghorn	
SE 18/138	18.9.18	Cleaning Standards		Share staff stories with Rachel Gidman to link with values/behaviours work.	L Wyatt	
QSE 18/139	18.9.18	Blood Products		Refer/discuss computer system concerns with Chief Executive.	M Battle	
QSE 18/141	18.9.18	Medical Devices/Equipment		Discuss issue of corporate responsibility - system, process and resource	Dr F Jenkins / S Curry	

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 18/142	18.9.18	Pressure Damage		Discuss responsibility for implementation of foot assessment tool.	Dr F Jenkins / R Walker	
QSE 18/144	18.9.18	Ombudsman Public Report		Present update on completion of further investigation.	R Walker	**QSE -** anticipated date
QSE 18/146	18.9.18	Cancer Peer Review – Cancer Pathway		Brief Chair on issues raised: IT infrastructure and governance oversight in tertiary services.	Dr T Turley / Dr G Shortland	
QSE 18/155.1	18.9.18	CD&T Minutes		Obtain environmental update re BMT for Committee	A Harris	
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
QSE 18/133	18.9.18	CRAF		Present new BAF format to Board.	N Foreman	**Board November 2018**
QSE 18/102	12.6.18	Ophthalmology Presentation		Update to come to QSE in Autumn.	S Curry	**QSE December 2018**
QSE 18/104	12.6.18	Sensory Loss		Update in 6 months' time.	S Curry	**December 2018 QSE**
QSE 18/148	18.9.18	Care of Deteriorating Patient/Hospital at Night		Further assurance report with timescales to be presented to QSE.	Dr G Shortland	**QSE February 2019**
QSE 18/146	18.9.18	MBRRACE Perinatal Mortality Surveillance		Provide QSE with report on maternal mortality/morbidity and other maternity reports for	Dr G Shorland	**QSE February or April 2019**

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				learning.		
QSE 18/053	17.4.18	Quality Safety & Improvement Framework		Receive detailed outcome based report.	C Evans	**QSE June 2019**
COMPLETED ACTION SINCE LAST MEETING						
QSE 18/145	18.9.18	Safeguarding Annual Report		Signpost Board to this report. Highlight report at Board.	J Harper D Ward	**Complete 20.9.18** **Complete 27.9.18**
QSE 18/138.2	18.9.18	Incident Reporting Policy & Procedure		Publish Policy & Procedure	J Harper	Published. **Complete 20.9.18**
QSE 18/153	18.9.18	Annual Volunteers Report.		Thank Volunteers at next Board meeting.	D Ward	**Completed at Board 27th September**
QSE 18/155.2	18.9.18	Mental Health Minutes		Provide assurance to CHC re medical cover at Llanfair.	R Walker / S Allen	Discussed on telephone and considered resolved as CHC will be engaged in further discussions. **Complete**
QSE 18/138.1	18.9.18	INNU Policy		Publish Policy	J Harper	Published. **Complete 20.9.18**

AN ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS OCTOBER 2017 – SEPTEMBER 2018
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 16th October 2018

Executive Lead : Executive Nurse Director
Author : Head of Patient Safety and Quality, Telephone 02920 74 6387
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact : There are significant potential financial implications associated with this work in relation to clinical negligence claims.
Quality, Safety, Patient Experience impact : The work outlined within this paper 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 and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The level of scrutiny applied internally and externally to the Serious Incident reporting process. Serious Incidents are reported and investigated within the required process. Furthermore, closure of SIs with Welsh Government (WG) is monitored at the Executive and Clinical Board performance reviews and by WG. Periodically, Internal Audit undertake related assurance reviews. The Delivery Unit also applies scrutiny to Never Event processes by exception.

The Quality, Safety and Experience Committee is asked to:

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

SITUATION

The purpose of this report is to present the Committee with an analysis of the themes and trends in Serious Incidents (SI) reported to Welsh Government between October 2017 and September 2018.

BACKGROUND

Welsh Government (WG) guidance on Serious Incident (SI) reporting and investigation procedures was updated in November 2013. It forms part of the Putting Things Right guidance which underpins the NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011.

The guidance stipulates that WG should be notified of an SI through the agreed electronic process within 24 hours of the incident occurring where possible. WG then reviews the incident and allocates a 60 working day timeframe for investigation of the incident.

The UHB has a process in place for the management of SIs and this is now well embedded, with a high level of ownership across Clinical Boards.

At the conclusion of the investigation, organisations are required to submit a closure form which summarises the findings, recommendations and learning from the investigation of the incident. The UHB continues to be praised by WG on the quality of the closure forms submitted as they demonstrate that a thorough investigation has been undertaken, root causes identified and solutions put in place to try and prevent similar incidents in the same set of circumstances.

ASSESSMENT AND ASSURANCE

The UHB continues to monitor progress with the WG SI closure report process. At the time of writing this report, the UHB has 94 SIs open with WG. Timely closure of SIs with WG continues to be a priority for the UHB. In September 2017, the UHB achieved 60% of SIs being closed within the prescribed timeframe. This is currently at 51% in September 2018 but it should be noted that the level of SIs reported this year has increased from 220 to 290 which has impacted on the closure process. Given the level of complexity of some investigations, conclusion within 60 working days can be problematic. WG currently requires 90% of SIs to meet their 60 working day target.

A detailed review of the themes and trends of SIs is attached as Appendix 1.

In summary, 290 Serious Incidents were reported to WG between 1st October 2017 and 30th September 2018. 8 of these incidents were classified as Never Events.

To compare, 220 Serious Incidents were reported to WG in the previous report to Committee for October 2016 – September 2017. Five of those incidents were also classified as Never Events. Therefore, there is an increase in the number of SIs and Never Events reported to WG. The increase in SIs is mainly due to an increase in the reporting of pressure damage in response to feedback from WG that the UHB was under-reporting when compared with peers across Wales.

The electronic incident reporting software purchased from Datix and implemented in 2015 is now well embedded in the UHB. Revisions to the system, continued provision of a helpdesk, user support groups and a regularly updated intranet site assisted the transition to an electronic system. A revised Incident Reporting Policy and new supporting procedures have been agreed at the Quality, Safety and Experience Committee in September 2018.

The UHB continues to upload patient safety incidents to the National Reporting and Learning System (NRLS). This is generally undertaken on a weekly basis. Timely management of incidents in line managers queues are reviewed as part of the monthly Executive and Clinical Board performance review procedures.

An important safety net and key benefit of the electronic incident reporting software is that it allows the establishment of various trigger mechanisms to assist earlier central knowledge and escalation of concerns.

Where appropriate, actions have been implemented to address arising clinical risk in response to individual incidents. Following investigation, it is recognised that focused attention is required on particular areas to address the root causes and ensure shared learning across the UHB, in particular relation to:

- Never Events
- Unstageable, Grade 3 and 4 healthcare acquired pressure ulcers
- Patient accidents/.falls
- Behaviour and Unexpected death or severe harm incidents particularly in the Mental Health setting
- Diagnostic processes/procedures
- Healthcare Acquired Infections
- IR(ME)R breaches due to patient misidentification

[Appendix 1]

AN ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS OCTOBER 2017 – SEPTEMBER 2018

Introduction

This report presents an analysis of trends and themes related to SIs reported to WG during the period October 2017 – September 2018. Detail of the individual incidents has previously been reported at each Board meeting.

Background

An SI is defined as an incident that occurred in relation to NHS funded services and care resulting in:

- The unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Permanent harm to one or more patients, staff, visitors or members of the public where the outcome requires life-saving intervention or major medical/surgical intervention or will shorten life expectancy;
- A scenario that threatens or prevents an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- A person suffering from abuse;
- Adverse media coverage or public concern for the organisation or the wider NHS;
- Never Events.

All SIs are currently investigated using Root Cause Analysis (RCA) methodology. There is a very well embedded process for the management of SIs which ensures a robust and consistent approach across the UHB regardless of the Clinical Board or nature of the incident. RCA training continues to be delivered to support identified staff in their role as investigating officers. There is an excellent in-house training session delivered by the UHB's Head of Patient Safety and this is very well evaluated. The UHB has been approached by other NHS Wales organisations to support their RCA training requirements.

In recognition of the need to assist staff with identifying suitable recommendations and compiling appropriate action plans post investigation, a series of workshops on action planning were implemented in autumn 2017. The workshops have continued in 2018 having been well attended and evaluated.

A weekly Executive Serious Concerns meeting continues to be held, led by the Executive Nurse Director, which reviews Serious Incidents and Concerns on a weekly basis as they are reported and seeks to gain early assurance on lessons learned from Clinical Boards by reviewing investigation reports and

implementation of action plans. The weekly meetings are also attended by the Medical Director, Assistant Medical Director for Patient Safety and Quality alongside representatives from Patient Safety and Quality and Concerns Departments. Clinical Boards will periodically attend the meeting to review the position in their area.

This weekly meeting process is considered to be good practice. The UHB has regular requests for senior staff to attend as observers from other NHS Wales organisations.

Number of Serious Incidents reported to WG and overview of Never Events reported in this reporting period

The table below demonstrates the number of SIs and Never Events reported to WG between October 2015 and September 2018:

Serious Incidents reported to WG	Number of incidents	Number of Never Events
October 2015 – September 2016	207	5
October 2016 – September 2017	220	5
October 2017 – September 2018	290	8

It is evident that the number of SIs reported has increased. This is largely in response to continued improved reporting of healthcare acquired pressure ulcers. The UHB now includes grade 3, grade 4 and unstageable pressure ulcers for inclusion in SI reporting and is working with Primary Care and Intermediate Care Clinical Board (PCIC) to promote SI reporting of appropriate pressure ulcers occurring in the community. This will be explored in greater detail later in this report. It should also be noted that general incident reporting rates are increasing, demonstrating that staff know how to report incidents and that a good reporting culture exists in the UHB.

The number of Never Events has increased in this reporting period and these incidents will be explored in further detail.

Never Events

The five Never Events reported between October 2015 – September 2016 were:

- A retained swab in an adult patient following major trauma surgery
- A retained throat swab in an adult patient following a surgical procedure
- Two wrong tooth extraction incidents
- A child received enteral nutrition via a misplaced nasogastric tube

The five Never Events reported between October 2016 – September 2017 were:

- An incorrect site procedure in Orthopedic surgery
- A wrong tooth extraction incident
- Wrong route administration of medication (oral medication administered intravenously)
- A retained guidewire following urgent central line insertion
- A retained swab following a forceps delivery

The eight Never Events reported between October 2017 – September 2018 were:

- An ABO compatible blood transfusion was administered to an incorrect patient. Fortunately, the intended and unintended patient were both blood group A and so no significant harm occurred. The UHB recognised the serious nature of the incident and reported it to WG who wished to classify it as a Never Event although the definition relates to ABO incompatible blood transfusions.
- A wrong tooth extraction incident
- Two incidents of wrong teeth selected for root canal treatment
- An incorrect site procedure in Trauma and Orthopaedic surgery
- Overdose of methotrexate for non-cancer treatment. A prescription error occurred which the UHB reported to WG although the UHB does not have electronic prescribing in place, as per the Never Event definition.
- A retained guidewire following central line insertion
- A wrong implant inserted in Ophthalmology

Although all of these incidents are very regrettable, none of the patients were seriously harmed, although one of the incidents is under investigation as a recently reported incident and impact to the patient needs to be confirmed.

The key areas of focus therefore, are to reduce the risk of incorrect site procedures, particularly in the Dental setting, avoidance of retained foreign objects post procedure and incorrect site procedures.

All Never Events were subject to review and close scrutiny by the Delivery Unit (DU). Their scrutiny was welcomed by the UHB since it ensured that the internal investigation procedures were rigorous and provided an additional opportunity for shared learning in NHS Wales. However, from April 2018 it has been determined that the DU will be asked to work with organisations on SIs and Never Events on an exception basis should problems with assurance of learning occur or in order to maximize opportunities for system wide learning.

Although each Never Event is unique, there are some common arising themes in the incidents reported by the UHB, including:

- Failure of staff to follow established processes and policies, particularly related to dissemination of policies or education required by staff to ensure policy implementation
- Communication of key information between staff
- Impact of distractions within clinical environments
- Requirement for increased vigilance with the WHO Surgical Safety Checklist
- Value of strong clinical leadership and impact of culture on safety

The Dental Clinical Board have undertaken a significant amount of work to address wrong site procedures. This includes:

- A review of the Dental Never Events to date in order to determine themes and trends which identified:-
    - Several incidents involve dental students as well as qualified dentists
    - Clarity of the role of clinical supervisor in the incidents involving dental students was not rigorous
    - Poor dentition or unusual anatomy within the patient's mouth has been a contributory factor
    - Changes to treatment plans or clinic lists has been a factor
    - Communication factors including between students and supervisors; dentist to dental nurse and inclusion of the whole team in pre-clinic safety briefings needs strengthening

- Actions already undertaken and planned include:-
    - A Clinical Lead for Oral Maxillofacial Surgery Department has been in post since October 2016
    - 5 Whole Time Equivalent dental nurses were recruited in September 2016 to increase establishment
    - The WHO surgical safety checklist is now used in the oral maxillofacial surgery department
    - A flow chart to support standardised practice in dental extraction has been developed
    - The Dental Clinical Board has engaged with the UHB's National Safety Standards for Invasive Procedures (NatSSIPs) group
    - The Clinical Board Director has attended all Dental audit groups, Community Dental Services (CDS) locality meetings and quality and safety meetings across both the University Dental Hospital and CDS to talk to staff about Never Events
    - Benchmarking visits to other centres in the UK to compare best practice have been undertaken
    - A standard operating procedure to standardise supervision in teaching environments in the Dental Clinical Board is in development
    - Procedures to support NatSSIPs implementation are in development, including formalising the second person check process
    - A working group has been established to develop standard operating procedures for restorative dental procedures

- The Clinical Board has benchmarked data across 8 other UK centres. It is acknowledged that in the timeframe reviewed, there were more dental Never Events in Cardiff than the other centres, with a range of 0 to 5 incidents in the other centres and 6 in Cardiff. Lessons learnt from all of the centres were comparable.

Avoidance of Never Events including retained foreign objects post procedure, wrong site procedures and wrong implant incidents are integral components of NatSSIPs.

The UHB has seen 2 incidents of a retained guide wire following central line insertion in the Specialist Services Clinical Board. One central line was inserted in an emergency; the second incident is newly reported and remains under investigation but the doctor reports distraction at the end of the procedure. These are commonly reported influences from a human factors perspective. Insertion of central lines is a very common procedure and the number of associated adverse events in the UHB is very low. There will be reconsideration of the use of a technical solution to avoid this Never Event, although it presents a financial pressure.

Investigation of a wrong site procedure (screw inserted to incorrect side) in a trauma patient has unearthed unique circumstances particular to the clinical condition of the patient which contributed to confused laterality identification that day. Additionally, the surgery was undertaken at the time of extreme weather conditions which altered staffing arrangements and posed challenges from a human factors perspective.

The wrong implant incident in Ophthalmology is recently reported and is under investigation so conclusions cannot yet be drawn.

A theme arising in Never Event investigations relates to education and competence assessment. There is often reliance on paper records and inconsistent methods in storing information about staff competence at a local level. Recent discussion at the Nursing and Midwifery Board (NMB) highlighted that Clinical Boards are reviewing core clinical competencies required by staff. The Learning, Education and Development Department advised NMB that a competence assessment module has been sourced for the Electronic Staff Record. It is anticipated that the revised competencies and additional module will assist with improved governance in this area. It must also be reinforced to staff that they have professional responsibilities to ensure they are appropriately trained and competent in the tasks they undertake.

Investigations after adverse events clearly demonstrate where Human Factors have significantly contributed to the incidents. The Patient Safety and Quality Department considers that it is imperative to take forwards a programme focussed on behavioural Human Factors and non-technical skills within the UHB. Other safety-critical industries are much further into the journey of understanding how cognition, decision-making, situation awareness, personality, team-working, leadership, communication skills, stress and fatigue impact on the care and treatment we provide to patients. Advanced clinical skills do not remove our human vulnerability. Improving our

understanding of non-technical skills can enhance our clinical skills and improve patient safety. Staff who undertake the Leading Improvements in Patient Safety programme gain an introduction to Human Factors which is positively received. It is appropriate for the UHB to consider options for implementing a specific Human Factors programme as part of the Quality, Safety and Improvement framework.

Feedback from WG in June 2018, relating to October 2017 – March 2018, indicated that 15 Never Events were reported across NHS Wales in that timeframe; 4 were reported by the UHB. Most of the incidents were surgical in nature.

All Wales Never Events October 2017 – March 2018	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Wrong route administration of medication	0	0	0	0	1	1
Transfusion or transplantation of ABO-incompatible blood components or organs	1	0	0	0	0	0
Retained foreign object post-procedure	1	0	0	0	1	2
Wrong implant/prosthesis	0	1	1	1	1	0
Wrong site surgery	0	1	1	0	0	2
Total	2	2	2	1	3	5

WG noted that the quality of investigations in the UHB remains high with senior clinical engagement and Executive oversight to the process. They were pleased to see Clinical Boards taking responsibility for agreeing and sign off of action plans as good practice. They reinforced the need to implement action plans in a timely manner and to share learning from these adverse events.

Categories of Serious Incidents reported to WG

The following table provides a breakdown of the category of SIs reported to Welsh Government between October 2015 – September 2018 by year.

October 2015 – September 2018 Incident Tier 1 type	Total Oct 2015 – Sept 2016	Total Oct 2016 – Sept 2017	Total Oct 2017 – Sept 2017	Trend
Administrative Processes (Excluding Documentation)	3	19	6	↓
Anaesthesia Care	3	3	1	↓
Behaviour (self-harming behaviours to self or others)	34	32	32	↔

Blood/Plasma Products	2	-	1	↓
Communication	-	1	-	↓
Diagnostic Processes/Procedures	17	18	16	↓
Documentation	-	2	-	↓
Infection Control Incident (Healthcare Associated Infection)	12	12	4	↓
Injury of unknown origin	2	-	-	↓
Maternity Care	1	2	1	↓
Medical Devices, Equipment, Supplies	1	3	-	↓
Medication/Biologics/Fluids	4	4	7	↑
Neonatal / Perinatal Care	-	2	2	↔
Patient Accidents/Falls	74	50	56	↑
Personal Property/Data/Information	2	-	-	↓
Pressure Ulcers	13	30	131	↑
Security of Organisation's Property, Data and Buildings	1	2	-	↓
Service Disruptions (environment, infrastructure, human resources)	-	1	2	↑
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	18	28	12	↓
Unexpected Deaths or Severe Harm	20	6	19	↑
Total	207	220	290	

Across the UHB in October 2017 – September 2018, the five following broad categories were the most frequently reported in SIs:

- Pressure ulcers
- Patient accidents/falls
- Behaviour
- Unexpected death or severe harm
- Diagnostic processes/procedures

These will be reviewed in turn.

Pressure Ulcers

WG requires healthcare acquired pressure ulcers that are unstageable, grade 3 or grade 4 to be reported as SIs. The UHB has significantly increased the number of such SIs reported to WG in 2017-18 by complying with the requirement to report unstageable pressure ulcers.

Community acquired pressure ulcers were frequently reported on the incident reporting system but clarification as to the grade of the pressure ulcer and other information required to facilitate SI reporting was not consistently in place. This led to low levels of SI reporting of pressure ulcers from PCIC

Clinical Board. This has been addressed in 2018 with a toolkit to support staff and education as part of the toolkit launch. The UHB is beginning to report the relevant incidents to WG.

The table below demonstrates the pressure ulcer incidents reported to WG by Clinical Board.

Healthcare Acquired Pressure Ulcers Unstageable, Grade 3 and Grade 4 reported as SIs	Total Oct 2016 – Sept 2017	Total Oct 2017 – Sept 2018
Children and Women's Services	0	2
Medicine Services	10	67
Mental Health Services	1	2
Primary Care and Intermediate Care	-	19
Specialist Services	4	20
Surgical Services	15	21
Total	30	131

The Director of Nursing for Surgery Clinical Board leads a pressure damage group and this has continued to meet during 2018. Excellent work has progressed including roll out of upgraded beds and pressure relieving mattresses to inpatient areas. A pressure ulcer prevalence audit undertaken in January 2018 and presented to the group in April 2018 showed an encouraging picture of pressure ulcer prevalence; suitable support surfaces in use and improving accuracy of pressure ulcer grading by staff.

The Tissue Viability Nurses (TVN) and Patient Safety Team actively contribute to a Pressure Ulcer Recording Workstream established by NWIS at WG's request in order to streamline how pressure ulcers are recorded as incidents across NHS Wales. It is anticipated that there will be changes to reporting mechanisms to WG in relation to pressure ulcers as a result of this work. A revised investigation toolkit has also been developed by the All Wales TVN group and will be launched as part of the reviewed WG reporting procedures.

A local process mapping workshop took place in order to troubleshoot the common problems experienced with pressure ulcer prevention, identification and management which supplements the workstreams already described.

Pressure ulcer incidents are included in key performance indicators for Clinical Boards to ensure there is appropriate scrutiny in place.

Patient Accidents/Falls

The following table demonstrates the number of SIs related to falls by Clinical Board. (NB – these figures are presented between October to September).

SIs relating to falls by Clinical Board	Total Oct 2015 – Sept 2016	Total Oct 2016 – Sept 2017	Total Oct 2017 – Sept 2018
Children and Women's Services	3	1	-
Medicine Services	32	27	38
Mental Health Services	19	10	6
Specialist Services	6	3	3
Surgical Services	11	9	7
Total	71	50	54

There has been a slight increase in falls related SIs since the previous report to Committee. Medicine Clinical Board continues to report the highest number of injurious falls. Mental Health Services have achieved a further reduction in their injurious falls over the last 12 months.

The prevention and management of falls is a high priority for the organisation and a number of initiatives are underway to continue this trajectory of improvement:

- A Falls Delivery Group continues to meet. In addition to health, partner organisations including Housing, Fire and Rescue, Welsh Ambulance and Care and Repair contribute to the Group.
- A Falls Strategy Implementation Lead has been recruited. This provides an opportunity for the UHB to review the falls related strategy to strengthen the UHB's compliance with the Welsh Health Circular (WHC (2016) 022) *Principles, Framework and National Indicators: Adult In-Patient Falls.* A strategy is in development.
- The UHB was shortlisted at the Health Service Journal Patient Safety Awards in the 'Patient safety in the community' category for the Community Resource Team's strength and balance programmes for reducing the risk of falls.
- A pilot session to provide intergenerational falls awareness sessions was completed in the summer of 2018 and a programme of sessions will be held across schools in autumn 2018.
- An increase of SIs related to patient falls in Medicine Clinical Board is evident. The Clinical Board is participating in a Leading Improvements in Patient Safety (LIPS) improvement project which has developed a falls simulation education package. A pilot has been undertaken and presented to the LIPS celebration event and Clinical Senate meeting in September 2018.

Tragically, in the last report to Committee there were three SIs related to patient falls where patients died following the incident. This year there has been one such incident.

This incident was reported by Medicine Clinical Board. An acutely unwell patient presented to University Hospital Llandough and sustained a fall during which a head injury occurred. The Coroner concluded that the patient's death

was accidental. The Coroner wrote to the UHB to query a matter raised during the inquest regarding communication and documentation of Do Not Attempt Resuscitation decisions. The lessons learnt from the internal investigation related to staff education regarding falls in clinical areas where this is not a regularly reported incident; ensuring walking aids are left within reach of patients deemed safe to use them independently; prolonged use of curtains to preserve privacy and dignity should be based on patient request and following risk assessment and appropriate use of lighting at night must be in use.

Behaviour and Unexpected Death/Severe Harm

There were 51 SIs reported in this timeframe where the high level category was 'behaviour' or Unexpected Death/Severe Harm. A range of incidents are included within these categories, but largely comprise:

- Patients who have sustained significant injury following self-harm, but not necessarily died as a result
- Patients who have died by suicide in community or prison settings
- Patients who have died related to substance misuse in community settings
- Patients who have unexpectedly died where the circumstances are unclear until the inquest process concludes

Such incidents are subject to internal investigation and often to HM Coroner's inquest processes. No Regulation 28 Prevention of Future Deaths Reports have been issued to the UHB as a result of these incidents in the reporting period.

Any deaths that occur in custody will also be subject to investigation by the Prison and Probation Ombudsman. No such death has been reported by Primary, Community and Intermediate Care Clinical Board in this timeframe.

In summary, the incidents in this reporting timeframe can be summarised as follows:

- Children and Women Clinical Board – an unexpected death of a child was reported; the child was transferred to the Children's Hospital for Wales from outside the area with a critical illness but their death at that time had not been expected.
- There were 7 incidents whereby the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) process was initiated. In 6 of the cases, there were physical illnesses that had caused the tragic deaths of the children. In one case, the Coroner concluded that the teenager had died by suicide. The patient had been referred to Child and Adolescent Mental Health Services and the UHB is awaiting the outcome of their investigation process having concluded in the UHB's internal investigation that care was appropriate.
- One incident was reported by Specialist Services Clinical Board whereby a patient took an overdose of prescribed medication be brought in to hospital from home. The investigation report has recently

concluded and an action plan is to be developed. The Coroner's inquest has not yet been held.

- The majority of the SIs in these categories were reported by Mental Health Clinical Board with 42 such incidents. They can be summarised as follows:-
    - 1 inpatient suicide
    - 1 inpatient attempted suicide
    - 4 incidents where patients have self harmed but not sustained longstanding physical harm as a result
    - 5 of the incidents have so far been concluded by the Coroner to be death by suicide
    - 2 deaths occurred where self harm was evident but the Coroner could not determine the person's intention
    - There were 17 deaths of patients known to substance misuse services where the Coroner concluded that alcohol or substance misuse was a factor in their death
    - There are 9 patient deaths where the inquest has not yet been held so conclusions cannot be drawn as the circumstances are not fully clear

The trend is very similar to the previous year.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) produces an annual report where data from the four UK countries is analysed. Their next annual report is expected to be published in October 2018. Key points previously raised for action in clinical practice from NCISH include:

- Ensure appropriate use of crisis and home treatment teams as they are unlikely to be suitable for patients at high risk of suicide or those who live alone
- People discharged from hospital services should be followed up within 2 – 3 days of their discharge
- There should be access to specialist services for people with alcohol and substance misuse problems
- There should be restricted access to suicide methods for example, limit access to opiate analgesics
- There should be development in expertise for new groups of people at risk including those with socio-economic problems; isolated people; recent immigrant population
- Liaison psychiatry services should be available 24 hours for those at risk of self-harm

Findings from investigations undertaken in Mental Health Clinical Board are consistent with key points identified by NCISH.

The Lead Nurse in Adult Mental Health has recently completed a Master's degree and focused on prevention of suicide in men under the care of adult mental health crisis services for her dissertation. The intention is to take

forward the learning from her dissertation and to implement it in clinical practice where appropriate.

The Patient Safety Team are working with Mental Health Clinical Board and the Commissioning Officer – Systems and Information in order to ensure a streamlined approach to reporting and investigation of incidents via the Fatal Drug Poisoning process. This forms part of the Welsh Government Substance Misuse Strategy.

NHS Resolution in NHS England launched a report 'Learning from suicide-related claims' on World Suicide Prevention Day on 10th September 2018 which can be accessed here. Five key areas were identified in the report including:-

- Support available for those with active substance misuse
- Risk assessment
- Observation process
- Communication spanning a range of environments
- Care provided to those in prison

This report has been shared with Mental Health Clinical Board for consideration in their Lessons Learnt process.

A more detailed report on unexpected deaths in patients known to mental health services will be presented to the December 2018 QSE Committee.

Diagnostic Processes/Procedures

There were 16 incidents reported under the category of Diagnostic Processes/Procedures. This is a high level category with sub-categories such as laboratory investigation issues, monitoring of patient status concerns, radiological/imaging problems and unplanned elevation of care to intensive care settings.

The incidents reported can be summarised as follows:

- Clinical Diagnostics and Therapeutics Clinical Board reported a breach in the consent process in cellular pathology which was reported onward to the Human Tissue Authority.
- Medicine Clinical Board reported 5 incidents of delayed procedures in patients waiting for care under the Gastroenterology service. This has been an ongoing concern since May 2015 with a total of 25 incidents reported; no new incidents have been reported since June 2018. An overarching action plan is in place and this is regularly reviewed within the directorate's quality and safety mechanisms. The directorate reports that there is encouraging progress with the action plan and waiting times that patients have experienced.
- Medicine Clinical Board also reported one incident where they were concerned about the recognition of sepsis in a young man. The Clinical Board is engaged in the sepsis group, led by Dr Paul Morgan, Consultant Intensivist and Gemma Ellis, Consultant Nurse. The UHB

participated in a recent event on World Sepsis Day. More information can be found here.

- 4 incidents were reported under the PRUDiC process where children were transferred to hospital for emergency care and had unplanned admissions to critical care areas. These are reported to WG in the interests of openness and transparency. They are investigated through morbidity and mortality procedures in the first instance in case any learning can be identified.
- Two incidents were reported by PCIC Clinical Board. One incident involved the emergency transfer of a person from HM Prison Cardiff to an intensive care setting where the patient sadly died from a cardiac problem. An incident was also reported where there was concern regarding triage and prioritisation of a call made to the Out of Hours service. Telephone triage training and an audit process regarding telephone triage has been implemented to strengthen the process.
- Specialist Services Clinical Board reported 3 incidents in this category. There were 2 incidents involving timely booking or repeat of clinical examinations. These incidents are both under investigation. The third incident involved timely review of a patient following an abnormal electrocardiogram (ECG). The potential for learning from these incidents in particular across the UHB is noted and the Patient Safety Team will work with the Clinical Board to conclude the investigations and share the learning where appropriate.

Trends to monitor

As previously indicated there are two other categories of SIs to draw attention to:

- Healthcare Associated Infections
- Ionising Radiation (Medical Exposure) Regulation breaches

Healthcare Associated Infections (HCAI)

Certain incidents involving HCAI must be reported to WG as SIs. These include:

- Any death where a healthcare associated infection (including *Clostridium difficile* and methicillin resistant *Staphylococcus aureus)* is mentioned on the death certificate as either the underlying cause of death or contributory factor
- An outbreak of a healthcare associated infection in a hospital that results in the closure of a ward/bay to admissions and causes signification disruption. closure of a bay which does not cause significant disruption to service should be reported as a No Surprise
- Transmission of infectious diseases

The table below indicates that 4 HCAI SIs were reported to WG in the reporting timeframe representing a significant reduction.

Infection Control Incident (Healthcare Associated Infection)	Total Oct 2015 – Sept 2016	Total Oct 2016 – Sept 2017	Total Oct 2016 – Sept 2017
Children and Women's Services	2	0	0
Medicine Services	3	4	0
Mental Health Services	0	0	1
Specialist Services	3	6	2
Surgical Services	4	2	1
Total	12	12	4

The incidents included presence of *Vancomycin Resistant Enterococcus* and *Pneumocystis jirovecii pneumonia* in Specialist Services Clinical Board; a patient with *Tuberculosis* known to Mental Health Clinical Board and a Surgical Services Clinical Board patient who had *Clostridium difficile* infection recorded on part 2 of their death certificate. All appropriate actions, in line with the IP&C Outbreak Policy were implemented in these cases.

It is evident from the SIs reported that the UHB must continue to strive to improve performance relating to HCAI. Individual staff must ensure the strictest adherence to standard IP&C best practice to underpin the strategic overarching actions underway. This is monitored via the Infection Prevention and Control Group which is chaired by the Executive Nurse Director. Key performance indicators for Clinical Boards in relation to this agenda are also monitored monthly with the Executive team.

Ionising Radiation (Medical Exposure) Regulation Breach Incidents

Prior to February 2017 NHS Wales organisations were required to report breaches of the IR(ME)Regulations to WG and Healthcare Inspectorate Wales. This was revised in February 2017 to sole reporting to HIW unless there was a particular need to also report the matter to WG as an SI in its own right. IR(ME)R breach incidents are subject to the same scrutiny internally and via HIW following this change in practice.

There have been four incidents reported to HIW in this reporting timeframe which is a significant reduction on the previous year where 8 were reported. The issues identified include:

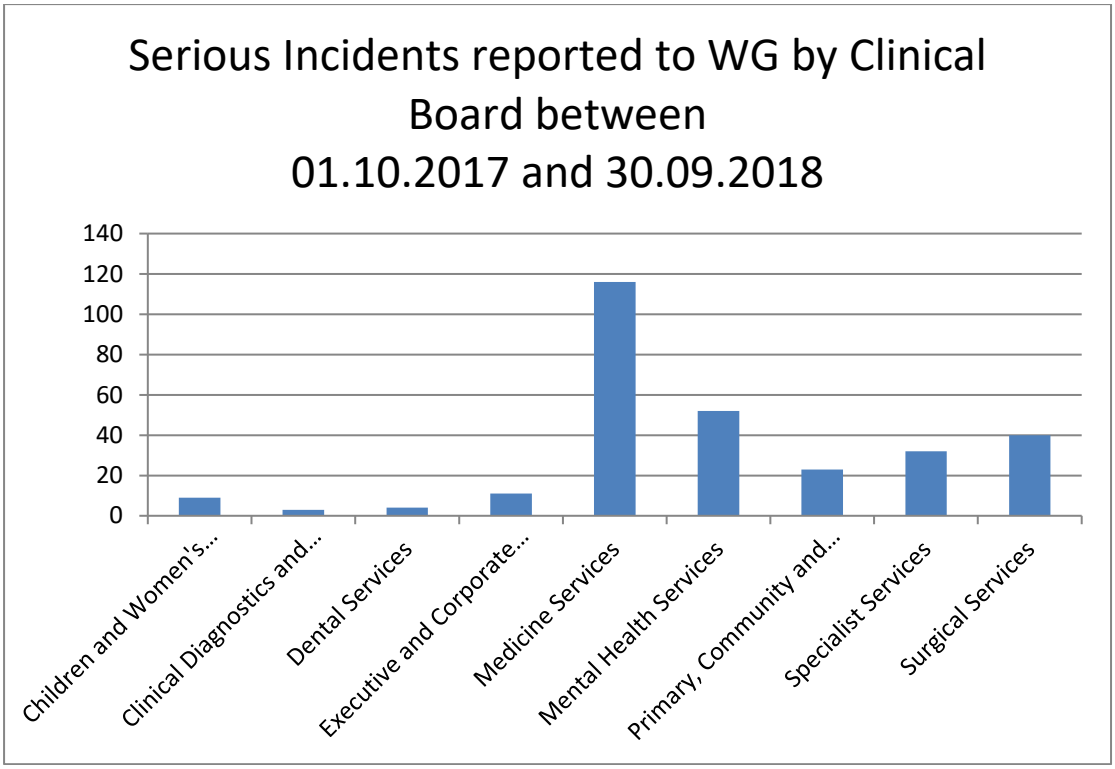
- The importance of positive patient identification
- Hazards associated with handwritten request forms
- Hazards associated with repeat examinations
- The need for radiologists to explicitly identify the correct imaging protocol as part of the justification procedure
- The potential for patients to confirm incorrect body areas are to imaged

The Patient Safety Team is progressing implementation of printing solutions for electronic wristbands for inpatients. The upgraded system has been

installed in Barry Hospital, St David's Hospital, UHL, Dental Hospital and the Children's Hospital for Wales in September 2018. The UHW site is now going live in October 2018 and the upgraded system is being positively received.

Investigations demonstrate that electronic requesting and vetting procedures would be beneficial. This is being explored by NWIS and Fuji.

Serious Incidents by Clinical Board



Trends across Clinical Boards remain largely the same with Medicine and Mental Health reporting the greatest number of SIs. This is due to volume of patient falls and pressure ulcers in Medicine and the numbers of deaths of patients known to mental health services. There has been an increase in the number of SIs reported by PCIC Clinical Board this year and this is due largely to an improvement in compliance with WG requirements for the reporting of pressure damage.

Closure of Serious Incidents with Welsh Government

The UHB is required to submit a closure form to Welsh Government on conclusion of a Serious Incident investigation process. This provides assurance on the measures that have been taken to avoid a similar incident in a similar set of circumstances. Closure forms are subject to review within Clinical Boards quality and safety mechanisms, prior to sign off by the Executive Nurse Director or Assistant Director of Patient Safety and Quality.

A trajectory to improve the position of closure form submission to WG was established with the Clinical Boards in April 2016. This has been subject to performance monitoring arrangements and is regularly reviewed to ensure the status of open SIs does not deteriorate. This has been very effective in securing a marked improvement and the UHB has continued to make considerable progress over the last 12 months. At the time of writing this report, the UHB has 94 SIs open with WG. In this reporting timeframe, 275 closure forms were submitted to WG.

CONCERNS AND CLINICAL NEGLIGENCE CLAIMS REPORT – SEPTEMBER 2016 – SEPTEMBER 2018
Name of Meeting: Quality, Safety and Experience **Date of Meeting:** 16th October 2018

Executive Lead: Executive Nurse Director
Author: Assistant Director Patient Experience - 029 2184 6108
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact: There are significant potential financial implications associated with this work in relation to clinical negligence claims.
Quality, Safety, Patient Experience impact: The work outlined within this paper reflects the significant activity taking place to improve patient safety and experience through the learning from complaints and claims - leading to improved quality and care outcomes for patients.
Health and Care Standard Number 2.1, 2.2, 2.3, 2.4, 2.6, 3.1, 3.3, 6.3
CRAF Reference Number 5.1, 5.1.5, 5.6, 5.7
Equality and Health Impact Assessment Completed: Not Applicable.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current position on all key indicators relating to concerns and to clinical negligence claims.
- Substantial assurance awarded for the most recent internal audit assessment of clinical negligence claims in 2017 and for Management of Ombudsman cases in 2018.
- Evidence of the action being taken to address key outcomes that are not meeting the standards required.
- A culture of openness and transparency within the UHB to examine all available sources of information to provide assurance on the quality, safety and experience of services.

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the content of this report.
- **NOTE** the areas of current concern and **AGREE** that the current actions being taken are sufficient.

SITUATION

The purpose of this paper is to present the Committee with a more detailed report of concerns and clinical negligence claims in the period 1st April 2018 to 30th September 2018

BACKGROUND

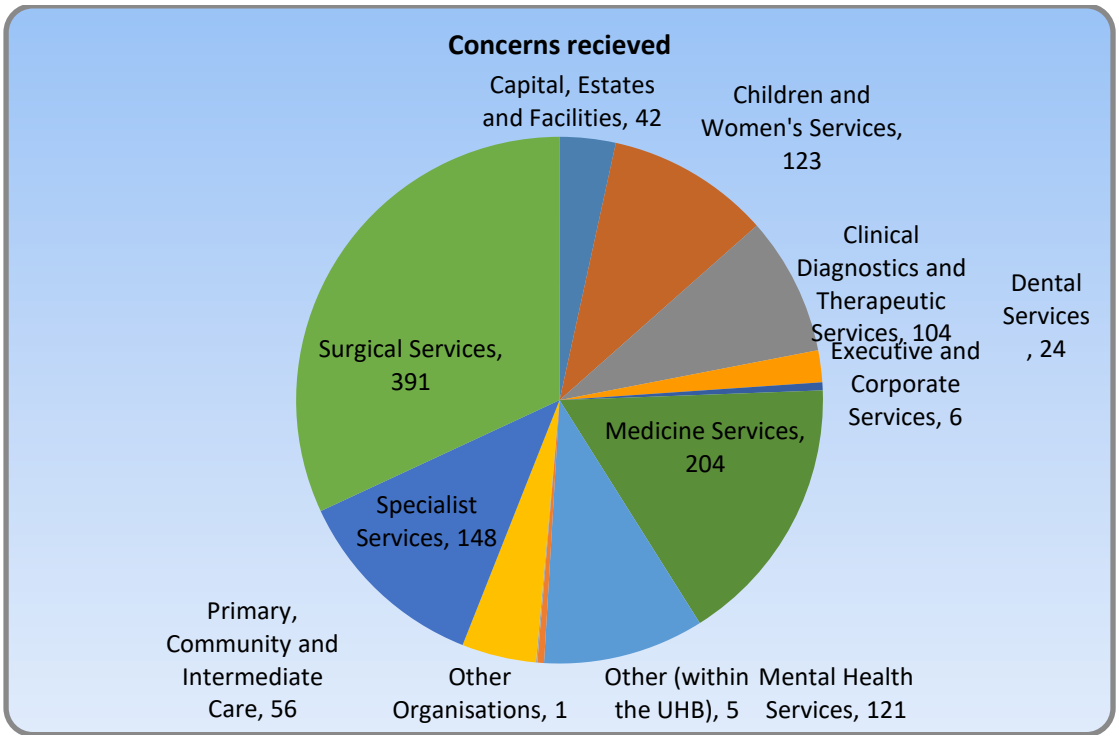
The UHB has a wide range of data which provides a level of assurance on the safety and quality of services, as well as on the experience of patients and families. This report provides an analysis of information drawn from the investigation of complaints and clinical negligence claims as well as examples of how areas of identified concern are being addressed.

ASSESSMENT

Complaints

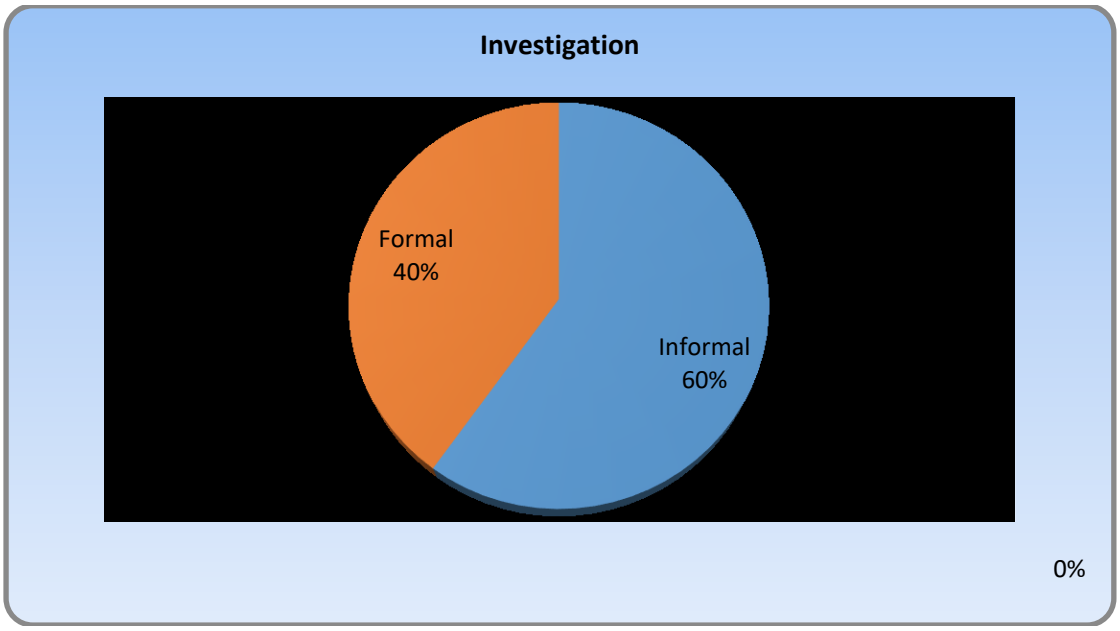
1st April 2018 to 30th September 2018 the UHB received 1225 concerns

The breakdown is as follows:



You will note from the figures above, that there is a huge difference in the number of concerns managed by the Surgical Clinical Board, This reflects the high number of contacts that this Clinical Board has in comparison to others.

The Health board encourages the use of informal resolution wherever possible –this is both in line with the Putting Things Right Regulations (PTR) and the Keith Evans Review “the gift of complaints” where a proportionate and timely response was encouraged. The Key Performance Indicator for Informal resolution is 60% and this has been achieved in this time period.

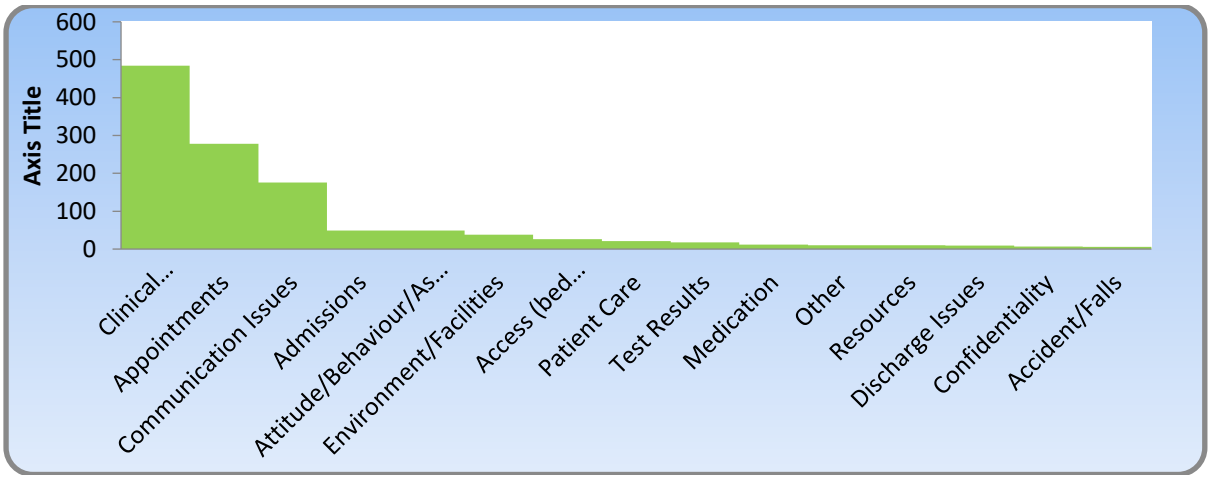


Response times

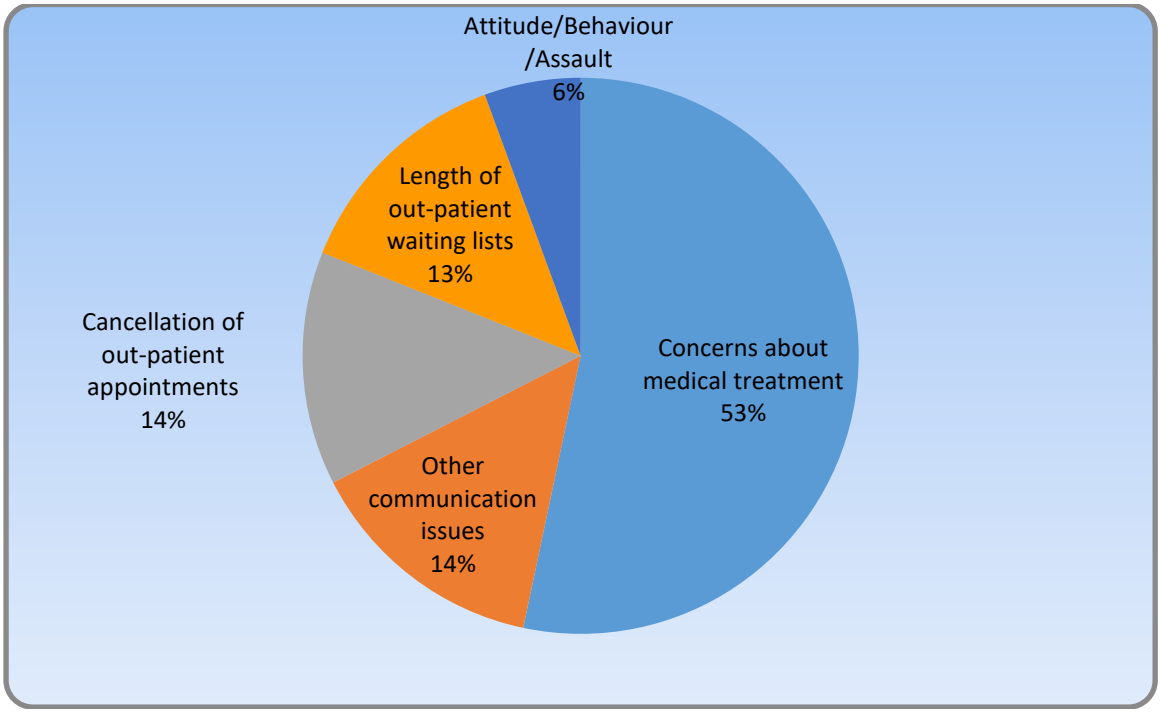
The Health Board has a trajectory of improvement in place to achieve a 30 working day response time of 80% across the Health Board by March 31st 2019.

The current response time is 76%

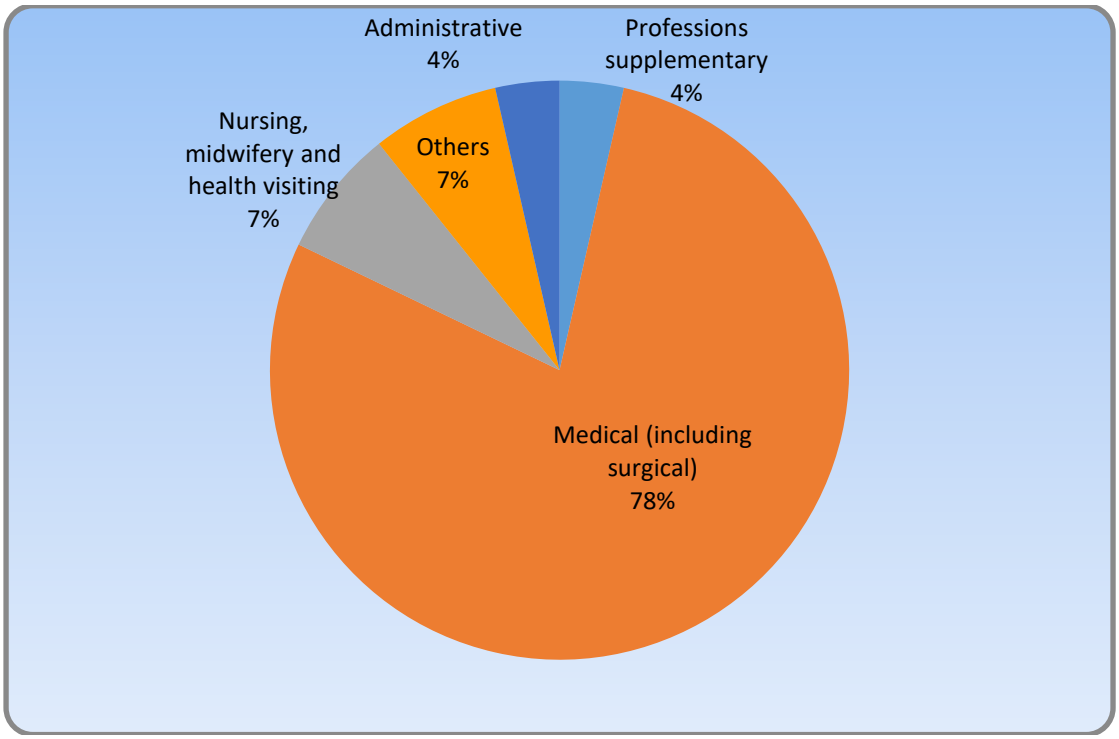
Themes from Concerns in this time period -Top 15 subjects illustrated below



On deeper analysis it is evident that the clinical care concerns can be further categorized



When reviewed by Profession 78% of concerns relate to medical and surgical staff.



Surgery Clinical Board

You said –We did –Examples relating to waiting times and Clinics

You Said	We Did
Informal concerns were raised about cancelled appointments for botox clinics to treat muscular disorders	We organised additional evening clinics to see and treat 200 patients
Concerns raised regarding prioritising and booking arrangements for Neuro clinic.	We have taken all of your comments seriously and reflected on them, and as a result the prioritisation and booking processes for the Joint 45 clinic will be reviewed.
Patients are having ophthalmology appointments cancelled sometimes on several occasions	The Clinical Board implemented a number of changes including, the introduction of a Nurse-Led Clinic for patients who meet specific criteria. The number of concerns reduced initially and is still closely monitored

As noted above 27% of the concerns have related to cancellation of out patients appointment and length of outpatient waiting lists. The majority of Surgery concerns related to waiting times and cancellation of appointments, in this period many concerns were s linked to the Ophthalmology Service.

There has been an increase in the number of Ophthalmology concerns and this specialty received the highest number of concerns across General Surgery. This has been as a result of a number of factors, including staff vacancies which the Clinical Board had difficulties appointing to due to national recruitment difficulties within this speciality. There continues to be a focus upon this area and we will monitor the service improvement activity to gauge if there is a reciprocal decrease in concerns.

Medicine Clinical Board

The highest number of the concerns raised related primarily to clinical diagnosis and treatment. However, some recurring concerns regarding the Sepsis pathway, falls, pressure damage and in previous reports managing the care of young patients with additional learning needs have been highlighted.

Falls
There has been considerable work undertaken to reduce injurious falls as evidenced in the Falls Assurance report, which is also presented to the Committee.

Sepsis
The Sepsis 6 pathway has been rolled out with an associated education programme. The availability of the sepsis trolley in EU and MEAU has helped with increasing awareness and the early implementation of sepsis

treatment. We will monitor concerns and claims in relation to sepsis recognition and management.

People who have learning needs

You Said	We Did
We needed to identify patients with Learning needs and communicate with them effectively	PMS has a flag to identify a patients with learning needs We have reviewed communication tools We have amended the NEWS chart We have ongoing patient experience feedback

In this period we have not identified concerns from medicine in relation to the care of people with learning needs in Medicine. The changes that have been made to the observation charts, the apps for staff, the use of the traffic light system and the on-going training being provided that focuses not only on the assessment of patients but also recognising the need to engage with and listen to carers.

The Health Board has also introduced the **Show Me Where™** (**SMW**) app to their clinical workstation booking system, to alert staff when admitting patients with Learning Difficulties. **SMW** tools, along with the 'Pain Toolkit for Patients with Communication Difficulties', ensure continuity of care throughout the hospital for these patients.

- Children and vulnerable adults
- Non English speaking people

Patients with a learning disability have improved access to emergency care in Cardiff and the Vale following the launch of the new initiative in 2017. In Patient Experience we have developed an ongoing survey to listen to the experience of patients and Carers who use our service when the individual has been identified as having a learning need.

Children and Women Clinical Board

You Said	We Did
Parents did not know when their children would have their surgery Waiting lists were too long	A considerable amount of work has been undertaken by the Clinical Board to reduce waiting times and at the time of writing there are no children waiting longer than 36 weeks for treatment.

Historically there have been a number of issues surrounding the cancellation of Paediatric Surgery, which, unfortunately has resulted in lengthy delays leading to deterioration in condition. The Improvement in RTT is reflected in

the concerns as we have seen a reduction in the number of issues being raised in relation to paedeatric surgery waiting times.

Clinical Diagnostics and Therapies Clinical Board

You Said	We Did
Waits for interventional radiology were too long.	Initially we gained support from other centers' whilst we recruited another interventional radiologist.

Radiology Directorate received the highest number of concerns. There has been an increase in concerns regarding the Neuro-radiology Service due to difficulty in appointing to this specialised role. This resulted in a number of patients being referred out of area. As a background the organisation had a single handed Consultant in position since October 2017. This resulted in improvements to the number of patients being managed locally and an associated reduction in waiting times for patients which continues. Support is being provided by other centres when this individual is on leave. The UHB advertised for a second Consultant but there were no suitable candidates and will advertise further in line with the availability of new trainees when they complete their training.

There has been one incident whereby a patient had been lost to follow-up for neuro-interventional radiology and this sadly resulted in harm. This has been fully investigated and resolved with the patient and the matter has been settled in line with Redress regulations.

Primary, Intermediate and Community Clinical Board

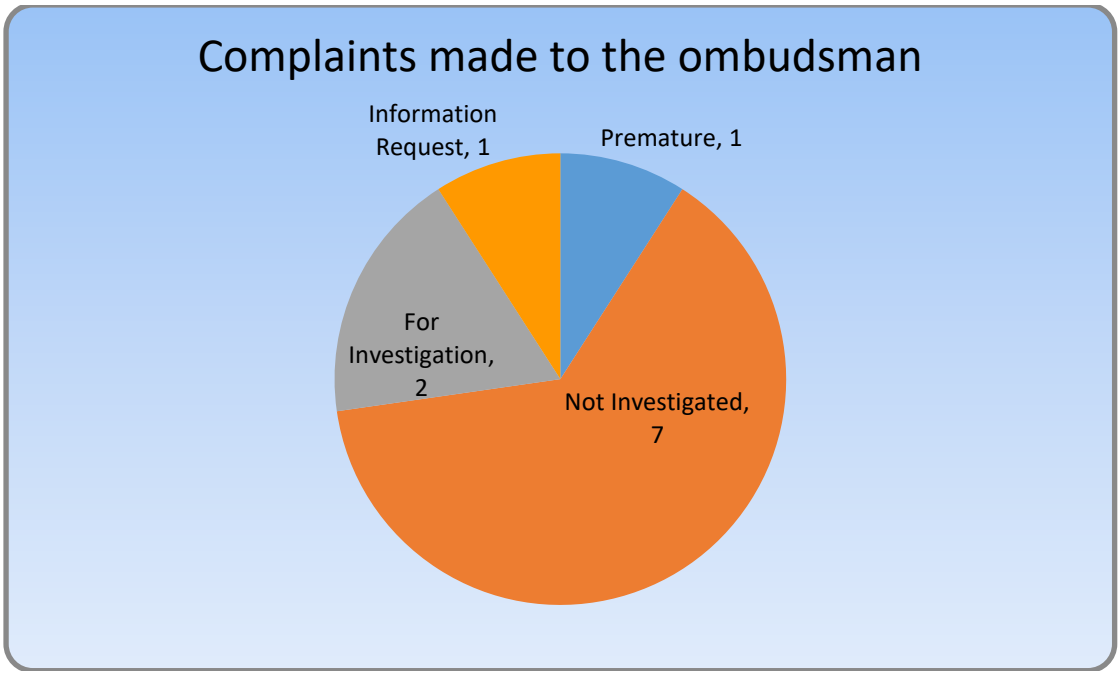
We have seen an increase in concerns being raised regarding primary care within the Prison setting and the Concerns Team are working with the Clinical Board to manage these ensuring they are managed in line with the Putting Things Right Regulations. We have also noticed a raised awareness of the option for patients to request the Health Board to investigate concerns regarding Primary Care, Independent Contractor's e.g. GP's etc. Whilst we encourage people to approach the primary care provider they can request that the Health Board undertakes the review.

Corporate Team review of concerns and improvements to our process

From our review of concerns over the past few years we have recognised the need to revise the subject codes in datix to enable better data capture and hence improved analysis. The Concerns Team from April 2018 revised the subject codes in Datix to better capture the themes from concerns. We have also implemented a process to contact all complainants and to agree with them the issues to be investigated and the questions for the Investigation Officer. This early personal contact is invaluable in truly capturing the themes that are inherent in the concern. The Investigation officer is sent a template response with the questions to be addressed clearly identified.

Public Service Ombudsman

From concerns received since April 2018 to date 11 people referred their concerns to the Ombudsman and the decisions are outlined in the graph below



One of the 2 cases for investigation has been completed and it was not upheld the other case remains in investigation.

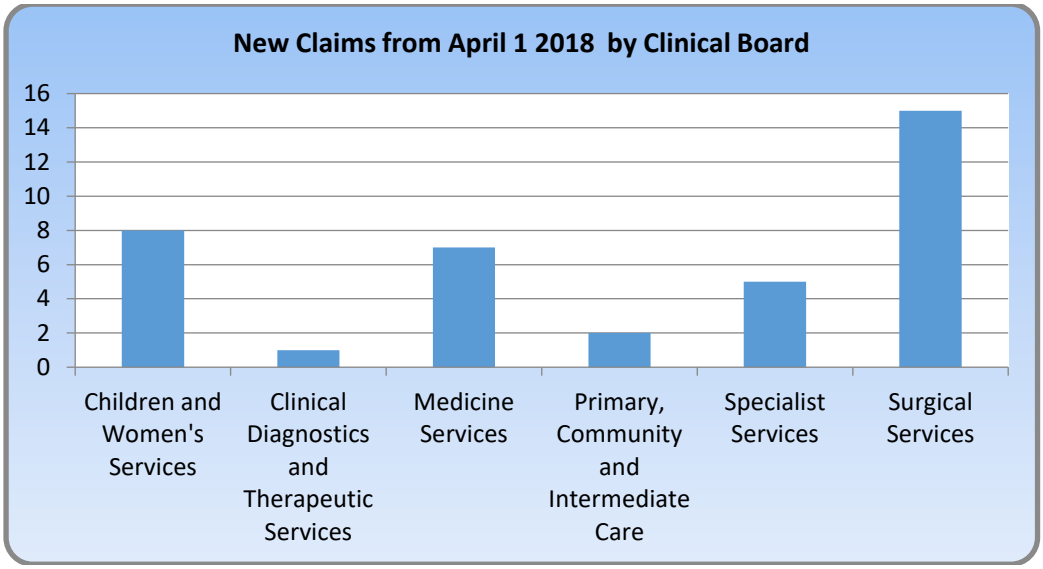
Section 16 Public Ombudsman Report

The Health Board had a section 16 Public report issued in July 2018 (the previous section 16 report prior to that time frame was in June 2015) This was a significant report and the compliance with the recommendations is ongoing.

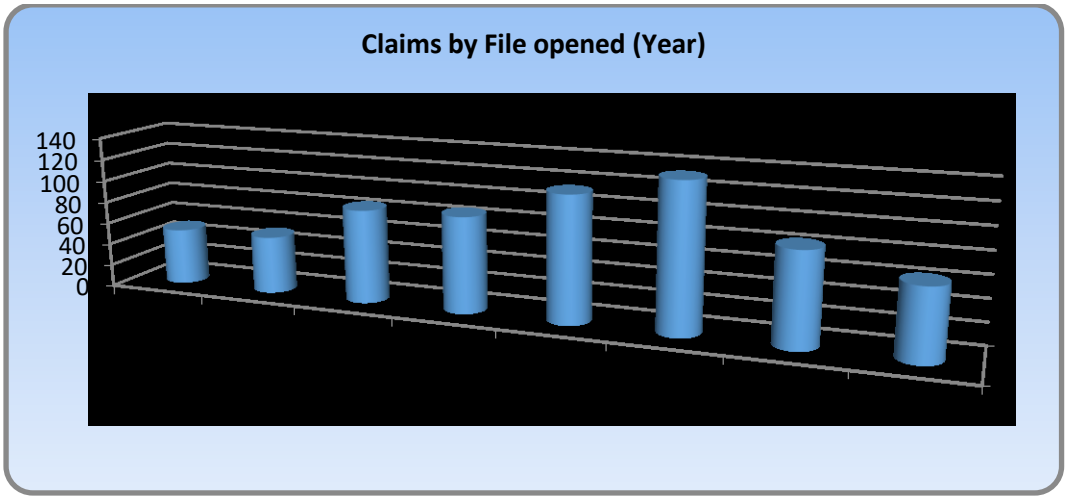
It Said (The Ombudsman report)	**We Did**
We should apologise to Ethan and his family	We apologized and offered to meet with them
Undertake a review of care since 2009	2 external exerts have been asked to provide reports
Consider a mechanism to prompt engagement with the referring health board if RTT will exceed 36 weeks	We are including this prompt but the drive is to keep RTT under 36 weeks
Review all urgent paedeatric urology referrals since June 2014 for the involved consultant	All cases are being triaged and any of concerns will be subject to further review
Share the report at the QSE committee	Shared in the September QSE

Clinical Negligence Claims

During the period of 1/4/18 - 30/9/18 there were 38 new clinical negligence claims opened across all the Clinical Boards.

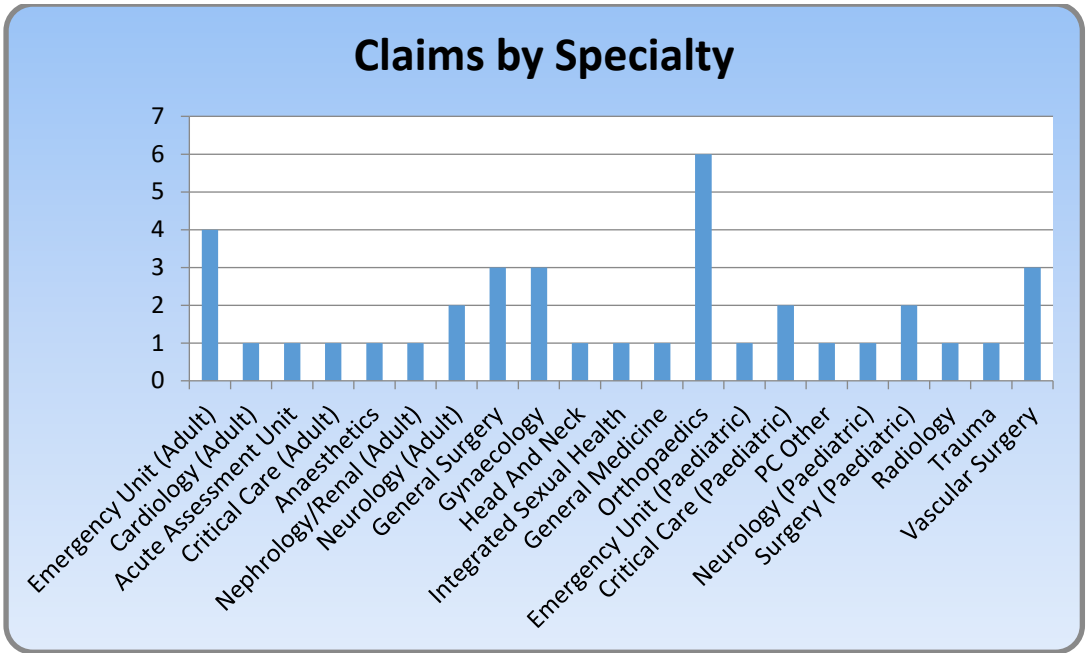


However it is pleasing to note a decrease since 2016/17 in our Clinical Negligence cases which may be partially accounted for by our active use of the redress process for claims under £25,000



The number of new Surgery claims shows a consistent figure with previous years, this volume can be explained given this area has a greater vulnerability of litigation, due to the nature of the cases. The categories of surgical claims can range from substandard surgical technique to issues related to the consent process.

It is evident the highest number of claims are in Orthopedic surgery, vascular surgery and general surgery



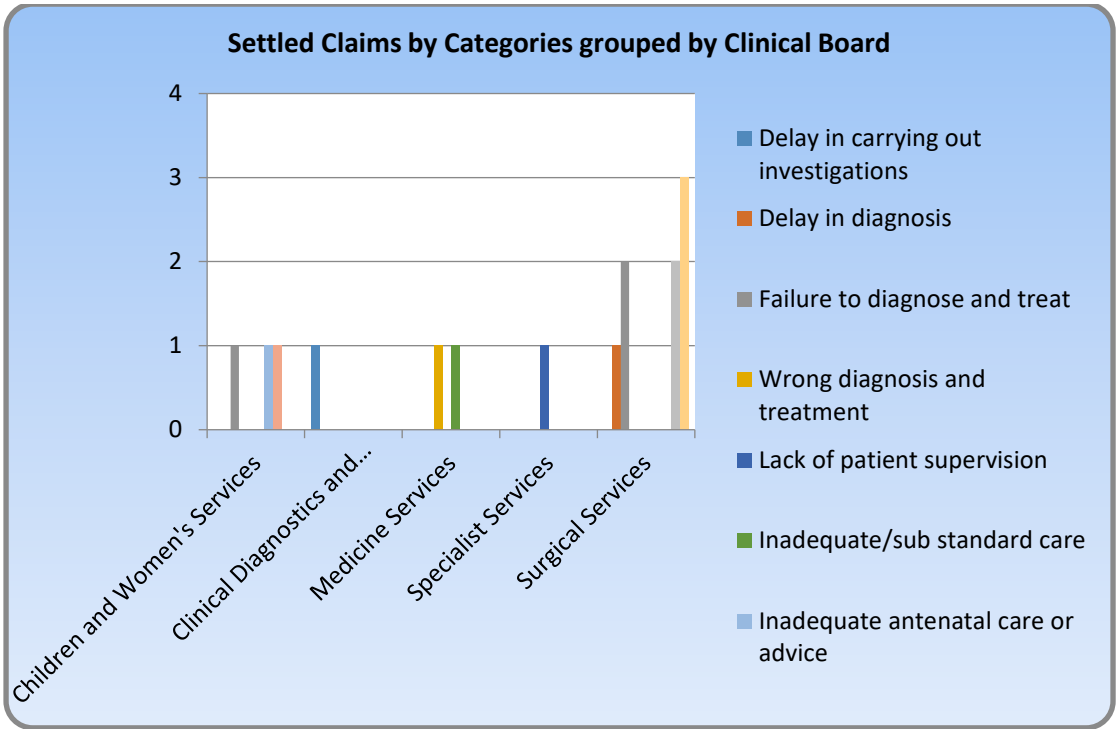
23 Claims relate to clinical treatment and include failures and delays in diagnosis, missed fractures and consent issues.

Although we have seen a few years pass since the Montgomery case law, the area of consent is a topical legal area that remains alive and generates major issues, when defending legal claims. The case of Montgomery (2015) changed the law relating to consent from a clinician-focused approach (what risks would a responsible clinician explain to the patient in order to obtain consent) to a patient-focused approach (the risks to be explained now need to be those which an individual patient would attach importance). However, it is worth noting that a claimant will not be successful simply because a Court finds that a remote risk was not discussed pre-operatively. A claimant will also need to prove that, if the risk in question had been discussed pre-operatively, they would have not gone ahead with the procedure.

Impact of Montgomery and actions being taken

A review of the data identified that although the Health Board was expecting this area of negligence to significantly impact on the claims portfolio, we have not experienced a significant increase in consent - only cases. However, we are mindful that this area of care is often hidden in the detail of the allegations presented and therefore remains important to continue to take opportunities to raise clinical awareness of the legal requirement, in this regard.

The All Wales Consent to Treatment Group was set up last year. The members are representative of key areas within the Welsh Health Boards and aim to look at failures in the process that will assist the Health Boards to comply with this legal weakness, as well as develop a consent process that ultimately supports improved patient centred care.
In this time period we settled 16 Clinical Negligence Claims



Upon review of the closed cases for high value obstetric cases in terms of lessons learned failings related to the interpretation of CTG and sometimes the timeliness of a response to CTG changes, continues to feature in the obstetric claims which is congruent with the UK wide national picture . The Head of Midwifery is committed to minimising the risks associated with this key skill area of both the midwifery and obstetric staff. Her approach has been stepped up to ensure maximum compliance with the online CTG training is evidenced for all staff. The Supervisors of Midwives have been informed not to sign off the annual midwifery return to practice document without sight of the individual evidence to support that the mandatory CTG studies have been completed. Last year 95% staff compliance was demonstrated. The aim is to have 100% of staff having completed their training.

Another area of learning that has been addressed this year relates to a number of cases where identified failures in our follow up processes resulted in patients suffering harm as a result of being 'lost to follow-up'. In response to identified area of concern the Health Board has a follow up Task and Finish group to improve management of follow up activity. The improvement work is currently ongoing within the Directorates who actively working through backlog of patients previously not allocated target dates. One of the notable proposed improvements is that it has been agreed to use a fully automated booking system for follow up appointments. We continue to monitor concerns and claims which should demonstrate a reciprocal decrease.

In the past year, there has been a greater commitment to encourage timely conferences for clinical negligence matters. This allows the UHB to test the defence of the witness evidence ahead of any trial or letter of response, if the case warrants this attention.

The choice of good experts, clinical witnesses and taking early appropriate opportunity to test them at conference, ensuring the right questions are addressed by the experts at the joint expert meetings, can greatly assist the management of the case with regards to costs savings. The feedback from clinicians has been positive and they are able to listen and reflect upon the expert evidence of a case that they have been involved with which facilitates reflection and learning.

Legal and Risk services have actively supported the Health Board to increase the Clinical Board knowledge in the key areas of breach of duty and causation by invite to their Quality and Safety meetings. This learning to support the claims process will continue be encouraged and offered the all the Clinical Boards as often as indicated. The training is bespoke to each area and the evaluation has been extremely positive.

The Wednesday Executive led concerns meetings ensures that there is a sustained and continued focus upon sharing of intelligence, identifying patterns and trends from Patient Safety and Patient Experience. Several Health Boards have asked to observe the Wednesday meeting and it is deemed best practice as the Executive engagement is key to the importance and significance of the agenda.

Welsh Risk Pool increasingly scrutinise all Health Board lessons learned and all appendix forms are scrutinised by the internal redress panel to ensure that a level of peer review is undertaken prior to Clinical Board and Executive confirmation. The focus should always be upon learning from concerns and ensuring that actions are proportionate and mitigate against any future reoccurrence.

FALLS ASSURANCE REPORT
Name of Meeting: Quality Safety and Experience Committee **Date of Meeting:** October 16th 2018

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

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The UHB is currently demonstrating a stable trend in incidents relating to slips trips and falls. Significant work is underway particularly in the community in relation to falls prevention
- There continues to be limited assurance relating to inpatient falls causing serious injury. The trend however has shown a decrease for the first six months of 2018-2019.

The Committee is asked to:

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

SITUATION

The purpose of this paper is to provide the Committee with an update on trends and themes in falls incident reporting as well as to provide an update on the development of a Falls Prevention Framework and the multi-agency work that is currently underway across the UHB.

BACKGROUND

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

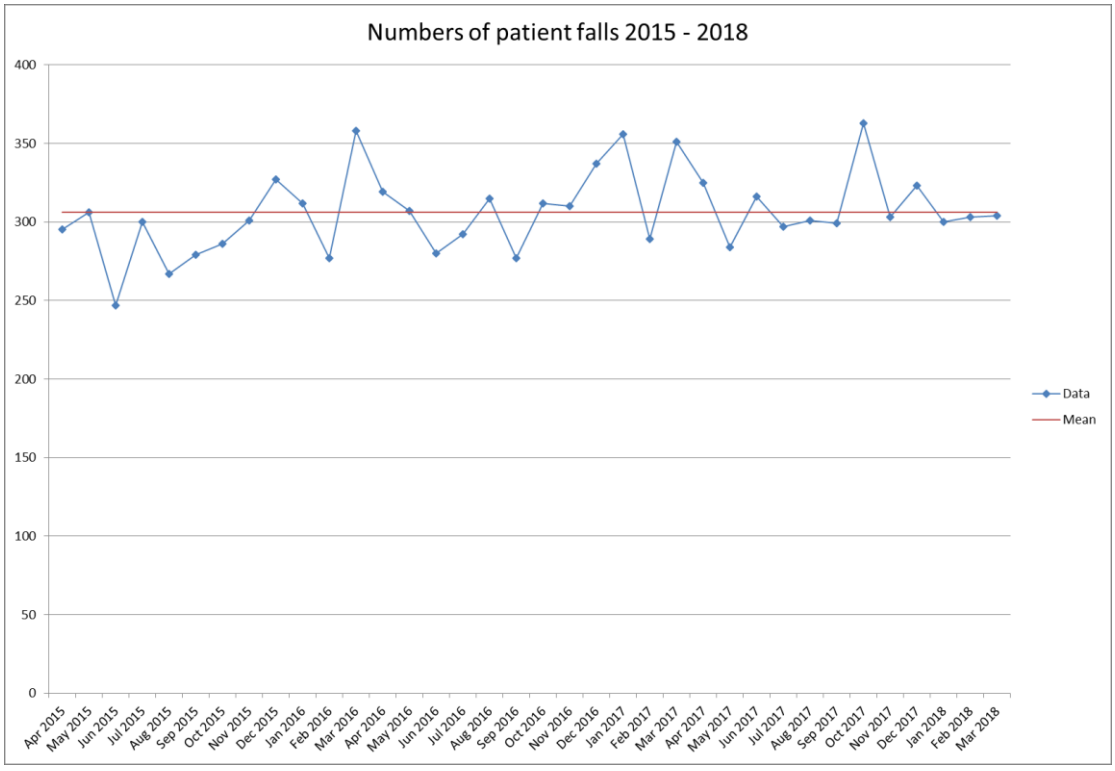
- Welsh Health Circular (2016) 022 Principles, framework and national indicators: Adult inpatient falls
- Health and Care Standards 2.3 Falls and 6.1 Promoting independence
- National Audits; Falls and Fragility Fracture Audit Programme, National Audit of Inpatient Falls; Royal College of Physicians imminent
- NICE/NPSA Guidelines
- 1000 lives #STEADYONSTAYSAFE Campaign to reduce falls in the community

The purpose of this paper is to provide an update to the committee on trends and themes in the reporting of patient falls as well as an update on the main work streams that are currently underway in relation to the prevention and management of falls across the healthcare community.

The Committee received a Falls Assurance report at the April 2018 Committee.

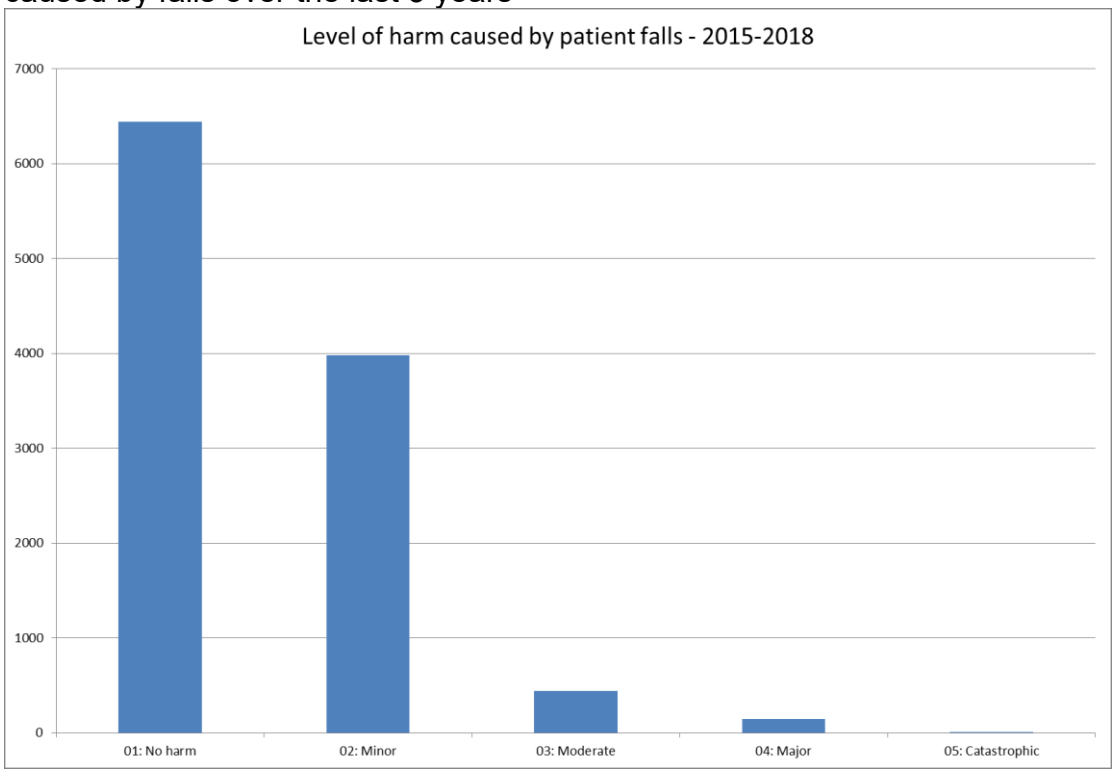
ASSESSMENT AND ASSURANCE

How are we doing?

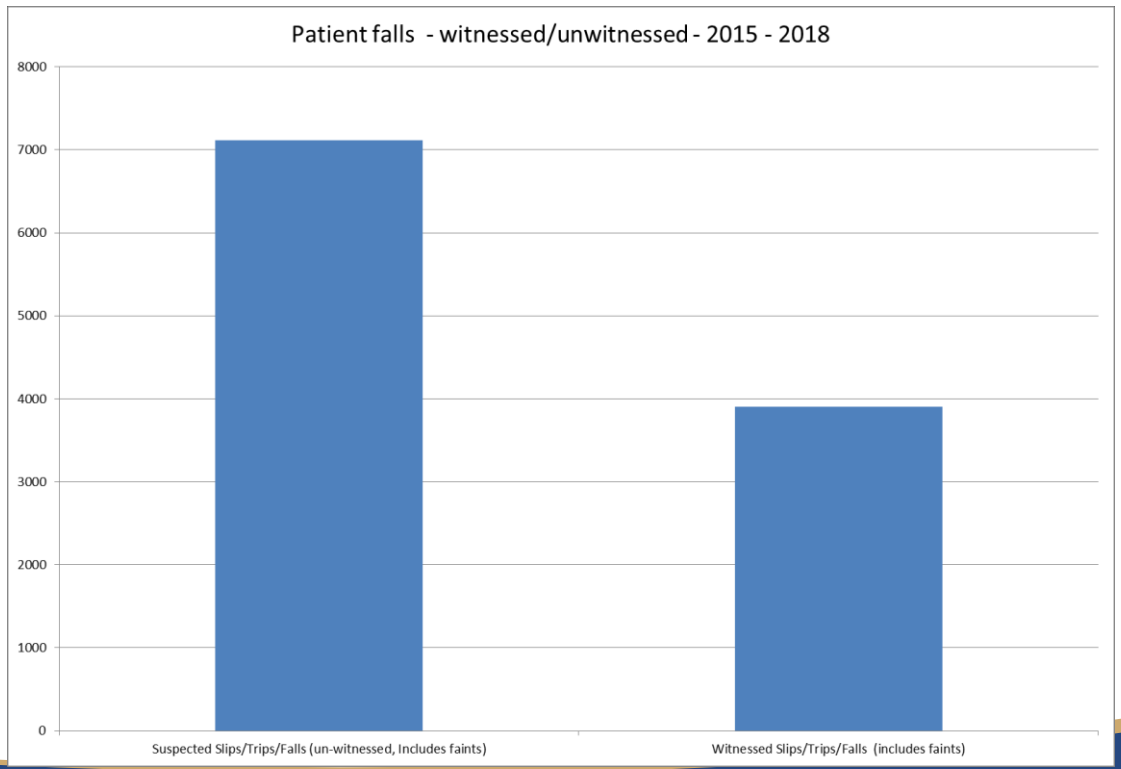


The Committee will note that the number of in-patient falls reported on a monthly basis is fairly consistent, with the mean number being in the region of 300 falls per month. (data is based on calendar years rather than financial years)

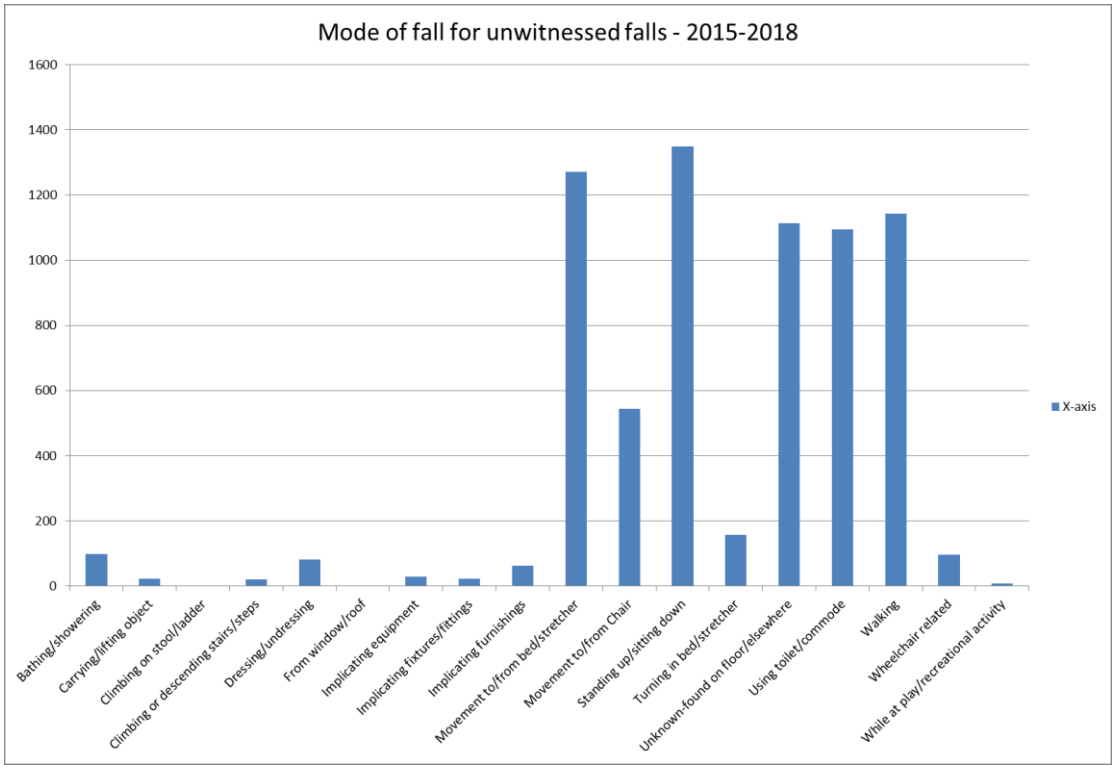
A large proportion of accidents/falls do not result in injury or lead to minor injury to the patient. The following graph demonstrates the rate of harm caused by falls over the last 3 years



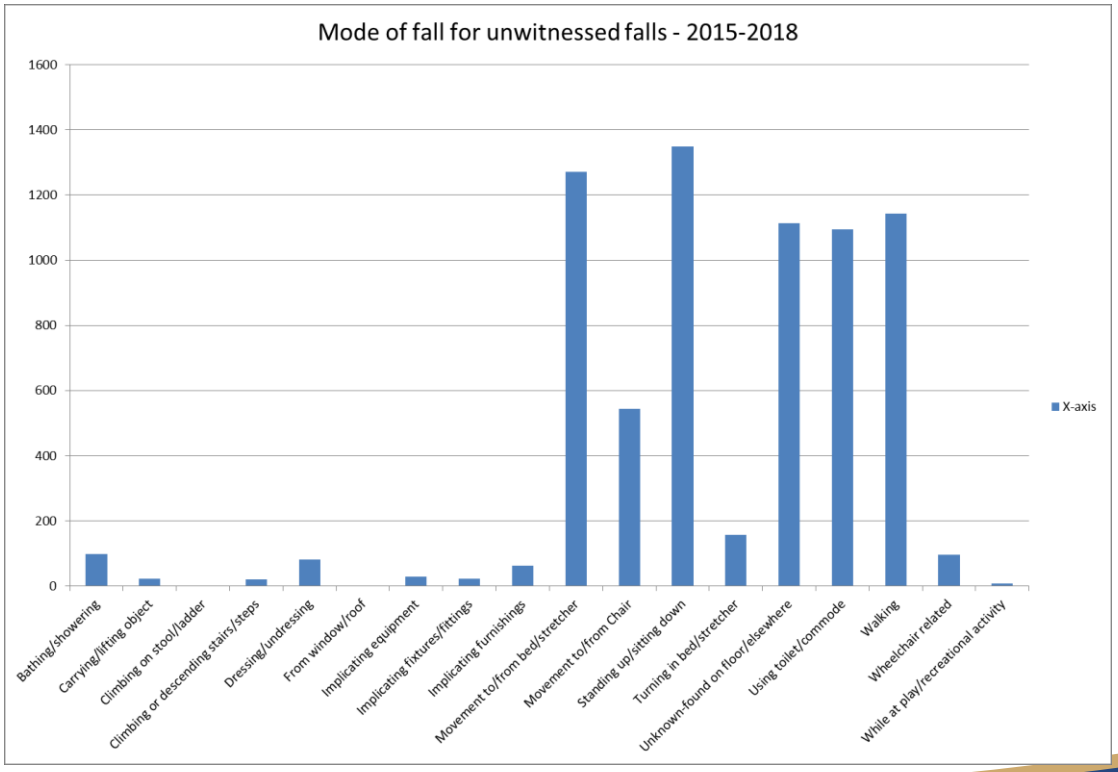
The greater proportion of in-patient falls are not witnessed and this is demonstrated in the graph below:



The majority of unwitnessed falls occur when the patient is getting in or out of bed, standing up out of a chair, using the toilet or commode or walking:

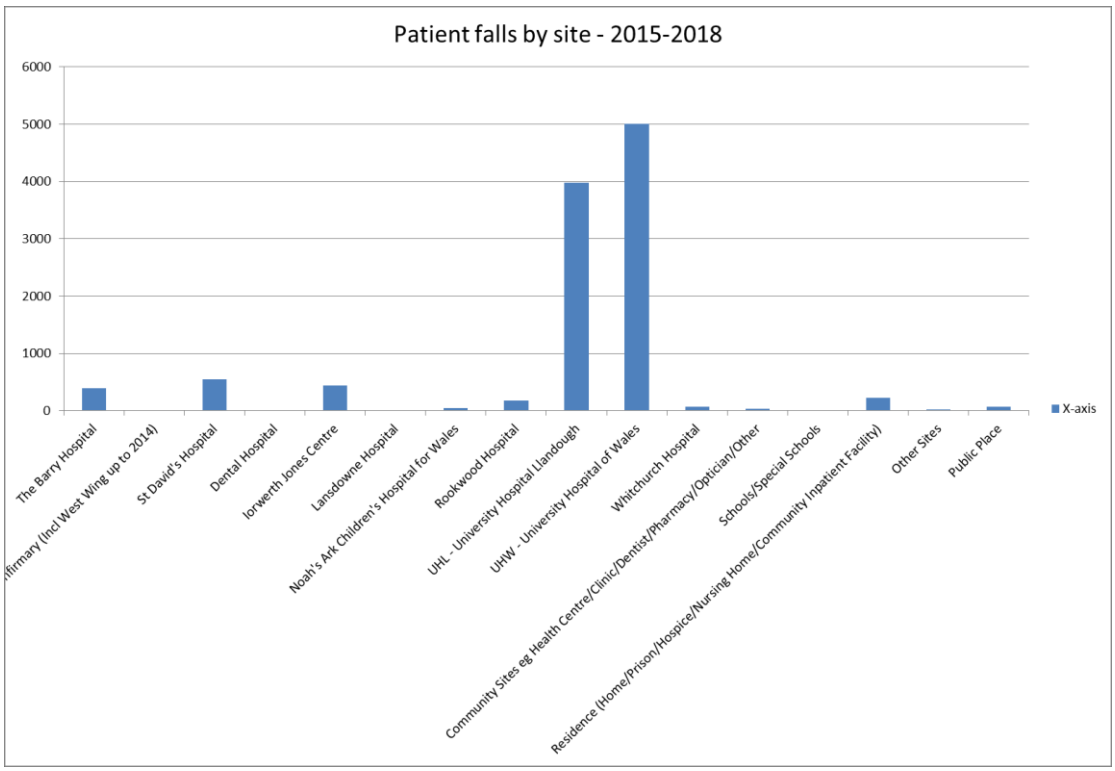


The majority of witnessed falls happen for similar reasons:

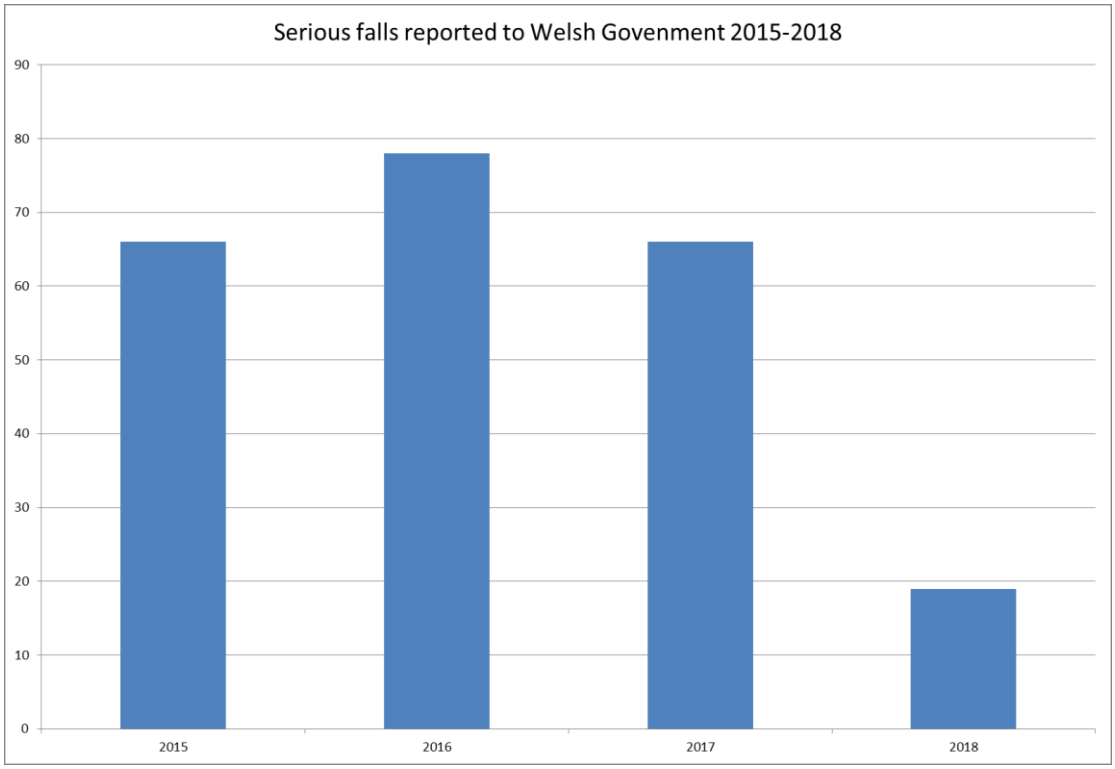


Clearly, these factors cover a normal range of activities that a person will engage in while an in-patient. However, it does help focus education of patients and also highlights the need for staff to check for postural hypotension in patients. We know from national Audit data that areas for improvement in falls prevention include the measurement of lying and standing blood pressure as well as vision assessment and availability of call bells. These will all be addressed as part of the Falls Prevention Framework

The following graph represents the number of falls by site. It is not surprising to see that the greatest number of falls occur at University Hospital of Wales and University Hospital Llandough. This is monitored regularly as part of the Integrated Quality, Safety and Experience report to Board.



Patient falls do however, represent the second highest volume of Serious Incidents (SIs) reported to Welsh Government (after pressure damage). These include patients who have sustained significant injuries such as fractured limbs or head injuries.



Analysis of the SIs by ward area demonstrates that SIs are not a reliable indicator of good or poor practice. There is no correlation between total number of falls and number of SIs. A .significant proportion occur in wards where there is very good falls awareness and practice. This demonstrates that using SIs as an indicator for falls reduction is a crude and unreliable measure. The numbers for the first six months of 2018-2019 however, have reduced and if this trajectory is to continue the UHB will see a potential decrease of 42% when compared with last year's figures.

Furthermore the use of falls as an indicator of the effectiveness off Falls prevention programmes is not reliable. This is because the metric collected in Emergency Departments (ED) includes all falls regardless of cause. In addition not all injuries presenting to ED will identify falls as a cause.

Paradoxically some of the interventions to improve strength and balance and promote independence can increase the number of falls reported. The measures to demonstrate the benefit of falls prevention programmes is an area of work that 1000 lives and Public Health Wales are developing and the UHB are actively engaged in this work through membership of the National Taskforce for Falls. In addition a number of work streams are already exploring measures, such as the Care Home Integrated Support Team (CHIST) work, Individual Strength and Balance Programmes (ISBP) on wards, Falls simulation training and the Staying Steady Clinics.

The Falls Delivery Group (FDG) continues to meet and be the focus for the development of the Falls Delivery Framework.

Oliver Williams, the Falls Strategic lead has completed a report highlighting the work that has been undertaken across the UHB to date. In addition he is leading a sub-group of the FDG to develop the Falls Prevention Framework. Given the multifactorial nature of falls prevention there is further work required to ensure the framework reflects the contribution from all partners. Next steps are therefore to present the first draft to the multi-agency group to agree our shared vision and content.

It is recognized that a shared vision and approach is required by the Regional Partnership Board which reflects the alliance approach adopted by the UHB in our Transformation Programme.

Building on the innovative resources that have already been developed; Oliver has been successful in being awarded a Bevan Exemplar to take forward the intergenerational work with schools and falls prevention.

In addition, the Community Resource Teams have been working in collaboration with WAST to deliver the Care Home Integrated Support Team (CHIST). A successful pilot was delivered with one care home, which showed a reduction in admissions to the Emergency Department and conveyancing by WAST. This has now been rolled out to a further eight care homes in Cardiff.

Cardiff and Vale University Health Board has received pace setter funding to launch new 'Staying Steady' clinics in October 2018. The clinics will initially run twice a week in the Northwest Cardiff area, with the hope of expanding across Cardiff and the Vale if successful. Northwest Cardiff was chosen as the initial area to launch clinics as it is the cluster that has the highest numbers of hospital admissions due fractured neck of femurs following a fall (taken from Public Health Wales data). The clinics will be accessible to anyone who feels at risk of falling and is able to attend the clinics independently. People can self-refer to the clinics by contacting the Independent Living Services in Cardiff, who will conduct initial telephone screening before signposting people to a clinic. The clinics will be run by Physiotherapists and Falls Technicians, offering multifactorial assessments and referrals/signposting to required interventions based off this. The aim is for the clinics to be a one stop shop for help and advice regarding falls, targeting those upstream on the falls risk scale in order to focus on prevention and early intervention, creating a proactive rather than reactive service.

A business case has been developed and submitted to the Business Case Approval Group (BCAG) to deliver a rapid response model in collaboration with WAST. This is in line with the recently published WAST Falls Prevention Framework. The underlying principle being to provide a rapid response by the CRTs to non-injurious fallers in the community. The benefits to patients are 2 fold; firstly to pick them up from the floor as quickly as possible to prevent

further complications from waiting for arrival of an ambulance (These patients are often low priority given non injurious nature of the fall). Secondly it enables rapid provision of appropriate interventions, building on evidence that people who have had 1 fall go on to have multiple falls if no interventions are provided. This will also have benefits for WAST by enabling them to focus on more urgent cases and for the UHB in reduced conveyance to hospital. This has been supported in principle but requires further work on the benefits and outcomes which is part of the work of the Transformation Programme. It will feature in the IMTP for the UHB in 2018/19

The Falls pathway is being used as an exemplar for the development of the Health Pathways work, which is the approach that the UHB are now taking as part of Canterbury - the Cardiff and Vale way. Work completed to date includes:

- Two workshops held with clinical leaders and front line clinical staff on a multi-agency basis to map the current pathway.
- A workshop pending w/c 15th October 2018, with Lightfoot to analyse data in relation to community based falls.

The promoting Independence 'Get up, get dressed, get moving' has now been implemented following a successful 70day#PJ Paralysis campaign. An evaluation will be reported at a future meeting

A review of training resources and tools is ongoing. A major part of this has been the development of a training package in the simulation training centre. This was launched in Spring 2018. .

In summary there is a considerable amount of work being undertaken across the UHB on the falls pathway.

What is evident from this work is that falls is a consequence of a number of factors, many of which are down to social determinants of health and the public health plan for promoting activity, reducing obesity and social isolation. One of the biggest causes of falls is frailty.

The Falls Prevention pathway and framework cannot be seen in isolation of the frailty pathway.