Bundle Quality, Safety and Experience Committee 18 December 2018

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9 PART 2: Items to be recorded as Received and Noted for Information by the Committee

9.1 Minutes from Clinical Board Quality Safety and Experience Sub Committees - Exceptional Items to be raised bythe Assistant Director, Patient Safety and Quality

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9.2 Agenda for the Private QSE, Safeguarding and Insourcing Opthamology Concerns

9.3 Items to bring to the attention of the Board / other Committee

9.4 Review of the meeting

9.5 Date of the next meeting - 9am on Tuesday 13th February 2019

QUALITY, SAFETY & EXPERIENCE COMMITTEE
9am on 18th December 2018
Corporate Meeting Room, HQ, University Hospital of Wales
AGENDA

1.	**Preliminaries**	
1.1	Welcome & Introductions	*Oral*
1.2	Apologies for Absence	*Oral*
1.3	Declarations of Interest	*Oral*
1.4	Minutes of the Committee Meeting held on 16th October	*Chair*
1.5	Action Log	*Chair*
1.6	Chair's Action taken since last meeting	*Oral* *Chair*
2.	**Governance, Leadership & Accountability**	
2.1	Patient Story	*CB*
2.2	Mental Health Clinical Board Quality, Safety and Experience Assurance Report	*Mental Health Clinical Board*
2.3	Presentation on Patient Suicide (Tolerance)	*Mental Health Clinical Board*
2.4	Tawel Fan Report	*Executive Nurse Director*
2.5 **2.5.1** **2.5.2** **2.5.3**	**Policies for Approval** Being Open Policy Being Open Procedure Confirmation of an Expected Death by Nurses Policy and Procedure	*Executive Nurse Director*
2.6	Health and Care Standards Self-Assessment Timetable for 18-19 as per work-plan	*Executive Nurse Director*
2.7	Emerging Theme from UK Maternity Service Reviews	*Executive Nurse Director*
2.8	Annual Quality Statement 2018/2019	*Assistant Director Patient Safety*
3.	**Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)**	
3.1	Nothing to Report	
4.	**Theme 2: Safe Care**	
4.1	High vigilance arrangements required for the use of synthetic vaginal mesh and tape	*Medical Director*
4.2	Infection Prevention and Control	*Executive Nurse Director*
4.3	Medication	*Medical Director*
4.4	Point of Care Testing	*Medical Director*
5.	**Theme 3: Effective Care**	
5.1	Cancer Peer Review – Breast	*Medical Director*
5.2	Cancer Peer Review – Acute Oncology Service	*Medical Director*
5.3	Clinical Audit Plan Progress	*Medical Director*
6.	**Theme 4: Dignified Care**	

	6.1	HIW Activity Update	
	6.2	Sensory Loss	*Chief Operating Officer*
	7.	**Theme 5: Timely Care**	
	7.1	Nothing to report	
	8.	**Theme 6: Individual Care**	
	8.1	Nothing to report	
	9.	**Items Received and Noted for Information by the Committee**	
	9.1 **9.1.1** **9.1.2** **9.1.3** **9.1.4** **9.1.5** **9.1.6** **9.1.7** **9.1.8**	**Minutes from Clinical Board Quality Safety and Experience Sub Committees – Exceptional Items to be raised by the Assistant Director, Patient Safety and Quality** Clinical Diagnostics and Therapeutics - July Mental Health – July Primary, Community and Intermediate Care – May Specialist Services – July Medicine – June Surgery – May Children and Women – May Dental - June	*Assistant Director, Patient Safety and Quality* *(Chief Operating Officer)*
	9.2 **9.2.1** **9.2.2**	**Agenda for the Private QSE** Safeguarding Insourcing Ophthalmology Concerns	*Executive Nurse Director*
	9.3	**Items to bring to the attention of the Board/Committee**	*Oral* *Chair*
	9.3.1		
	9.4	**Review of the Meeting**	*Oral* *Chair*
	9.4.1		
	9.5	**Date and Time of next Meeting**	
	9.5.1	Date of next meeting – 9am on Tuesday 13th February 2019	

UNCONFIRMED MINUTES OF THE ANNUAL SPECIAL MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 16 OCTOBER 2018 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Susan Elsmore	Independent Member, QSE Chair
Akmal Hanuk	Independent Member – Community
Prof Gary Baxter (part)	Vice Chair/Independent Member – Cardiff University
Dawn Ward	Independent Member – Trade Union
Michael Imperato	Independent Member – Legal

In Attendance:

Angela Hughes	Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Chris Lewis	Deputy Director of Finance
Dr Graham Shortland	Medical Director
Maria Roberts	Head of Patient Safety
Nicola Foreman	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Dr Tom Cromarty (part)	Trainee Doctor (Observer)
Urvisha Perez (observer)	Wales Audit Office

Apologies:

Maria Battle	UHB Chair
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Kinghorn	Interim Director of Public Health
Robert Chadwick	Director of Finance
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Steve Curry	Interim Chief Operating Officer
	Julia Harper

Secretariat:

QSE 18/171 WELCOME AND INTRODUCTIONS

The Chair, Cllr Susan Elsmore welcomed everyone to the annual special meeting. She explained that there would be a presentation later in the meeting and that in the meantime, Members were asked to consider two questions:

- What do human factors mean to you?
- How do you define resilience?

QSE 18/172 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 18/173 DECLARATIONS OF INTEREST

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

QSE 18/174 MINUTES OF THE COMMITTEE HELD ON 18th SEPTEMBER 2018

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

QSE 18/175 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log and **NOTED** the number of actions that had been completed. Due to the short time frame since the last meeting, and the challenging agenda, it was agreed that the updated action log would be received at the December meeting.

QSE 18/176 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 18/177 HOT TOPICS

The Executive Nurse Director, Mrs Ruth Walker referred to the recent announcement on Cwm Taf's maternity services. The Committee had received the MBRRACE report on perinatal mortality at the last meeting. In light of recent developments, the UHB had reviewed its own reporting processes and assurance was provided that they were robust and in maternity there was good multi-disciplinary challenge. There were currently no concerns about the UHB's maternity service and this would be reported back to Welsh Government.

In terms of the issues found in Cwm Taf, a culture of not reporting in Royal Glamorgan's maternity services was found. Whilst staff were very busy which may account for non-reporting, it was noted that there was also a lack of challenge when incidents were reported that demonstrated a lack of transparency and openness. Mrs Walker also advised that the UHB was providing advice and support on the completion of root cause analysis and had seconded a number of staff.

The UHB continued to monitor its own service. Information on incidents was prepared for performance reviews that demonstrated a comparison over time. The Patient Safety team also attended Clinical Board QSE Sub Committee meetings and this UHB Committee received the minutes of the Sub Committee meeting. The maternity department held a weekly meeting and

was honing in on triggers for incidents and a Still Birth Forum met regularly. There was a follow up process for dealing with parents who had lost a baby and links with information from neonatology was being developed.

It was noted that Cwm Taf treated around 80 UHB patients per annum. It was important, therefore, to raise issues as a commissioner with Cwm Taf and it was agreed that Mrs Walker would discuss this separately with the UHB's commissioning officer.
Action – Mrs Ruth Walker

Independent Member, Mr Michael Imperato, advised Committee of a recent judgement from the Supreme Court involving Croydon Health Trust and the liability of an A&E receptionist who gave the wrong waiting time to a patient. The Court found that there was no defence despite the receptionist not being a member of clinical staff. Mrs Hughes commented that this had been picked up by legal and risk and a newsletter was being prepared. There would be training implications across the board, including community staff.

QSE 18/178 ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS

The Executive Nurse Director, Mrs Ruth Walker presented the comprehensive report to assure Committee on the trends and themes identified from serious incidents (SIs) and what actions had been taken to address the risks and shortfalls.

In terms of process, the Datix reporting system was available 24 hours a day for any staff member to report not only incidents, but also any worries. A buddy system was also in place for staff without access to a computer. The system generated a report to the line manager and Patient Safety team, incidents were categorised in terms of the level of seriousness and were automatically flagged to the appropriate people. The Executive Nurse Director was notified within 24 hours and a weekly meeting reviewed the most serious incidents. In addition, Welsh Government was notified within 24 hours which required response within 60 working days. There were times when this was a real challenge, especially where the Coroner or Prudic processes were involved. Compliance with timescales was 60% in 2017 and 51% in 2018 though this figure was improving. The number of incidents reported to Welsh Government had also risen from 220 to 290. Clinical Boards were held to account through performance reviews and incidents were also reported via the National Reporting and Learning System (NRLS).

Focused attention was required on several areas to address the root causes and ensure shared learning:

- Never events
- Pressure damage
- Falls
- Behaviour/unexpected death in Mental Health
- Diagnostics

- Healthcare acquired infection
- IR(ME)R breaches due to misidentification of patients

Details of the never events since October 2015 were included in the report along with all the actions taken. In addition, a breakdown of the causes of all Wales never events was included. Whilst there had been 15 Welsh never events mainly related to surgery, there had been 4 in the UHB. These patients were well but being managed through the Putting Things Right process. Human factors had played a part in these events. In terms of previous never events in Dental, it was not yet possible to provide assurance that the same thing would not happen again.

Concern was expressed that safety may be affected during a period of change/transition in the Dental Clinical Board. It was noted that no events had been reported. In addition, improvements and clarity around the supervision of students was being worked through. Dental had visited other hospitals and benchmarked their services and NATSIPS was going to be introduced to reduce the risk of recurrence.

In the last year the 5 most reported categories of SIs were:

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

The number of pressure damage reports had risen considerably. This was because the UHB was complying with the need to report unstageable pressure damage. Mrs Walker anticipated that the figure would continue to climb for a while before a reduction would be seen. In terms of learning, the UHB had refreshed its approach, retrained staff, looked at investigation and reporting arrangements whilst staff continued to be vigilant. In addition, tissue viability nurses were working closely with staff and pressure mattresses and cushions had been changed, particularly in critical care in response to staff concerns. A prevalence audit had been undertaken led by Medstrom which provided assurance that the UHB was improving.

The number of falls was high but the picture was improving with more work to be completed in the hospital setting. The Committee would be receiving a separate report later in the meeting.

51 instances involving behaviour and unexpected death / severe harm had been reported and details were provided within the report. However, Mrs Walker drew attention to an incident where she had provided assurance to Board that 15 minute observations had been carried out on a patient. During the investigation it emerged that one set of observations had been missed when a member of staff left the shift early leaving a staffing gap. Consideration was being given as to whether a POVA referral was required.

Concern was expressed that this year's trend was similar to last year and therefore either lessons were not being learned or more needed to be done.

In terms of suicide, it was noted that the Committee would receive a presentation in December looking at whether the UHB had done everything it could have to prevent suicides. It should be remembered, however, that many of the suicides involved patients with addiction issues. Such patients needed to consent to engagement with addiction services and it was not always known if death by overdose was intentional or accidental.

Details of the 16 incidents involving diagnostic process and procedures were provided. Improvements had been made in waiting times for endoscopy and work was about to start on targeting surveillance patients. In addition, awareness of sepsis was being raised across the UHB.

Mrs Walker then talked about historical infection outbreaks that had led to the closure and refurbishment of the neonatal unit. The UHB was on course to deliver further improvements but more work was required in terms of isolation facilities. The effect of the estate on infection was also discussed and it was noted that the Committee had received reports on cleanliness and unfortunately routine maintenance often slipped due to finance pressures and other priorities. This had caused problems in the past when routine work was left too long before being addressed. Two areas currently of concern were the bone marrow transplant unit and critical care.

It was important not to squeeze patients in via "onboarding" which another health board had tried. This resulted in higher infection levels which reduced again once the practice was stopped. There was an important lesson to learn with regard to winter pressures, though Heulwen ward that would be opened this winter had more single rooms.

Four incidents involving Ionising Radiation Regulation breaches had been reported to Healthcare Inspectorate Wales, a reduction from 8 the previous year. Cases of patient misidentification were human error and were not linked to the safety alert on patient wristbands. However, a new system for wristbands was being rolled out.

The Committee noted that the UHB was in line with its peers in terms of performance but an outlier in the amount of community work being done. A review report from Welsh Government was received twice a year. The feedback was mainly positive, did not demonstrate the UHB was an outlier and focused on the need to close incidents.

Mr Walker thanked Mrs Maria Roberts for all her work on the patient safety agenda.

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the Serious Incident reporting process. Serious Incidents were reported and

investigated within the required process. Furthermore, closure of SIs with Welsh Government (WG) was monitored at the Executive and Clinical Board performance reviews and by WG. Periodically, Internal Audit undertook related assurance reviews. The Delivery Unit also applied scrutiny to Never Event processes by exception.

The Quality, Safety and Experience Committee:

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

QSE 18/179 ANALYSIS OF TRENDS AND THEMES IN CONCERNS AND CLINICAL NEGLIGENCE

The Assistant Director Patient Experience, Mrs Angela Hughes presented the report with figures from 1st April to 30th September 2018, highlighting that most complaints came from surgical services and that the majority of concerns (60%) across the UHB were resolved locally with a target of 65%. The response times to complaints had improved and the trajectory was to reach 80% compliance with the 30 day response time by the end of March.

A big area that needed to be tackled was the number of complaints (27%) about outpatient waiting times and cancellation of outpatient appointments, however, the majority of complaints (53%) were about medical treatment.

The report contained details of "you said we did" as feedback had shown that the public liked this format. Mrs Hughes also drew attention to the sustainability of ophthalmology after years of concern and the work being led by Andy Jones on learning disabilities after two patients had died of sepsis. Feedback had been provided to both families. Mr Jones had been shortlisted for RCN Nurse of the Year award for this. As there were still vacancies in ophthalmology, concern was expressed about the pressure put on existing staff to maintain the service. An insourcing initiative had taken place but following a number of concerns this had been ceased. Further details would be provided in private to the Committee.
Action – Mrs Ruth Walker

It was pleasing to see that the number of concerns about paediatric surgery and waiting times had reduced, but concerns around cover in radiology were starting to emerge.

Mrs Hughes commented on the benefits being realised by providing greater support to the Clinical Boards. Early contact with complainants made it possible to agree the specific areas that required investigation and this enabled a more targeted response that resulted in fewer follow up questions.

The annual letter from the Ombudsman had recently been received which would also be shared with the Board.

In terms of clinical negligence, the UHB had not seen the significant increase in claims experienced in other health boards and it was believed this was due to managing concerns through the Putting Things Right process. Nevertheless, 38 new claims had been opened in the last 6 months. A meeting had been held with Welsh Risk Pool and the Obstetrics department to look at high value claims and feedback was awaited. New reporting arrangements for medical negligence would be introduced next April and greater focus would be put on learning lessons.

ASSURANCE was 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 were 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:

- **CONSIDERED** the content of this report.
- **NOTED** the areas of current concern and
- **AGREED** that the current actions being taken were sufficient.

QSE 18/180 FALLS ASSURANCE REPORT

In the absence of the Director of Therapies and Health Sciences, Mrs Carol Evans, Assistant Director Patient Safety and Quality presented the report based on data from the last 3 years. On average there were 300 falls per month the majority of which did not result in injury and were not witnessed by staff. The number of falls by site correlated with the number of beds.

In 2018 there was a drop in the number of serious falls. The Falls Delivery Group was developing a multi-agency strategy and the Falls Lead was working on community falls prevention schemes to develop an exemplar for falls, the Cardiff and Vale way. In addition, simulation training was being well received by staff and a business case was being prepared by the Community Resource Team to support patients at home.

It was thought that excessive specialling had been taking place to prevent falls. When that additional support was removed, no increase in harm had been noticed, but this was being monitored.

The Chair invited comments:

- Mr Hanuk suggested that contact be made with Torfaen Council who had undertaken good work on falls prevention.
- The national audit on fractured neck of femur was expected shortly which would provide a good marker of how patients were being treated.
- Multi-disciplinary working should include more than physiotherapy.

ASSURANCE was provided by:

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

The Committee:

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

QSE 18/181 UHB HUMAN FACTORS – INITIATIVES TO SUPPORT STAFF AND IMPROVE SAFETY AND QUALITY PRESENTATION

Consultant Anaesthetists, Dr Mark Stacey and Dr Cristina Diaz Navarro attended the meeting and gave presentations.

Dr Stacey focused on how human factors affected the way staff worked and their interaction with technology. In addition, the environment and systems in place also had an impact. A number of tools had been developed to provide staff with the skills to improve the way they functioned and to become more resilient. There remained a challenge with the environment as much of it was not conducive to wellbeing. It would be hard to change culture before the environment was right.

Dr Stacey also commented on the principles of avoiding error in the first place, trapping error and mitigating the consequences of error.

It was agreed that staff needed to look after themselves first and noted the start of conversations on how new environments could be made to feel good.

Dr Navarro talked about the benefits of clinical debriefing – a process of talking about and reflecting on difficult situations. Evidence pointed to the fact that debriefing improved patient safety and outcomes.

The process was summarised as:
T – target

A - analysis
L – learning points
K – key actions
The values were positivity, a focus on finding solutions, professional communication and taking things step by step. A Charity called the Talk Foundation had also been set up.

It was noted that A&E had been using this process for some time and it had gradually evolved. A project was being run in theatres and it was starting to be used in radiology. Statistics demonstrated that within 6 months, the practice of debriefing was starting to change the culture. The process was also being used in areas overseas.

The Chair invited comments:

- The work on human factors had influenced how never events were investigated.
- Trainees and students felt able to speak up during the pilot in EU.
- There had been great improvement in adherence to the WHO surgical checklist.
- Staff found time to use this technique and benefits were also seen the following day.
- The insight of issues allowed staff to make improvements at the earliest opportunity.
- Mr Hanuk, as Chair of the UHB Charitable Funds Committee, suggested a conversation outside.
- Debriefing should be something people wanted to do and were not told they had to do.
- Work on outcomes of the Debrief process would be worked on during the next 2 years.

QSE 18/182 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

It was agreed to bring to the attention of the Board:

- The Annual Special Meeting of the QSE Committee was the Committee's way of demonstrating assurance to the Board.

QSE 18/183 REVIEW OF THE MEETING

The Annual Special Meeting looked at the trends and themes arising from serious incidents, complaints and litigation. Improvements achieved and actions to be taken were noted but there was still more to be done. Consideration was given to refocusing work. The work on falls was continuing. Lessons would be learned and positives would be shared as well as negatives.

QSE 18/184 DATE OF NEXT MEETING

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

ACTION LOG
FOLLOWING QSE COMMITTEE MEETING
OCTOBER 2018

MINUTE REFERENCE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
ACTIONS IN PROGRESS					
QSE 18/087 QSE 18/126	12/06/18 18/09/18	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	12/06/18 18/09/18	CHC Reports Scrutiny Overview	"Unable to take personal responsibility" to be discussed with END	S Allen, CHC	A meeting to be set up. The UHB was unable to respond until details were provided by the CHC
QSE 18/138	18/09/18	Cleaning Standards	Share staff stories with Rachel Gidman to link with values/behaviours work	A Harris	Ongoing
QSE 18/144	18/09/18	Blood Products	Refer/discuss computer system concerns with Chief Executive	M Battle	COMPLETE and ongoing discussions taking place with all Chairs and CEOs at the national leadership collaborative
QSE 18/155.1	18/09/18	Ombudsman Public Report	Present update on completion of further investigation	R Walker	Will be presented at Board on receipt
QSE 18/138	18/09/18	CD&T Minutes	Obtain environmental update re BMT for Committee	A Harris	A plan has been developed to re-provide the BMT facility in purpose-built accommodation. This capital development will also address a number of other pressing service issues. A business case is being developed to secure the necessary capital and a programme brief has been submitted to WG. Improvements are being made to the day unit in the short term and the plans are being finalised
QSE 18/177	16/10/18	Hot Topics – Cwm Taf Maternity Service	Discuss the monitoring of approx. 80 UHN maternity	R Walker	On the current agenda

MINUTE REFERENCE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
			patients receiving care in Cwm Taf		
REPORTS SCHEDULED FOR FUTURE MEETINGS/COMMITTEES					
QSE 18/133	18/09/18	CRAF	Present new BAF format to Board	N Foreman	**Board November 2018**
QSE 18/102	12/06/18	Ophthalmology Presentation	Update to come to QSE in autumn	S Curry	**QSE December 2018**
QSE 18/104	12/06/18	Sensory Loss	Update in 6 months' time	S Curry	**QSE December 2018**
QSE 18/178	16/10/18	Analysis of Trends and Themes in Concerns and Negligence Claims	Presentation on patient suicide by Mental Health	R Walker	**QSE December 2018**
QSE 18/179	16/10/18	Analysis of Trends and Themes in Concerns and Negligence Claims	Provide details of concerns following insourcing in Ophthalmology	R Walker	**QSE Private December 2018**
QSE 18/148	18/09/18	Care of Deteriorating Patient/Hospital at Night	Further assurance report with timescales to be presented to QSE	Dr G Shortland	**QSE February 2019**
QSE 18/053	17/04/18	Quality Safety & Improvement Framework	Receive detailed outcome based report	C Evans	**QSE June 2019**
COMPLETED ACTIONS SINCE LAST MEETING					
QSE 18/128	18/09/18	Medicine CB QSE Assurance Report	Support CB to get their patient/relative story digitalized and shared Provide UHB Chair with briefing on the possibility of weekly pay to Bank staff to share with the Minister	A Hugh R Walker	Discussions are ongoing with all Clinical Boards – **COMPLETE** Survey Monkey results had just been received and would be shared. They indicated that staff were in favour of weekly bank pay – **COMPLETE**
QSE 18/141	18/09/18	Medical Devices/Equipment	Discuss issue of corporate responsibility – system, process and resource	Dr F Jenkins/|S Curry	**COMPLETE**
QSE 18/142	18/09/18	Pressure Damage	Discuss responsibility for implementation of foot assessment tool	Dr F Jenkins/|S Curry	**COMPLETE**
QSE 18/147	18/09/18	MBRACE Perinatal Mortality Surveillance	Provide QSE with report on maternal/morbidity and	Dr G Shortland	**QSE February or April 2019** Agreed to be done within the next biannual mortality report – date in

MINUTE REFERENCE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
			other maternity reports for learning		workplan is December 2018 – **COMPLETE**
QSE 18/138.1	18/09/18	INNU Policy	Provide CHC with links to information on website	F Kinghorn	**COMPLETE**
QSE 18/146	18/09/18	Cancer Peer Review – Cancer Pathway	Brief Chair on issues raised: IT infrastructure and governance oversight in tertiary services	DR T Turley/Dr G Shortland	Discussed outside of meeting - **COMPLETE**

Report Title:	**MENTAL HEALTH CLINICAL BOARD QSE ASSURANCE REPORT**								
Meeting:	**Quality, Safety and Experience Committee**						**Meeting Date:**	**18/12/18**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	**Executive Nurse Director**								
Report Author (Title):	**Director of Nursing, Mental Health Clinical Board**								

SITUATION

This report has been prepared to provide assurance to the Committee that Quality, Safety and Patient Experience is at the heart of the delivery of services to the mental health services users within Cardiff and Vale UHB. This report describes the activity of the Mental Health Clinical Board over the last year. The Mental Health Clinical Board links very clearly with the 'home first' strategy of the UHB, with community facing services supporting around 5000 individuals and supports individuals to participate as fully as possible in making choices that direct their own care moving toward recovery.

BACKGROUND

The Mental Health Clinical Board works collaboratively with partners in delivering services to the most vulnerable people in our society. It is essential that alongside service strategic plans the quality, safety, patient experience and effectiveness of services is of the highest standard. The Clinical Board is continuously trying to improve quality within a positive risk management culture to promote recovery.

ASSESSMENT & ASSURANCE

Governance, Leadership and Accountability

The Clinical Board meets on a monthly basis as part of the quality, safety and experience arrangements. There are two set agendas with each being met on a bi-monthly basis. The first is the standardised agenda that follows the Health and Care Standards with the Directorate Management Teams and heads of profession attending, and the second agenda is a 'Lessons Learnt' agenda where recommendations following Serious Incident investigations are discussed and cascaded to all bands of staff. The Lessons Learnt meeting is open to all/any staff that wish to attend and is very well attended by the MDT. Terms of Reference are in place for the Quality Safety and Experience (QSE) subcommittee.

The key risks identified are:

- The length of stay in MHSOP inpatient services which UK benchmarking notes as 130 days compared to a mean of 78 days. The Clinical Board has secured the support of the executive team to employ a project manager to support the MHSOP Directorate to look at the patient pathway and the barriers to effective and timely discharge. The project manager will be supported by the deputy senior nurse and the Complex Care and Commissioning Team.
- The inpatient nursing establishments have not been signed off as they do not comply with the WTD 1998. The Clinical Board and Directorate teams have been innovative with shift patterns to address some of the issues, but this remains a challenge. This work feeds into the national mental health workstream for the Nurse Staffing Levels (Wales) Act 2016. The most challenging areas will be a requirement to uplift the current establishment from 22% headroom to 26.9% as directed by the Act, and an increase in establishment to permit the ward sisters to be supernumerary, in line with the Act.
- Staff are exposed to high levels of violence and aggression – staff are trained in accordance with the All Wales Violence and Aggression Passport and all inpatient staff receive SIMA (Strategies and Interventions to Manage violence and Aggression) training on an annual basis and all community staff receive Breakaway training. SIMA breakaway training is also offered to housekeeping staff. The Clinical Board follows best practice and only uses supine restraint. 80% of violent incidents against all healthcare staff occur in mental health inpatient settings and it has been recognised that the police response to such incidents is inconsistent. Following the

launch of the Obligatory responses to violence in healthcare on 21st November 2018, there is a commitment by SWP and the CPS to support staff who have been assaulted. One of the main points for clarity is that the term capacity is a concept in civil not criminal law and that officers must assess /gather the factual evidence and that intent is the most significant fact. In collaboration with SWP, the Clinical Board will host a police officer within HYC to assist in these issues.

Initiatives to improve in patient care

A Day of Care audit was conducted on 25th July in the Adult Directorate to consider whether the patient required an in-patient bed that day. Criteria were set to consider the severity of illness and the service intensity requiring in-patient care. The headline presentation is attached with the overarching message that 27% patients did not require in-patient care, with the main reason for not being discharged being a wait for funding for a placement or a vacancy at placement.

A more detailed analysis of the data is with the Adult Directorate and an action plan / work streams will be developed to consider the issues raised.

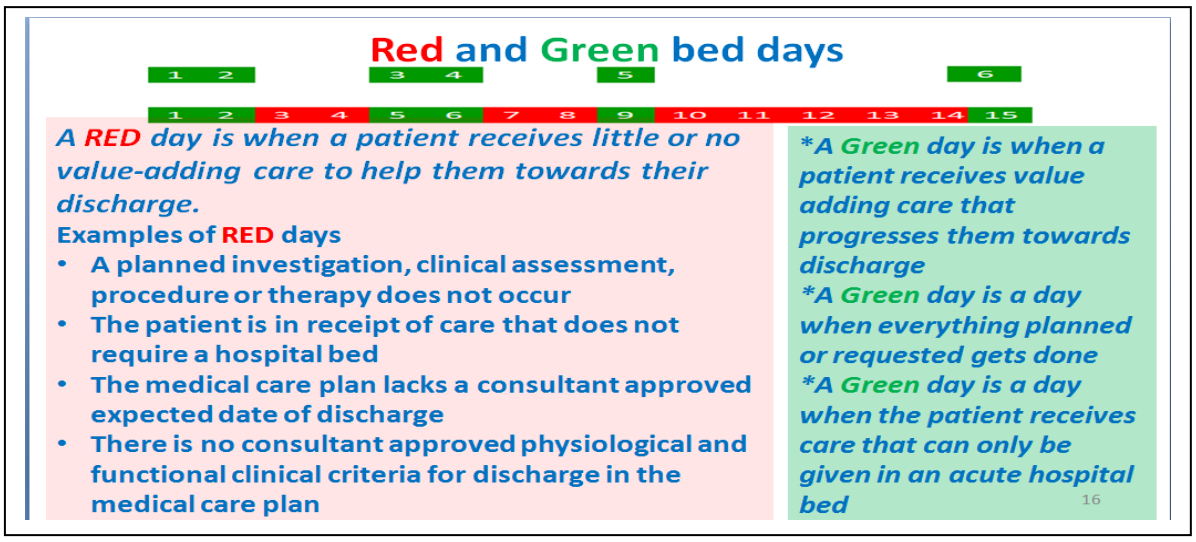
DOCA MH 180725.pptx

Safer Flow Bundle

This has been amended for use within mental health services and is being piloted on Willow ward. The procedure is:

- Ward Round prompt – what is the patient's criteria for discharge?
- What needs to change?
- How do we achieve this?
- Predicted date for Discharge?

A weekly Board Round will consider whether the Crisis Team could be utilised to provide intensive support for Early Discharge. A daily Board Round will indicate whether the patient is having a red or green day.



The pilot will be audited at 1 and 3 months – if a reduced length of stay is achieved, the initiative will be rolled out to Oak and Beech wards.

Preceptorship Programme

A preceptorship programme has been developed by Natalie Hulbert, Practice Development Nurse, for

newly qualified Band 5 nurses, following feedback about the need for additional support, advice, guidance etc. The workbooks are in print and the initiative will be rolled out in the New Year. The year long programme examines the UHB values and how they can be used to support and communicate with our patients, reflective practice, various competencies, CPD and supervision and areas for progression at the end of the programme.
S:\Mental Health\Preceptorship\preceptorship pack final blue.doc

Safe Care
The Dashboard (link below) highlights the Clinical Incidents reported by the Clinical Board. These incidents relate to acts of deliberate self harm, use of restraint, verbal and actual assaults on staff, completed suicide and Grade 3 and above pressure ulcers. A thematic review of suicide is covered in a separate paper accompanying this report. The Clinical Board encourages a culture of reporting incidents.
file:///H:\QS%20and%20Experience%20Committee\2018\MHCB%20Dashboard%20Dec%2017-Nov%2018%20(2).doc

Effective Care
The Clinical Board has established a 'Psychological Therapies Hub' as a virtual hub of expert practitioners providing and supervising the provision of a suite of evidence based psychological interventions to individuals in primary and secondary mental health care. The Hub will soon expand having recently secured additional funding.
The Care Home Liaison team has been successful in developing a service supporting Nursing Homes across C&V. They have recently expanded following a successful pilot, from supporting 15 Nursing Homes to supporting all 50 Homes in C&V. Assessment, training, management plans and medication reviews are successfully preventing admissions to A&E and the DGH.

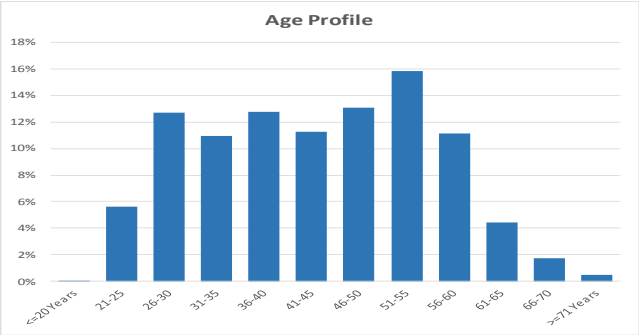
Dignified Care
HIW and DECI visits have not identified any significant issues related to dignity and the Clinical Board is supporting clinical teams to go through the accreditation scheme with DIVERSE Cymru.

Timely care
The First Episode Psychosis service has successfully recruited to all posts and is working with CAMHS and Barnados developing the pathways. FEP will work with 14-25 year old service users.
Following a successful pilot within the East Cardiff Primary Care Cluster, the Health Board is supporting the roll out of the mental health primary care practitioner across C&V, initially in the Vale locality. The pilot demonstrated that early intervention can impact upon the demand for both GP and CMHT, freeing up clinician's time for ongoing psychological work with their caseload rather than focusing on 'fire fighting' at front of house. There are risks associated with this which will be monitored by the Clinical Board. These relate to burnout, 3rd sector support and a recruitment / retention challenge should community practitioners move into these posts and the subsequent drift from inpatient services to back fill.

Individual care
Following an audit completed by the Delivery Unit, PHW, issues were raised relating to the quality of Care & Treatment Plans and the numbers of patients on consultant case loads. The Clinical Board is reviewing the status of specific groups of patients as defined by the Mental Health (Wales) Measure 2010 and training is being implemented to address quality issues in developing the CTPs. The Clinical Board has also liaised with Cardiff University to ensure that CTPs are part of the year 3 education for student nurses.
The Clinical Board has received 279 concerns over the past year. 259 related to adult services with themes of staff attitude, medical treatment and communication. 20 related to MHSOP with themes of communication and nursing/medical care. Following training, more are being managed informally.

Staff and Resources
The Clinical Board has 34% of the employed workforce aged 51 years or over: 36% are in Adult Services, 32% MHSOP and 38% are in the Mental Health Management team. The biggest areas at risk

of an ageing workforce are: 43% unregistered nursing, 39% of administrative staff, 31% of the 540 registered nurses and 30% the 78 of psychologists/psychological therapists are 51 years or over.



In regard to nursing recruitment, the Clinical Board is more successful than other areas in Wales, with 95% of band 5 positions being filled. The new student streamlining process is yet to fully unfold, however, at the last event we employed 22 new Staff Nurses. The next event is in the New Year with a cohort of 54 in Cardiff University.
To engage more fully with staff, the Clinical Board publishes a quarterly newsletter which outlines service changes, celebrates staff/team successes, promotes health and wellbeing etc. The Board also hosted a Garden Party to welcome the rest of the UHL site into Hafan y Coed and conducted its own ward Christmas decoration competition.

RECOMMENDATION
The Committee is asked to:

APPROVE the actions being taken by the Mental Health Clinical Board.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term		Integration		Collaboration	X	Involvement	X
Equality and Health Impact Assessment Completed:	No								

Mental health Clinical Board

Band 5 Preceptorship Pack

Personal Responsibility – Respect – Integrity – Care – Kindness - Trust

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

Content

For any enquiries please contact:

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Natalie.hulbert@wales.nhs.uk

Our Values

in Mental Health

We Care About The People We Serve And The People We Work With

- Demonstrate a compassionate manner towards colleagues and service users
- Uses evidenced based care to inform decisions
- Uses balanced explanations to communicate with service users in a way that they understand
- Takes action to support, protect and care for people or to find someone else that can do so safely
- Promotes personal wellbeing and that of our service users
- If necessary, uses physical restraint as a last resort and strives to maintain the service users dignity

We Trust And Respect One Another

- Strives to demonstrate sensitivity and patience
- Is open to better ways of doing things Treats people as individuals and works on their strengths
- Regularly seeks feedback from others, including service users
- Demonstrates a non-discriminatory attitude

We Treat People With Kindness

- Actively creates an environment that promotes a culture of kindness, safety and dignity
- Advocates for those deemed vulnerable
- Adopts a collaborative approach with service users that is underpinned by their recovery goals

We Take Personal Responsibility

- Adheres to good time keeping practise
- Demonstrates professionalism through reflection on the NMC Code
- Engages fully with continually improving services
- Effectively coordinates work load around the needs of the service user

We Act With Integrity

- Overcomes barriers to meet individual needs
- Says sorry when it is needed and learns from mistakes
- Escalates concerns relating to standards of care
- Always introduces themselves and their role
- Maintains privacy, dignity and seeks consent to share information

PREAMBLE

1. The aim of the Nursing Preceptorship Package is to help and **support newly qualified** nurses to fulfil their new role
2. This package aims to enable Cardiff and Vale UHB and the newly registered nurse to **meet the preceptorship requirement set by the Nursing and Midwifery Council** (NMC).
3. This preceptorship package should be **completed within 12 months**

This package will assist the Preceptor and Preceptee to:

Understand the need to **work together** and provide guidance **throughout the process of Preceptorship**

Plan and achieve the targets within a dedicated time frame

In order to support the learning of the preceptor and preceptee, we encourage:

Attendance at scheduled study days

Regular engagement in reflective, solution focused and problem solving exercises to address any issues or concerns

Highlight areas of achievement.

This package has also taken into consideration:

KSF requirements for Band 5's within Cardiff and Vale University Health Board. The 6 Core Dimensions of the **KSF at Level 2 have been integrated** within the main competencies that need to be achieved.

Upon successful completion of the preceptorship programme, the KSF dimension should be reviewed to reflect successive progression to KSF level 3 dimensions

An evaluation of this programme will take place regularly to ensure that the programme is robust and is supportive to both Preceptor and Preceptee. This will enable the ongoing development and enhancement of the package during the Preceptorship.

This Preceptorship process needs everyone's support and commitment to ensure that the newly qualified staff will be able to provide a very high standard and quality of care for our service users.

INTRODUCTION

Welcome to Cardiff and Vale University Health Board. We would like to congratulate you on your success and hope that you are looking forward to working with us.

The preceptorship pack is intended to support, assist and encourage you to develop your nursing knowledge and skills depending on your experience. The desired aim is to aid your continued professional development through completion of self assessments, clinical skills objectives and to encourage reflective practice through the support and guidance of your Preceptor.

The UHB is committed to support and encourage newly registered nurses and those returning to practice to develop their skills and competencies to the required level in their professional career. This pack has been developed following some research into the needs and requirements outlined by newly qualified nurses and those experienced nurses who have provided support and tuition in the clinical area.

The Preceptorship programme is designed to assist newly qualified nurses to make the smooth transition into the professional culture of being a safe, competent and accountable practionner. During your preceptorship you will be allocated an experienced preceptor who will discuss with you your goals, aims and objectives and support you to achieve your identified personal development plan

We at Cardiff and Vale UHB hope that you will enjoy working with us in your chosen area of practice and continue to progress and develop to reach your fullest potential.

WHAT IS PRECEPTORSHIP?

A preceptorship should be a structured period of transition for the newly registered nurse when they start their employment with the NHS. They should be supported by an experienced practionner (a preceptor), to develop their confidence as an independent professional, and to refine their skills, values and behaviours. Investing in a preceptorship programme can deliver a range of benefits for the preceptor and preceptee as well as the employer. It gives a foundation for lifelong learning and allows nurses to provide effective patient-centered care confidently.

Advantage to the Employer:

- Enhanced quality of patient care and experience
- Reduced sickness and absence.
- Enhanced staff satisfaction.
- Opportunity to identify those staff that requires additional support or a change of role.
- Reduced risk of complaints.
- Opportunity to 'talent spot' to meet the leadership agenda.

Advantage to the Newly registered nurse

- Develop confidence
- Increased job satisfaction leading to better patient satisfaction
- Feels valued and respected
- Feels invested in and is able to plan future goals
- Feels proud and committed to the UHB's corporate strategies and objectives
- Develops an understanding and commitment to working within the profession and regulatory body requirements
- Takes personal responsibility to maintain up to date knowledge.

FRAMEWORK FOR PRECEPTORSHIP

On Appointment

- Line manager to allocate preceptor and arrange for starter pack to be sent out.
- Preceptor to facilitate induction day training and SIMA (within 3 months)
- Ward manager to complete a workplace induction and refer on to NFP and Mental Health New Starter programme (within 3 months)
- Preceptor arranges to meet with preceptee at nearest opportunity (preferably before start date)
- Preceptor to discus roles and responsibilities of each and go through learning competencies and expectations.
- Preceptor to arrange that preceptee works all of the same shifts for the first week and 50% of shifts worked together for the following month.
- Monthly supervision dates to be diarised and protected time given.
- Preceptee to complete a SNOB analysis to inform learning objectives and training needs for next review.
- Preceptee to arrange a clinical supervisor and organise a supervision session.

3 Month review

- All induction study days to have been completed.
- CPD log must be documented in the portfolio
- Reflections should be provided by preceptee to evidence learning.
- All mandatory training to be up to date.
- Preceptor to arrange a date for PADR at 6 month review to enable preceptee opportunity to make appropriate choices on training, development opportunities and evaluate progress.

6 Month review

- Meeting arranged with Preceptee/Line Manager and Preceptor to review portfolio.
- Discuss feedback from others and discuss reflections.
- PADR to be completed by Line manager/Preceptor or PPDN's
- Clinical competences to be completed
- ALERT training is completed

9 Month onwards

- Preceptor and Preceptee to continue to meet on a monthly basis (protected time)
- Portfolio to be updated and reviewed every month displaying evidence of CPD, reflections and competencies.
- Clinical supervision to be accessed and recorded in portfolio on a monthly basis
- Clinical competencies to be completed.

12 Month sign off

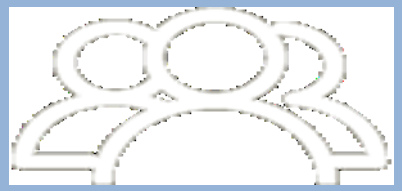
- Portfolio to be reviewed and signed off by Line manager, Preceptor and PPDN
- Certificate of competence and achievement to be awarded.
- Final PADR to be completed by Preceptor
- Revalidation requirements have been met and signed off.

Roles and Responsibilities

Preceptee

- Agree protected learning time, during the first month
- Identify specific learning and skill development needs and develop action plans
- Compile and keep up to date a learning development log/portfolio as evidence of professional development and actively participate in reflective practice
- Understands the standards and competency requirements and agree to be supported in the preceptorship period
- Seek regular feedback from preceptor on progress and learning needs/skills development
- To take responsibility for, and be proactive in, their own learning,

"Nurses are personally accountable for their own practice from the point of registration regardless of any support system"



PRECEPTOR

- Commit to the role of preceptor and its responsibilities in accordance with guidance and to share knowledge and expertise with less experienced colleagues.
- Provide a high standard of professional practice at all times.
- Undertake relevant preparation/ training to fulfill this role
- where required.
- Ensure adequate time is allocated for preceptorship activities, with evaluation and reflection of the preceptee's progress.
- Reflects on the experience of preceptorship and how it effects practice and informs own personal learning and development
- Provide effective, supportive guidance and coaching in an empathetic and professional manner to develop the preceptee's confidence and competence
- Commit to the successful orientation and socialisation of the preceptee's to the General Practice Workplace.
- Facilitate learner progression and skills to meet the preceptee and service needs. Collaboratively set goals, develop action plans, observe and evaluate progress. Give constructive feedback and complete the documentation as required
- Raise any concerns regarding the preceptee progress/ professional development with the preceptorship lead/ manager in a timely manner so that so that any additional support or resources required can be initiated.

PRACTICE DEVELOPMENT NURSE

- Ensure that policies and procedures are aligned with the standards of preceptorship are in place to facilitate the delivery and support of an effective preceptorship programme in General Practice and that all members of the practice team are aware of the preceptorship process.
- Identify a practice lead for preceptorship within the practice.
- Ensure that systems are in place for appraisal of the preceptee's progress through the preceptorship programme and any under-performance is managed in accordance with practice policy and procedure
- Ensure that the preceptee receives induction training including the relevant statutory and mandatory training.
- Provide the new registrant with a suitably prepared preceptor, an experienced Practice Nurse who has mentorship experience and is familiar with pre-registration nursing courses.
- Ensure that preceptorship is adequately resourced within the practice in terms of time, support and access to training and development for both preceptee's and preceptors.

GUIDELINES

PRECEPTOR AND PRECEPTEE MEETING

1. Allocated time is to allow you the opportunity through discussion to identify your learning needs and discuss your personal development plans.

2. The meetings will be documented on the forms provided titled Preceptorship Meeting Record and should be signed by yourself and your mentor at the end of each session

3. These informal meetings should ideally take place once a month between you and your preceptor. Time needs to be allocated and protected when you are both on duty. The sessions should take no longer than an hour.

The initial meeting should be within the first week.

ACCOUNTABILITY

Nurses are personally accountab[illegible] registration regardless of

AIMS AND OBJECTIVES

To provide a supportive induction and orientation programme to newly qualified staff, aiming to accumulate previous knowledge and experiences linking theory to practice and providing an incentive to engage in continuing learning and redevelopment

To develop practionner's who are politically aware of changes and developments and welcome and adapt to an evolving NHS Trust

Identify learning objectives within a specified timescale and developing action plans to achieve goals of practice

To blend preceding learning with competencies using the preceptor as a vehicle to evaluate and reflect on practice.

The development of a skilled, confident and competent practionner who will provide high standards of care and professionalism at all times.

The promotion of reflective practionners

To support, teach and facilitate learning and achievements

To enable newly qualified staff to identify future learning opportunities and development through the PADR framework of the UHB.

To support newly registered nurses to realise the importance and acceptance of personal responsibility and accountability within their scope of practice

To provide preliminary knowledge and opportunities to nurture professional development and encourage lifelong learning

Meetings & Reflections

→ Preceptorship meeting record

→ SNOB Analysis

→ Reflective practice

→ Reflective writing requirements

PRECEPTORSHIP MEETING RECORD

NAME OF PRECEPTEE - .....

NAME OF PRECEPTOR - .....

WARD/DEPARTMENT - .....

DATE PRECEPTORSHIP COMMENCED - .....

AGREED DATES FOR FUTURE MONTHLY MEETINGS

MEETING 1.....

MEETING 2.....

MEETING 3.....

MEETING 4.....

MEETING 5.....

MEETING 6.....

MEETING 7.....

MEETING 8.....

MEETING 9.....

MEETING 10.....

MEETING 11.....

MEETING 12.....

SELF ASSESSMENT

Self assessment is the initial step in planning your development. Identifying strengths and weaknesses, interests and skills and is a useful tool to inform your future personal and professional goals.

It is important to identify and discuss your attributes and skills with your preceptor and others and to receive feedback. Often we do not see ourselves the way others do.

The information you gain from self assessment can help you identify the knowledge and skills you need to fulfil your role and inform your future career development. Your professional development plan will be a summary of your key objectives for your Preceptorship through to your KSF foundation gateway review.

Self assessment is the key to encourage your development strategy so utilise the self assessment tools provided and discuss them with your preceptor in your second meeting.

This will allow further discussion and provide a platform for goal setting

SNOB ANALYSIS

It is a method of self assessment, which essentially allows you to identify your strengths, needs, opportunities and barriers. In order to gain the most out of this exercise, you need to be honest with yourself. Honesty will allow you to identify your goals, which will then enable you to formulate a personal development plan.

Strengths/Skills

What do you do well?

What are you confident about?

What are your good qualities?

Opportunities

How can you improve?

Are there any learning opportunities available?

What is happening in your part of the profession?

Needs

What would you like to do better?

Do you perceive any problems in yourself?

Is there anything holding you back?

Barriers

What might stop you developing?

Does anything worry you about the profession and your part in it?

Does anything worry you about the UHB and your role in it?

Use the SNOB tool to assist you in identifying your learning and development needs. You should discuss this with your preceptor, manager or PPDN

SNOB ANALYSIS

STRENGTH/SKILLS	NEEDS
OPPORTUNITIES	BARRIERS

REFLECTIVE PRACTICE

It is important for you to examine the concept of reflection, how it functions and how you can improve your own ability to reflect. It's about learning and increasing your capacity to reflect on what is happening, learn from it and to document this as evidence.

The influence of feelings on the learning process cannot be over emphasised. Learning and experience can evoke both negative and positive feelings. Positive experiences such as being recognised for providing quality care can validate our worth as individuals and promote learning.

While theoretical knowledge is very important, it does not lead to good practice on its own. Mental Health nurses need to have knowledge of the principles of effective problem solving by reflecting on experiences.

Professional practice requires that you use your judgement to choose from a range of alternative choices whilst at the same time recognising the likely consequences of those choices. Reflective practice requires that you draw upon theoretical knowledge in a creative way to address and solve problems everyday generating practice from theories and theories from practice.

Reflection is an essential part of professional practice. Reflecting on past experiences increase our expertise in the present and the future by offering new insight and integrating theory and practice.

As newly qualified nurses you will be expected to write a reflective account when each of the 7 competency areas has been fully achieved.

Nursing & Midwifery Council

REFLECTIVE ACCOUNTS FORM

You must use this form to record five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user or colleague. Please refer to our guidance on preserving anonymity in the section on non-identifiable information in **How to revalidate with the NMC**.

Reflective account:
What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?
How did you change or improve your practice as a result?

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

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CLINICAL COMPETENCIES

- → Shift management & Leadership
- → Risk Management
- → Record keeping
- → MHA/ Measure / DOLS
- → Physical health care
- → Policies & Procedures
- → Medication Management

SHIFT MANAGEMENT & LEADERSHIP

1.1	ACCURATELY UNDERTAKES CLINICAL HANDOVER AND COMMUNICATES OUTCOMES OF CARE, IDENTIFIED NEEDS OF THE SERVICE USER AND PRESCRIBED ACTIONS.
Evidence should be observed by the preceptor Additional Comments Signature (preceptor)..... Signature (preceptee).....	
1.2	ORGANISES OWN AND OTHERS WORKLOAD BY DELEGATING WORK ACCORDING TO THE NEED OF THE SERVICE USER, PRIORITISING APPROPRIATELY, CONSIDERING ANY CHANGES IN SERVICE USER'S PRESENTATION.
Evidence should be observed by the preceptor Additional Comments	

Signature (preceptor)..... Signature (preceptee).....	
1.3	DELEGATES TASKS APPROPRIATELY, GIVING CONSIDERATIONS TO THE CAPABILITIES AF INDIVIDUAL STAFF AND SKILL MIX.
Evidence should be observed by the preceptor Additional Comments Signature (preceptor)..... Signature (preceptee).....	
1.4	ENSURES THAT STAFF DELEGATED TO MAINTAIN LEVELS OF OBSERVATIONS/ENGAGEMENT ARE FULLY AWARE OF THEIR RESPONSIBILITIES UNDER THE UHB'S POLICY, THE RATIONALE FOR THE OBSERVATIONS AND ANY OTHER RELEVANT RISK FACTORS.
Evidence should be observed by the preceptor Additional Comments Signature (preceptor)..... Signature (preceptee).....	
1.5	SAFELY MANAGES THE CLINICAL AREA; ENSURING THAT A RANGE OF THERAPEUTIC ACTIVITIES ARE FACILITATED TO MEET THE SERVIC E USERS NEEDS.
Evidence should be observed by the preceptor Additional Comments Signature (preceptor)..... Signature (preceptee).....	
1.6	CTRITICALLY ANALYSES AND MANAGES DIFFICULT SITUATIONS, ESCALATING CONCERNS AS REQUIRED.
Evidence should be observed by the preceptor Additional Comments Signature (preceptor)..... Signature (preceptee).....	

1.7	IN THE EVENT OF STAFF SICKNESS OR ABSENCE, PREPERATIONS FOR THE SUBSEQUENT SHIFTS TO BE MADE TO ENSURE SAFE AND APPROPRIATE STAFF SUPPORT.

Evidence should be observed by the preceptor
Additional Comments

Signature (preceptor)..... Signature (preceptee).....

1.8	ORGANISES WORKLOAD EFFECTIVELY AND IN A TIMELY MANNER.

Evidence should be observed by the preceptor
Additional Comments

Signature (preceptor)..... Signature (preceptee).....

1.9	ENSURES AT THE END OF EACH SHIFT THAT THE CLINICAL AREA IS CLEAN, SAFE AND PREPARED FOR THE FOLLOWING SHIFT.

Evidence should be observed by the preceptor
Additional Comments

Signature (preceptor)..... Signature (preceptee).....

1.10	ENSURE THAT THERE ARE ADEQUATE STAFFING NUMBERS TO MAINATIN THE SHIFT SAFELY. ESCALATE S STAFF SHORTAGES TO THE APPROPRIATE PERSON AND ARRANGES ADDITIONAL STAFF.

Evidence should be observed by the preceptor
Additional Comments

Signature (preceptor)..... Signature (preceptee).....

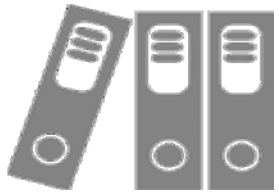
RISK MANAGEMENT

2.1	DEMONSTRATES AN UNDERSTANDING OF THE SIGNS AND SYMPTOMS OF MENTAL ILLNESS IN TERMS OF TYPOLOGY, SEVERITY, IMMEDIATE AND ON GOING SUPPORT NEEDS AND RISK ASSESSMENT
Evidence to be observed by preceptor. Additional comments Signature (preceptor)..... Signature (preceptee).....	
2.2	COMPLETES A COMPREHENSIVE ASSESSMENT UTILISING APPROVED DOCUMENTATION, INCLUDING A REVIEW OF PREVIOUS PSYCHIATRIC AND RISK HISTORY
Evidence should be observed by the preceptor Additional comments Signature (preceptor)..... Signature (preceptee).....	
2.3	EFFECTIVELY ASSESSES AND EVALIUATES THE ENVIRONMENT IN REGARDS TO RISK (LIGATURES, FIRE, PROHIBITED ITEMS ETC)

Evidence to be observed by preceptor Additional Comments Signature (preceptor)..... Signature (preceptee).....	
2.4	EFFECTVELY CONSIDERS THE ENVIRONMENT, STAFFING LEVELS AND CAPABILITIES TO SAFELY MANAGE CLINICAL AREA AND REDUCE RISKS ASSOCIATED WITH VIOLENCE AND AGGRESSION
Evidence to be observed by preceptor Additional Comments Signature (preceptor)..... Signature (preceptee).....	
2.5	SUITABLY SHARES OUTCOMES OR RISK ASSESSMENTS WITH THE MDT AND ANY OTHER RELEVANT AGENCIES
Evidence to be observed by preceptor Additional Comments Signature (preceptor)..... Signature (preceptee).....	
2.6	PARTICIPATES IN REGUALR COLLABORATIVE REVIEWS OF RISK ASSESSMENTS WITH THE SERVICE USER, FORMULATING SAFE STRATEGIES TO REDUCE IDENTIFIED RISK BEHAVIOURS
Evidence to be observed by preceptor Additional comments Signature (preceptor)..... Signature (preceptee).....	
2.7	ENSURES THAT RISK ASSESSMENTS AND RISK MANAGEMENT PLANS ARE REVIEWED WEEKLY AND UPDATED TO INCLUDE ANY CHANGES IN RISK
Evidence to be observed by preceptor Additional comments	

Signature (preceptor)..... Signature (preceptee).....	
2.8	IS FAMILIAR WITH AND ADHERES TO POLICIES/PROCEDURES RELATING TO THE MANAGMENT OF RISKS WITHIN AREA OF PRACTICE (FALLS, VIOLENCE AND AGGRESSION)
Discussion o take place with preceptor to evidence. Additional comments Signature (preceptor)..... Signature (preceptee).....	
2.9	CAN PREPARE A RISK FORMULATION INCORPORATING HISTORIC, CURRENT AND CHANGING RISK FACTORS TO FORMULATE A RISK PROFILE
Evidence to be observed by preceptor Additional comments Signature (preceptor)..... Signature (preceptee).....	
2.10	FEEDS BACK ANY CHANGES IN RISK BEHAVIOURS TO MDT
Evidence to be observed by preceptor Additional comments Signature (preceptor)..... Signature (preceptee).....	

RECORD KEEPING



3.1	RECORDS INFORMATION IN A TIMELY MANNER ON EACH SHIFT		
	Evidence to be observed by preceptor Additional comments	Signature (preceptor).....	Signature (preceptee).....
3.2	KEEPS CLEAR AND ACCURATE RECORDS USING THE UHB APPROVED/RECOGNISED DOCUMENTS		
	Evidence to be observed by preceptor Additional Comments	Signature (preceptor).....	Signature (preceptee).....
3.3	GAINS CONSENT TO TREATMENT AND RECORDS EVIDENCE OF THIS		

	Evidence to be observed by preceptor Additional comments	Signature (preceptor).....	Signature (preceptee).....
3.4	RECOGNISES, SUPPORTS AND DOCUMENTS A PERSON'S RIGHT TO ACCEPT OR REFUSE CARE OR TREATMENT GIVING RATIONALE FOR DECISION. (ADVANCE DIRECTIVES)		
	Evidence to be observed by preceptor Additional comments	Signature (preceptor).....	Signature (preceptee).....
3.5	RECORDS, DEMONSTRATES AN APPRECIATION AND RESPECT OF THE CONTRIBUTION THAT SERVICE USERS MAKE TO THEIR OWN HEALTH AND WELL BEING		
	Evidence to be observed by preceptor Additional comments	Signature (preceptor).....	Signature (preceptee).....
3.5	ENSURES THAT SERVICE USERS ARE ACTIVELY INVLOVED IN THE FORMULATION OF RECOVERY FOCUSED CAREPLANS		
	Discussion to take place with preceptor. Evidence to be observed by preceptor Additional Comments	Signature (preceptor).....	Signature (preceptee).....
3.6	ENSURES THAT ALL SERVICE USERS HAVE A COMPREHENSIVE RISK ASSEMENT AND INDIVIDUALISED, RECOVERY FOCUSED CAREPLANS		
	Evidence to be observed by preceptor Additional Comments	Signature (preceptor).....	Signature preceptee).....

3.7	ENSURES THAT CAREPLANS, RISK ASSESSMENTS AND ALL OTHER RELEVANT DOCUMENTATION IS REVIEWED AND EVALUATED ON A WEEKLY BASIS AND EVIDENCE OF THIS TO BE CLEARLY DOCUMENTED.		
	Evidence to be observed by preceptor Additional Comments	Signature (preceptor).....	Signature preceptee.....
3.8	ENSURES THAT EACH SERVICE USER HAS A COMPREHENSIVE ASSESSMENT AND ANY PERSONAL INFORMATION IS RECORDED APPROPRIATELY AND CORRECTLY.		
	Evidence to be observed by preceptor Additional Comments	Signature (preceptor).....	Signature preceptee.....

MENTAL HEALTH MEASURE/ACT/CAPACITY AND DOLS

4.1	DEMONSTRATES WORKING KNOWLEDGE OF MENTAL HEALTH ACT LEGISLATION AND ITS IMPACT ON THE PROVISION OF NURSING CARE, WITH PARTICULAR REGARDS TO SECTIONS RELATING TO COMPULSORY ADMISISON AND DETENTION.		
	Discussion to take place with preceptor Additional Comments	Signature (preceptor).....	Signature (preceptee).....

4.2	DEMONSTRATES ACCURATE KNOWLEDGE AND UNDERSTANDING OF ALL RELEVANT M.H.A DOCUMENTATION, CAN COMPLETE ALL MHA PAPERWORK FULLY, LEGIBLY AND CORRECTLY AND DELIVER TO APPROPRIATE AUTHORITY	
	Evidence to be observed by preceptor Additional comments .	Signature (preceptor)..... Signature (preceptee).....
4.3	SHOWS AWARENESS AND UNDERSTANDING OF THE USE OF NURSE'S HOLDING POWERS	
	Discussion to take place with preceptor Evidence to be observed by preceptor Additional comments	Signature (preceptor)..... Signature (preceptee.....
4.4	UNDERSTANDS THE RESPONSIBILITIES OF THE NURSE RELATING TO THE AUTHORISATION OF LEAVE UNDER THE SECTION 17 LEAVE POLICIES AND BY THE SERVICE USERS'S RC.	
	Evidence to be observed by preceptor Additional comments	Signature (preceptor)..... Signature (preceptee.....
4.5	ENSURES THAT SERVICE USERS ARE GIVEN THE APPROPRIATE INFORMATION BOTH VERBALLY AND IN WRITING AND FULLY UNDERSTANDS THEIR MENTAL HEALTH ACT STATUS AND RIGHT OF APPEAL DECISON	
	Evidence to be observed by preceptor Additional comments	Signature (preceptor)..... Signature (preceptee.....
4.6	DEMONSTRATES AN AWARENESS OF THE MENTAL HEALTH MEASURE AND THE ROLE AND RESPONSIBILITIES OF THE CARE COORDINATOR	

	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
4.7	DEMONSTRATES AN AWARENESS OF THE MENTAL CAPCITY ACT AND DOL'S AND ITS APPLICATION WITHIN PRACTICE, GIVING CONSIDERATION TO THE ROLE AND RESPONSIBILITIES OF ADVOCACY.		
	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
4.8	UNDERSTANDS HOW THE MENTAL CAPACITY ACT APPLIES TO SPECIFIC AREAS OF PRACTICE SUCH AS BEST INTEREST, LEAST RESTRICTIVE PRNICPLES AND HOW TO ACCESS THIS SUPPORT AND ASSESSMENT.		
	Discussion to take place with preceptor Evidence to be observed by preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
4.9	CONSIDERS ALL EIGHT DOMAINS WHEN DEVELOPING CARE AND TREATMENT PLANS AND ENSURES THAT EACH SERVICE USER RECEIVES A COMPREHENSIVE INDIVUDUALISED CTP.		
	Discussion to take place with preceptor Evidence to be observed by preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
5.0	HAS AWARENESS OF THR ROLES AND RESPONSIBILITIES OF ADVOCACTY AND IS ABLE TO DEMOBSTRATE HOW TO REFER ON TO SERVICE.		
	Evidence to be observed by preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....

PHYSICAL HEALTH CARE

5.1	COMPLETES A RANGE OF MEDICAL ASSESSMENTS INCLUDING NEWS, NEUROLOGICAL OBSERVATIONS, BLOOD GLUCOSE MONITORING, URINARY ANALYSIS, POST FALLS ASSESSMENT AND REVIEW OF MEDICAL HISTORY .

Evidence to be observed by preceptor
Additional comments

Signature (preceptor)..... Signature (preceptee.....

5.2	WHEN DELEGATING A TASK TO A HCSW, ALL ASSESSMENT/MONITORING DOCUMENTATION TO BE REVIEWED TO ENSURE VALIDITY OF SCORES
	Discussion to take place with preceptor Evidence to be observed by preceptor Additional comments Signature (preceptor)..... Signature (preceptee.....
5.3	IS ABLE TO IDENTIFY ANY ABNORMAL ASSESSMENT SCORES AND ESCALATE CONCERNS ABOUT A SERVICE USERS HEALTH TO THE APPROPRIATE MEDICAL STAFF.
	Evidence to be observed by preceptor Additional comments Signature (preceptor)..... Signature (preceptee.....
5.4	PROMOTES HEALTHY LIVING CHOICES AND PHYSICAL HEALTH AWARENESS WITH SERVICE USERS
	Discussion to take place with preceptor Evidence to be observed by preceptor Additional comments Signature (preceptor)..... Signature (preceptee.....
5.5	IS ABLE TO RECOGNISE AND INFORM SERVICE USERS OF SIDE EFFECTS/CONTRAINDICATIONS OF MEDICATIONS
	Discussion to take place with preceptor Evidence to be observed by preceptor. Additional comments Signature (preceptor)..... Signature (preceptee.....
5.6	IS FULLY AWARE OF THE PROCESS TO FOLLOW IN THE EVENT OF A MEDICAL EMERGENCY OR CARDIAC ARREST
	Discussion to take place with preceptor Additional comments

		Signature (preceptor)..... Signature (preceptee.....
5.7	CAN DEMONSTRATE AN UNDERSTANDING OF THE **SKIN BUNDLE** AND THE **ALL WALES CONTINENCE BUNDLE**	
	Discussion to take place with preceptor Evidence should be observed by preceptor Additional comments	Signature (preceptor)..... Signature (preceptee.....
5.8	IS ABLE TO RECOGNISE WHEN REFERRAL TO OTHER AGENCIES IS APPROPRIATE AND HOW TO REFER (PHYSIO, PODIATARY, DENTIST, ANP)	
	Discussion with preceptor Evidence should be observed by preceptor Additional comments	Signature (preceptor)..... Signature (preceptee.....
5.9	HAS AN AWARENESS OF CONTRACEPTION AND SEXUAL HEALTH AND HOW TO REFER TO APPOPRIATE SERVICES	
	Discussion with preceptor Evidence should be observed by preceptor Additional comments	Signature (preceptor)..... Signature (preceptee.....
5.10	MUST ENSURE THAT THE PHYSICAL HEALTH DOMAIN ON PARIS IS COMPLETED AS PART OF THE ADMISSION PROCESS.	
	Discussion with preceptor Evidence should be observed by preceptor Additional comments .	Signature (preceptor)..... Signature (preceptee.....
5.11	IS AWARE OF THE ROLE OF THE ADVANCED NURSE PRACTIONER AND HOW TO ACCESS FOR ADVICE AND PHYSICAL HEALTH INTERVENTIONS	
	Discussion with preceptor Evidence should be observed by preceptor	

	Additional comments	Signature (preceptor).....	Signature (preceptee.....
5.12	HAS AN AWARENESS OF THE UHB SMOKING CESSATION SERVICE AND HOW TO ACCESS SUPPORT AND ADVICE THROUGH ANP		
	Discussion with preceptor Evidence should be observed by preceptor Additional comments .	Signature (preceptor).....	Signature (preceptee.....

POLICIES AND PROCEDURES

6.1	IS AWARE OF THE SICKNESS AND ABSENCE POLICY AND THEIR OWN PERSONAL RESPONSIBILITY IN REPORTING ANY PERIODS OF ABSENCE		
	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
6.2	IS ABLE TO FOLLOW THE CORRECT PROCEDURE OF ESCALATION IF A CONCERN OR COMPLAINT IS RAISED IN THE CLINICAL AREA.		

	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
6.3	IS FULLY AWARE AND ADHERES TO THE POLICIES/PROCEDURES RELATING TO POVA (PROTECTION OF VULNERABLE ADULTS)		
	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
6.4	IS AWARE OF AND CAN DEMONSTATE THE PROCEDURE/PROTOCOL FOR REPORTING MEDICATION ERRORS		
	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
6.5	IS AWARE OF THE ROLE OF THE EMERGENCY RESPONDER IN CLINICAL INCIDENTS		
	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....

MEDICATION MANAGEMENT

7.1	TO ENSURE THAT MEDICATION MANAGEMENT BOOKLET IS COMPLETED AS PER POLICY BEFORE ADMINISTERING MEDICATION		
	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
72	DEMONSTRATES SOUND AWARENESS OF THE CONTROLLED DRUG POLICY AND IS ABLE TO ORDER, STORE, ADMINISTER CONTROLLED DRUGS AS PER POLICY		
	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
7.3	IS ABLE TO PERFORM RAPID TRANQUILISATION DEMONSTRATING SOUND KNOWLEDGE OF DOSE AND POTENTIAL SIDE EFFECTS		
	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
7.4	UNDERSTANDS THE REQUIREMENT FOR MEDICATION TO BE ORDERED AND AVAILABLE		
	Discussion to take place with preceptor Additional comments	Signature (preceptor).....	Signature (preceptee.....
7.5	IS ABLE TO DEMONSTRATE AN UNDEERSTANDING OF STAT DOSE ONE OFF MEDICATION, GIVING CONSIDERATION TO HOW IT IS PRESCRIBED AND DOCUMENTED		
	Discussion to take place with Preceptor Evidence of correct procedure to be observed Additional comment	Signature (preceptor).....	Signature(preceptee).....

CPD & Supervision

→ CPD Log
→ Clinical supervision defined
→ Clinical supervision record

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

LOG TEMPLATE

NMC Nursing & Midwifery Council

Guide to completing CPD record log		
Examples of learning method • Online learning • Course attendance • Independent learning	**What was the topic?** Please give a brief outline of the key points of the learning activity, how it is linked to your scope of practice, what you learnt, and how you have applied what you learnt to your practice.	**Link to Code** Please identify the part or parts of the Code relevant to the CPD • Prioritise people • Practise effectively • Preserve safety • Promote professionalism and trust

Please provide the following information for each learning activity, until you reach 35 hours of CPD (of which 20 hours must be participatory). For examples of the types of CPD activities you could undertake, and the types of evidence you could retain, please refer to our guidance sheet at **revalidation.nmc.org.uk/download-resources/guidance-and-information/**

Dates	**Method** Please describe the methods you used for the activity	**Topic(s)**	**Link to Code**	**Number of hours**	**Number of participatory hours**
				Total:	**Total:**

CLINICAL SUPERVISION SUPPORT

Clinical supervision in the workplace was introduced as a way of using reflective practice and shared experiences as a part of continuing professional development (CPD). It is supported by the NMC and it fits well into the clinical governance framework whilst assisting in improving standards of care.

It is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice. "Supervision aims to identify solutions to problems, improve practice and increase understanding of professional issues" UKCC (1996). There are various models or approaches to clinical supervision; one-to-one supervision, group supervision, peer group supervision. The choice of approach will depend upon a number of factors, including personal choice, access to supervision, length of experience, qualifications, availability of supervisory groups, etc.

A Supervisor is a skilled professional who assists practitioners in the development of their skills, knowledge and professional values. A supervisor, in this instance, is a qualified practitioner who has sufficient experience to deploy advice in a supervisory situation. Supervisors may be line managers, or colleagues, who are in a position to counsel staff on practice guidelines and applied policy.

A Supervisee is a practitioner who receives professional advice, support and guidance from a supervisor. The UKCC (1996) suggests that clinical supervision will enable the supervisee to develop greater knowledge and a deeper understanding of accountability. Of course, for those practitioners who are very experienced in their field of work, a supervisor may be used more as a source of support for reflection on practice.

Clinical Supervision is not a mandatory requirement within Cardiff and Vale UHB; however, we would strongly encourage newly qualified nurses to engage in this activity as a support mechanism which encourages reflection in practice. There are many Clinical Supervisors within the Trust and these can be accessed via CavWeb Intranet. The preceptorship programme fully supports Clinical Supervision. The meetings with your clinical supervisor can be listed on the Clinical Supervision Record and will be helpful with your revalidation requirement.

CLINICAL SUPERVISION RECORD

NAME OF PRECEPTEE:

NAME OF PRECEPTOR:

NAME OF CLINICAL SUPERVISOR:

MEETING MONTH 1 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 2 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 3 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 4 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 5 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 6 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 7 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 8 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 9 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 10 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 11 SUPERVISOR…… PRECEPTEE……..

MEETING MONTH 12 SUPERVISOR…… PRECEPTEE……..

Closing

→ Area of progression
→ Final word
→ References

AREAS OF PROGRESSION DIFFICULTY

Any areas of difficulty which has resulted in deferred progression and cannot be resolved through Preceptorship support should be discussed with the Line Manager and an appropriate action plan agreed.

AREA OF DIFFICULTY

STRATEGIC INTERVENTIONS APPLIED.

FUTURE ACTION PLAN AGREED BETWEEN LINE MANAGER, PRECEPTEE AND PRECEPTOR.

PRECEPTEE SIGNATURE……..

PRECEPTOR SIGNATURE……

LINE MANAGER SIGNATURE……

DATE……

Final Word

Cardiff and Vale UHB would like to congratulate you on your success in the transition from newly registered nurse by successfully completing your preceptorship. We hope the programme has been valuable to you and you have received the support and guidance required to develop your knowledge skills and competence within your chosen field.

We are committed to supporting nurses to reach their full potential and hope that the programme has been a tool to help facilitate this and support all aspects of your personal and professional development.

We wish you all the best in your future and hope that the foundation skills that you have been taught throughout the first year of your career will continue to flourish and enable you to reach your goals and capabilities.

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

SUPPORTING YOU TO IMPROVE SERVICES

Mental Health Clinical Board Day of Care Survey Hafan Y Coed

25th July 2018

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

Day of care survey

Provides a rapid assessment of the in-patients present within the hospital or unit using an appropriateness evaluation protocol (AEP).

Developed by an expert multi-disciplinary group. Over 10, 000 patients surveyed to date using this tool.

Each in-patient is assessed using contemporaneous case note review by a consultant and senior nurse/midwife/manager/AHP.

Current treatment regime is not questioned.

For example if a patient is on IV antibiotics it is accepted that appropriateness criteria are met and the appropriateness of the patient being on IVs is not assessed.

This builds a picture of bed usage in the hospital or unit , helps identify system delays, and suggests opportunities to improve flow.

How it works

The protocol considers the intensity of nursing or level of care required and types of treatment ordered as well as the clinical characteristics according to history, examination and laboratory investigations.

2 sets of criteria are applied:

1. Clinical criteria (severity of illness)
2. Care based (intensity of care required)

Only one criterion from either set has to be satisfied for bed use to be deemed appropriate, although reviewers have the option of over-riding the protocol in either direction

If patients do not meet the criteria, auditors are asked to suggest the alternative appropriate setting for that patient , in a community care setting or at home or for out patient investigation.

1. Clinical criteria

Severity of illness criteria

#	Criteria
1	Acute or ongoing deterioration in mental state where risk to self is so significant or immediate that they cannot be cared for in a community setting.
2	Acute or ongoing deterioration in mental state where risk to others is so significant or immediate that they cannot be cared for in a community setting.

2. Care based criteria

Service intensity that requires access to mental health inpatient facilities

#	Criteria
1	Requires ECT and home support unavailable for the 24 hours post anaesthesia
2	Medication initiation
3	Planned respite, e.g. part of CTP
4	CTO Recall
5	Requires prolonged assessment of complex needs / diagnosis
6	Directed by Court / MoJ

Day of care survey Hafan Y Coed results summary

Bed Occupancy	95.48%
Number of beds (allocated)	155
Number of patients	148
Beds closed	6
Beds empty	1
Patients being discharged today	0
Day of Care criteria not met	40
% Day of Care criteria not met	27%
Clinical override used	5 (0 appropriate, 5 inappropriate)

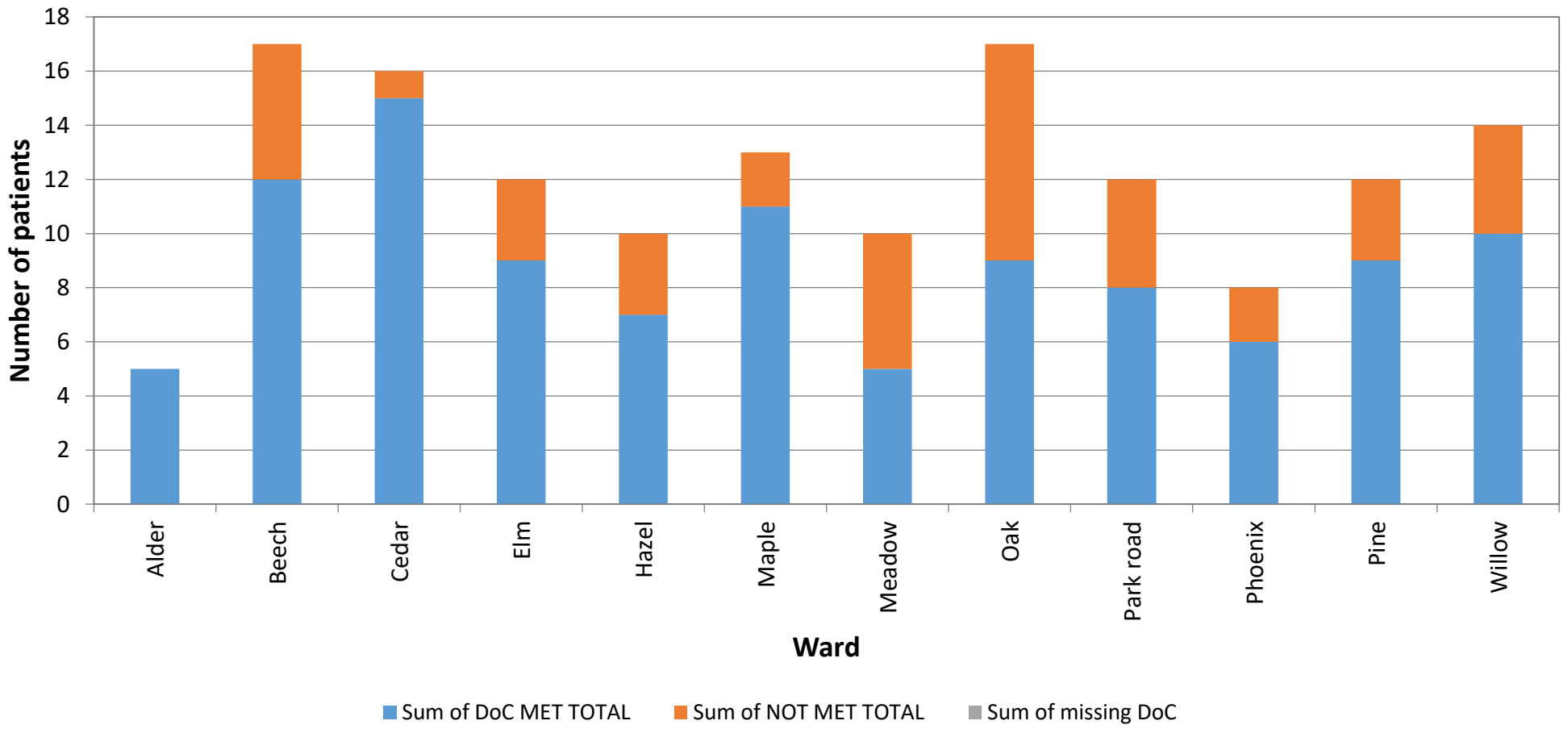
Day of care survey Hafan Y Coed

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

CSI
SUPPORTING YOU TO IMPROVE SERVICES

DoC criteria met, by ward

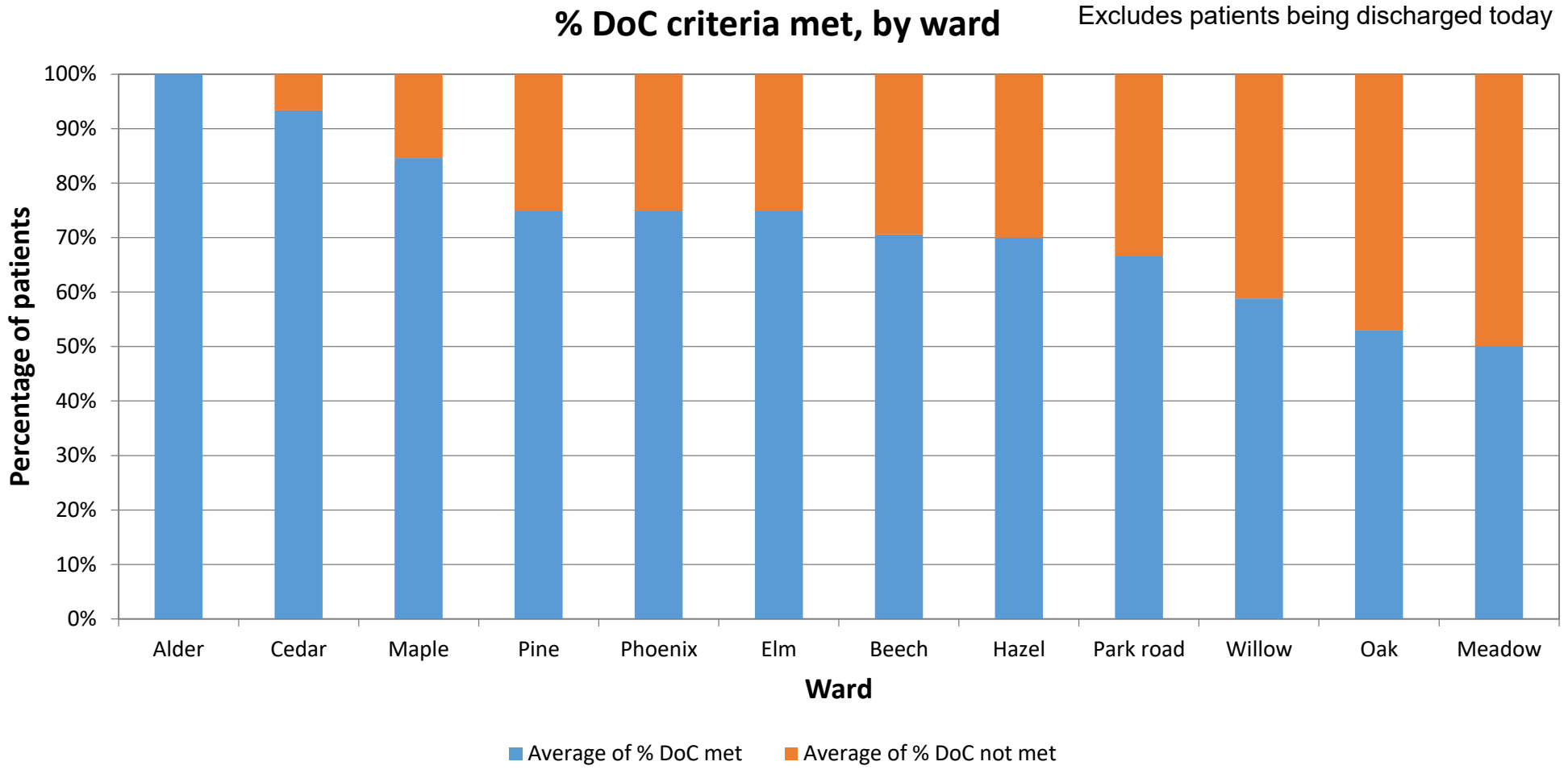
Excludes patients being discharged today.



Day of care survey Hafan Y Coed

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

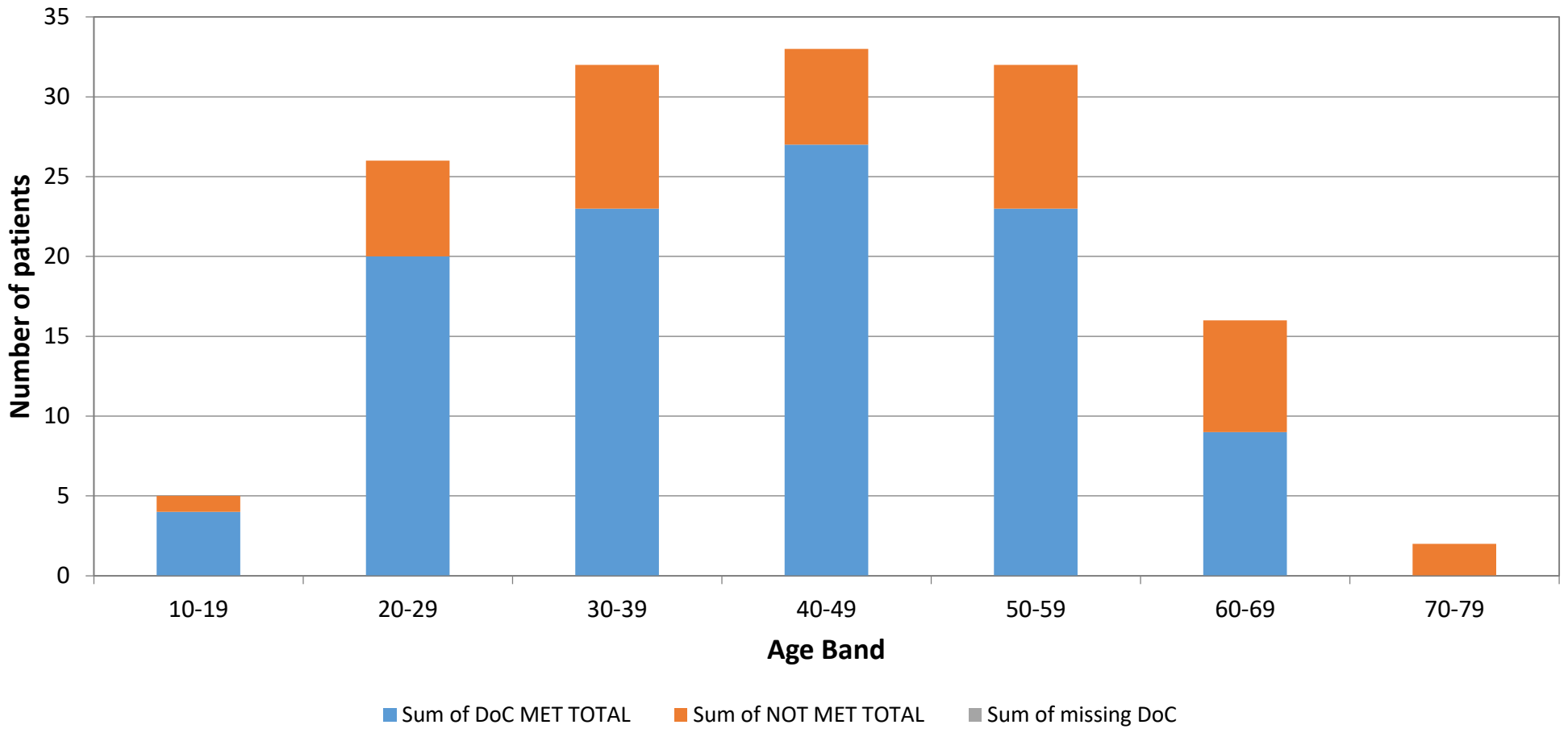
SUPPORTING YOU TO IMPROVE SERVICES



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

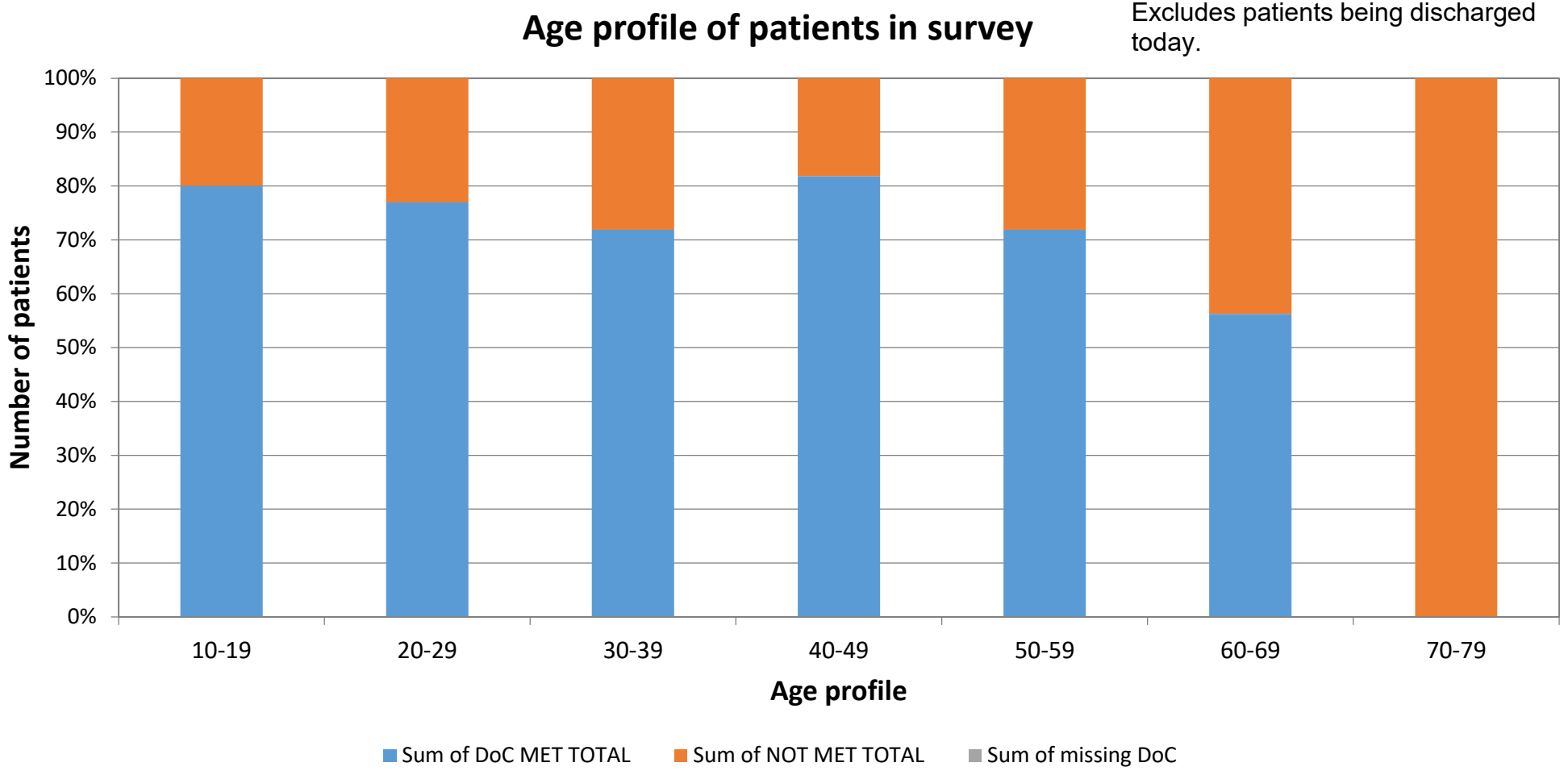
Day of care survey Hafan Y Coed

Excludes patients being discharged today.



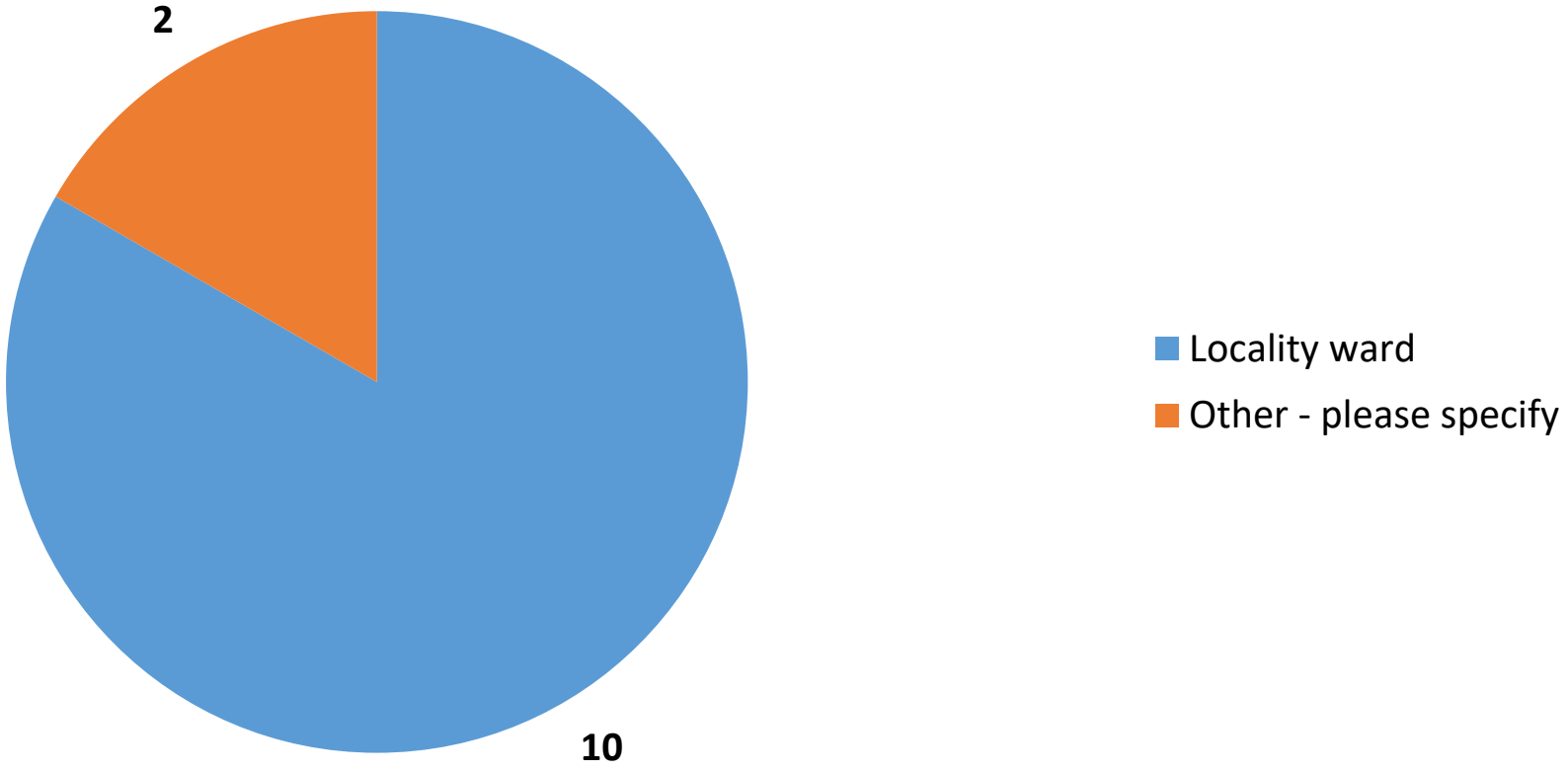
Day of care survey Hafan Y Coed

Excludes patients being discharged today.



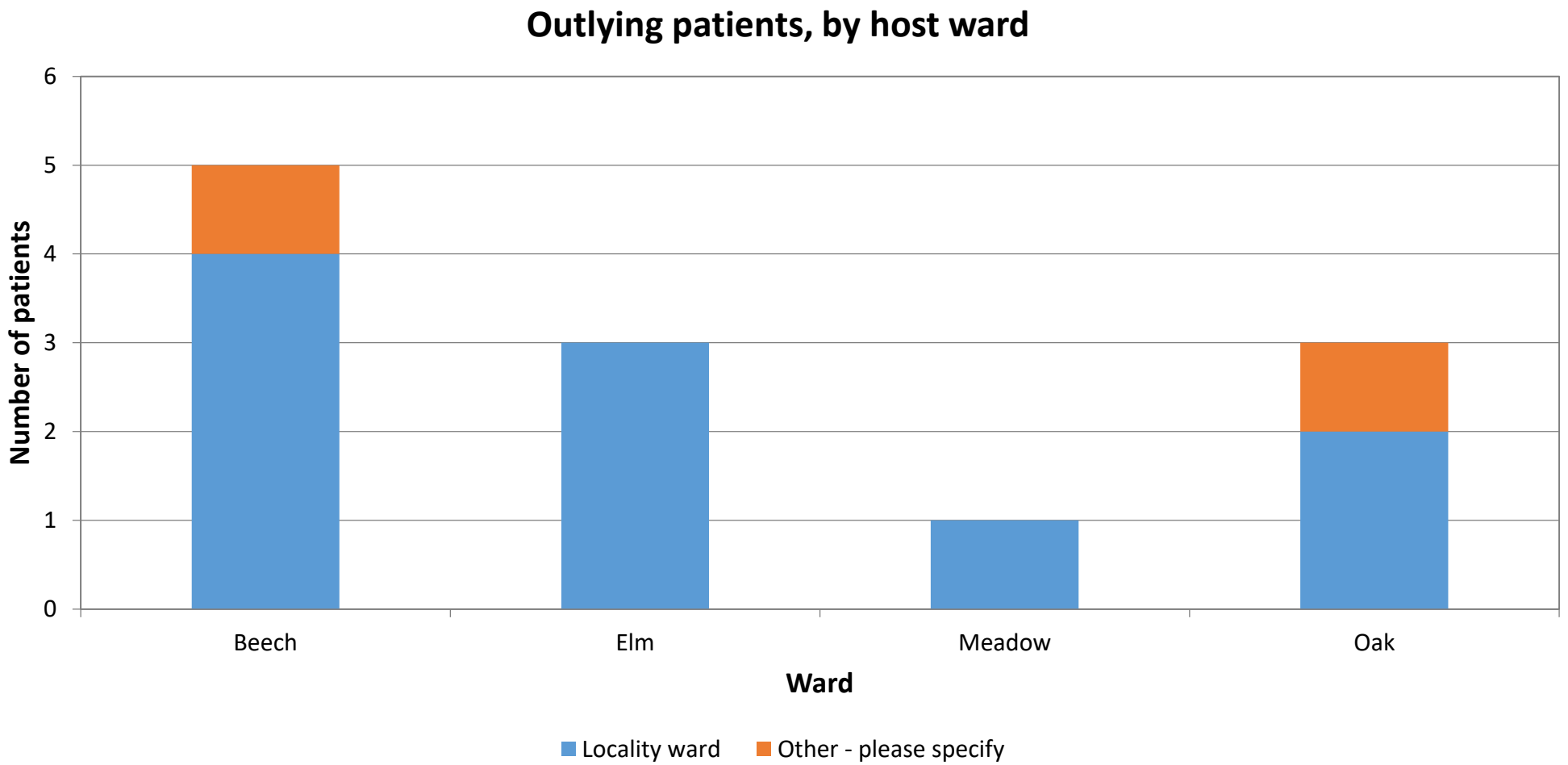
Day of care survey Hafan Y Coed

Outliers



Caring for People, Keeping People Well

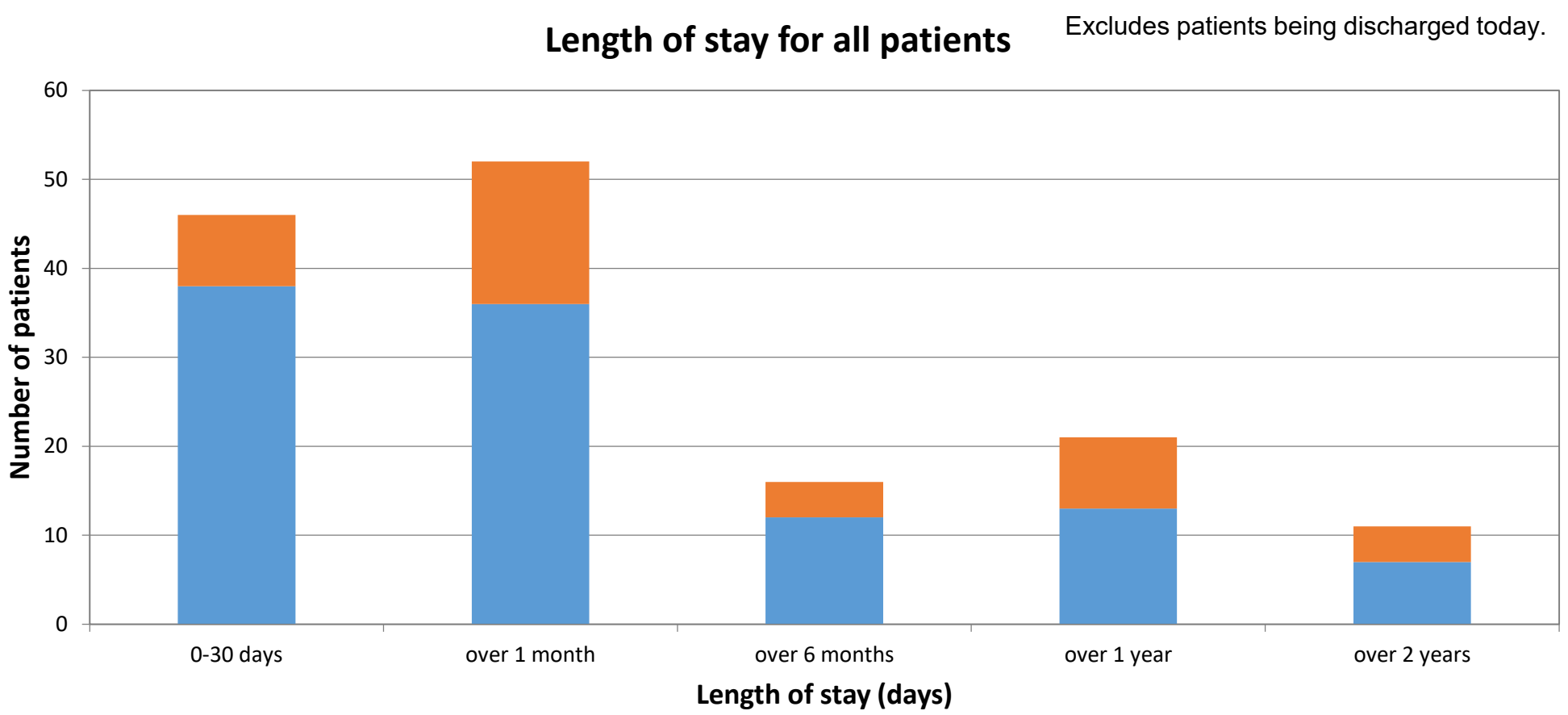
Day of care survey Hafan Y Coed



Caring for People, Keeping People Well

Day of care survey Hafan Y Coed

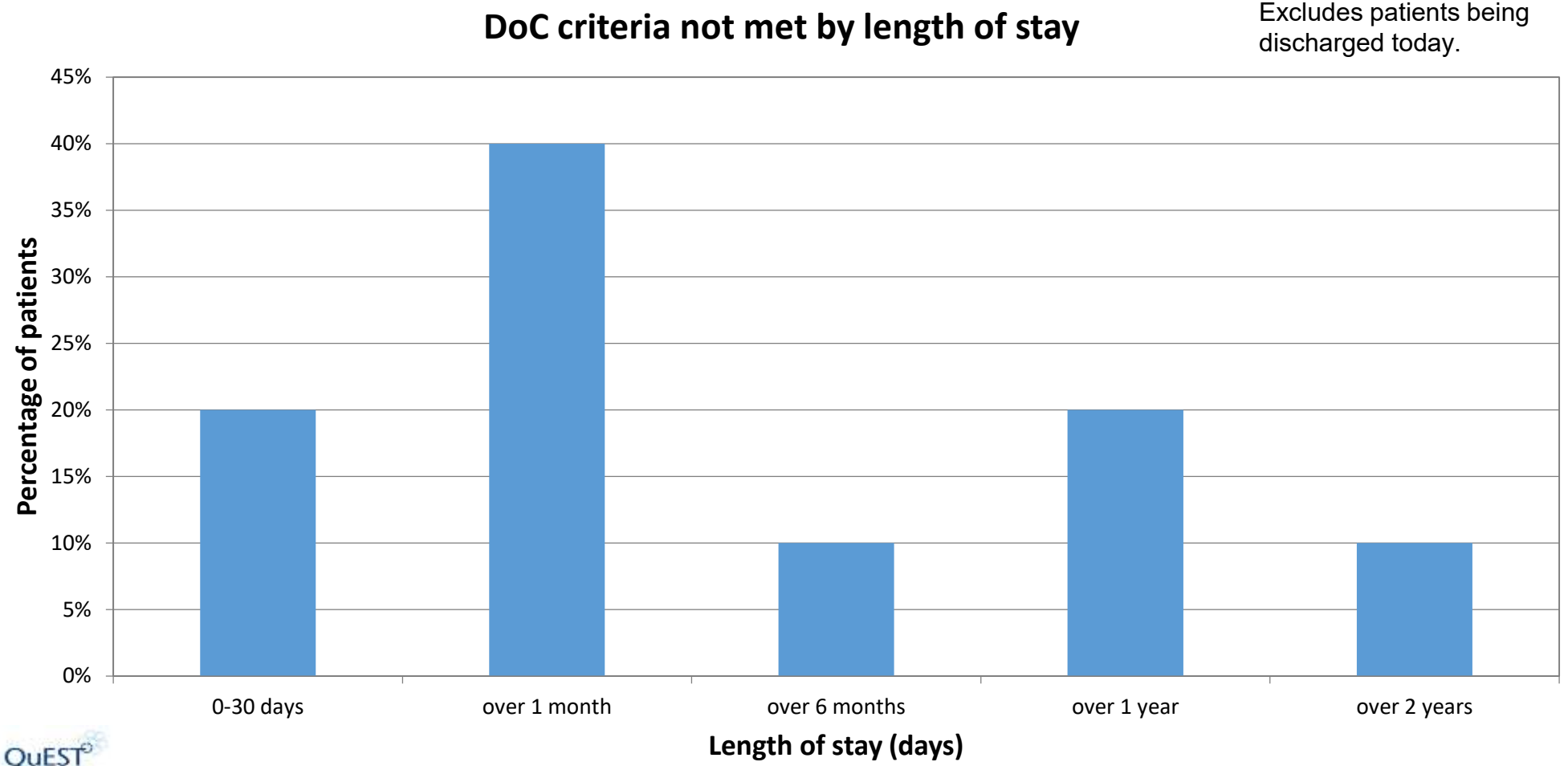
Excludes patients being discharged today.



Caring for People, Keeping People Well

Day of care survey Hafan Y Coed

Excludes patients being discharged today.



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

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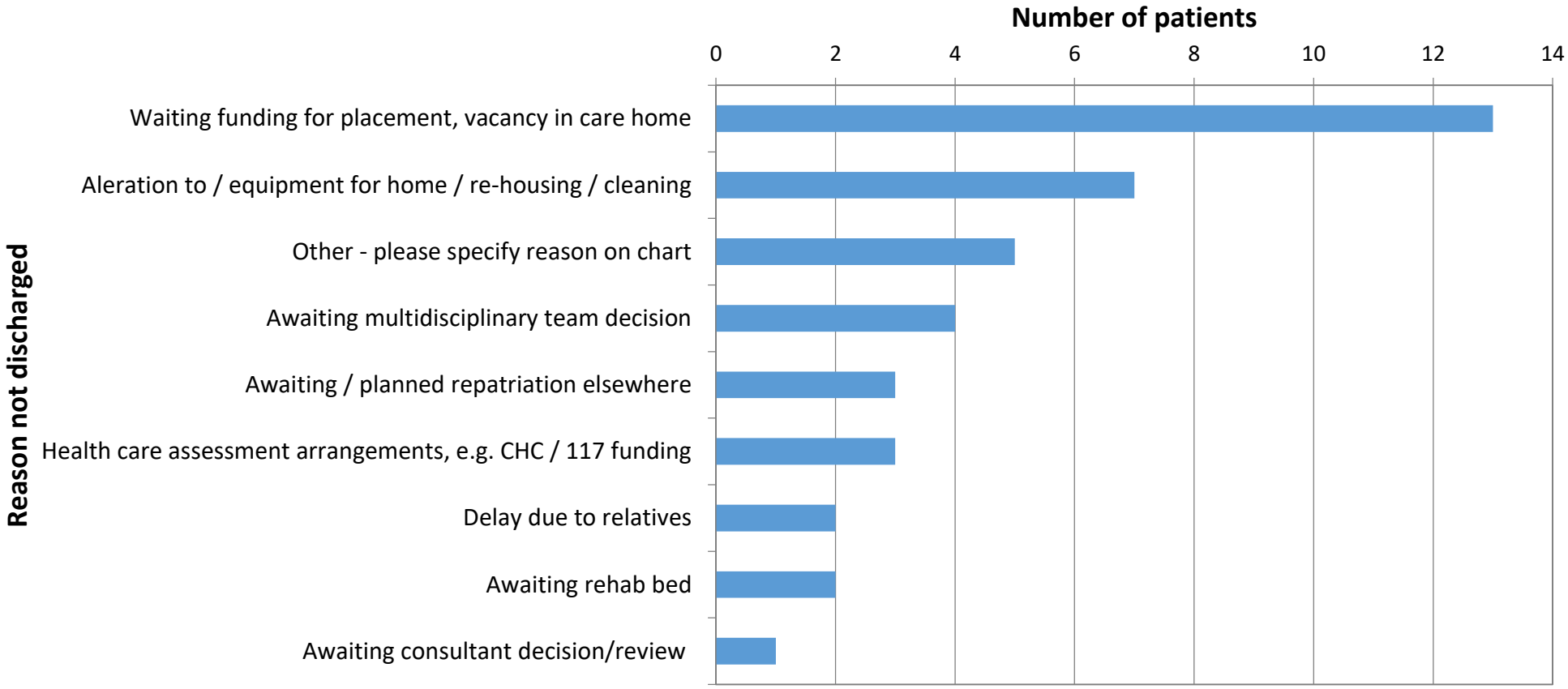
QuEST

Caring for People, Keeping People Well

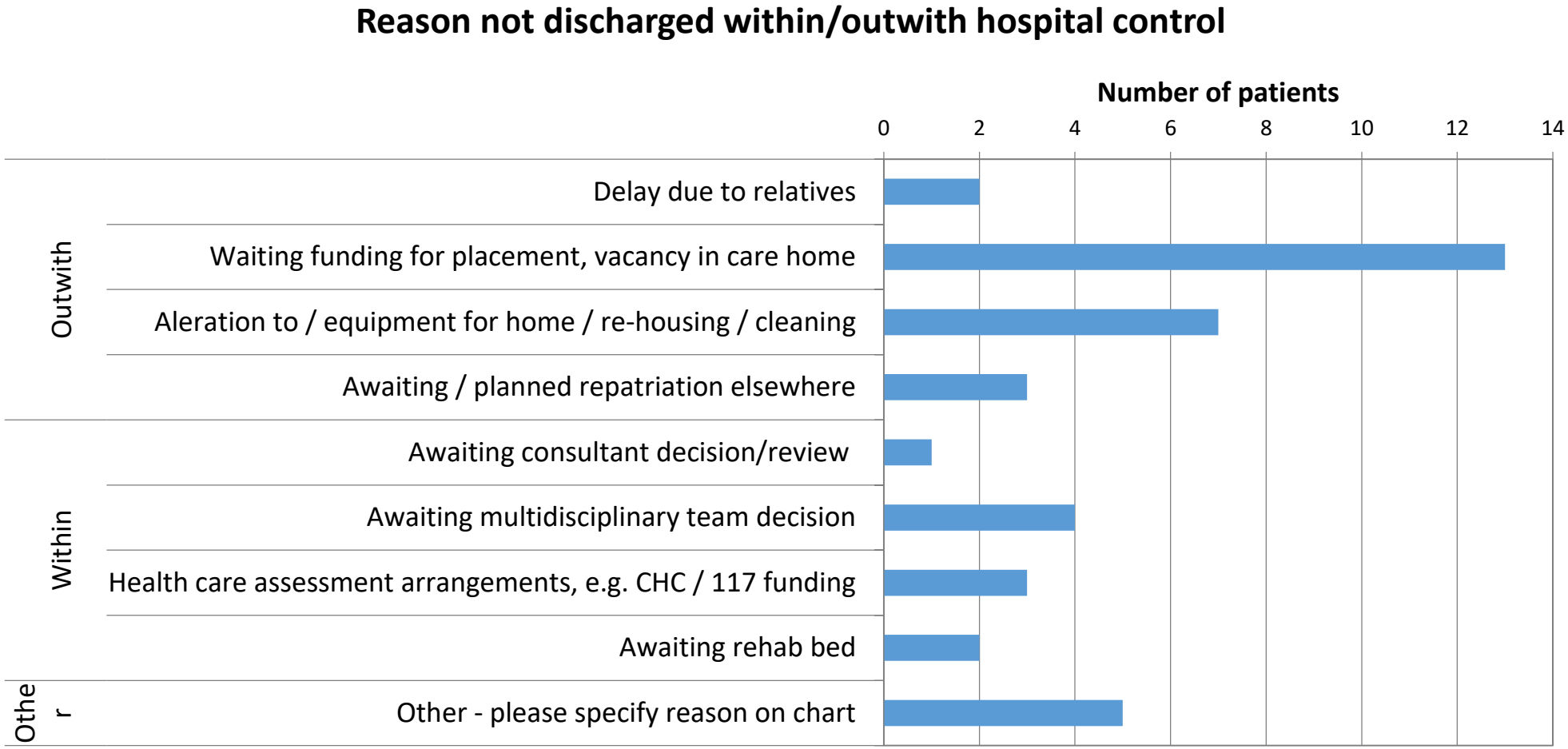
Day of care survey Hafan Y Coed

Reason not discharged

Excludes patients being discharged today.

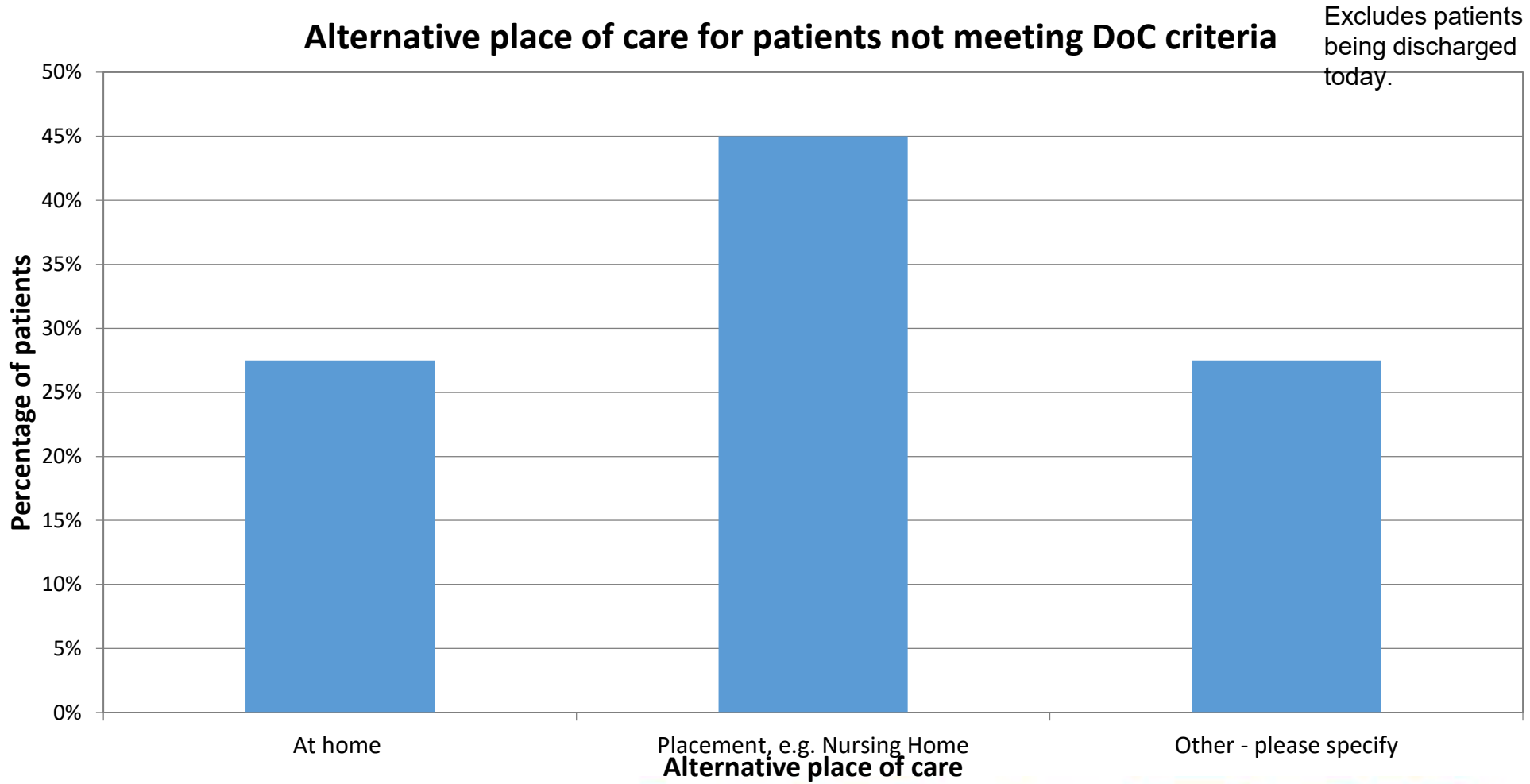


Day of care survey Hafan Y Coed



Day of care survey Hafan Y Coed

Excludes patients being discharged today.



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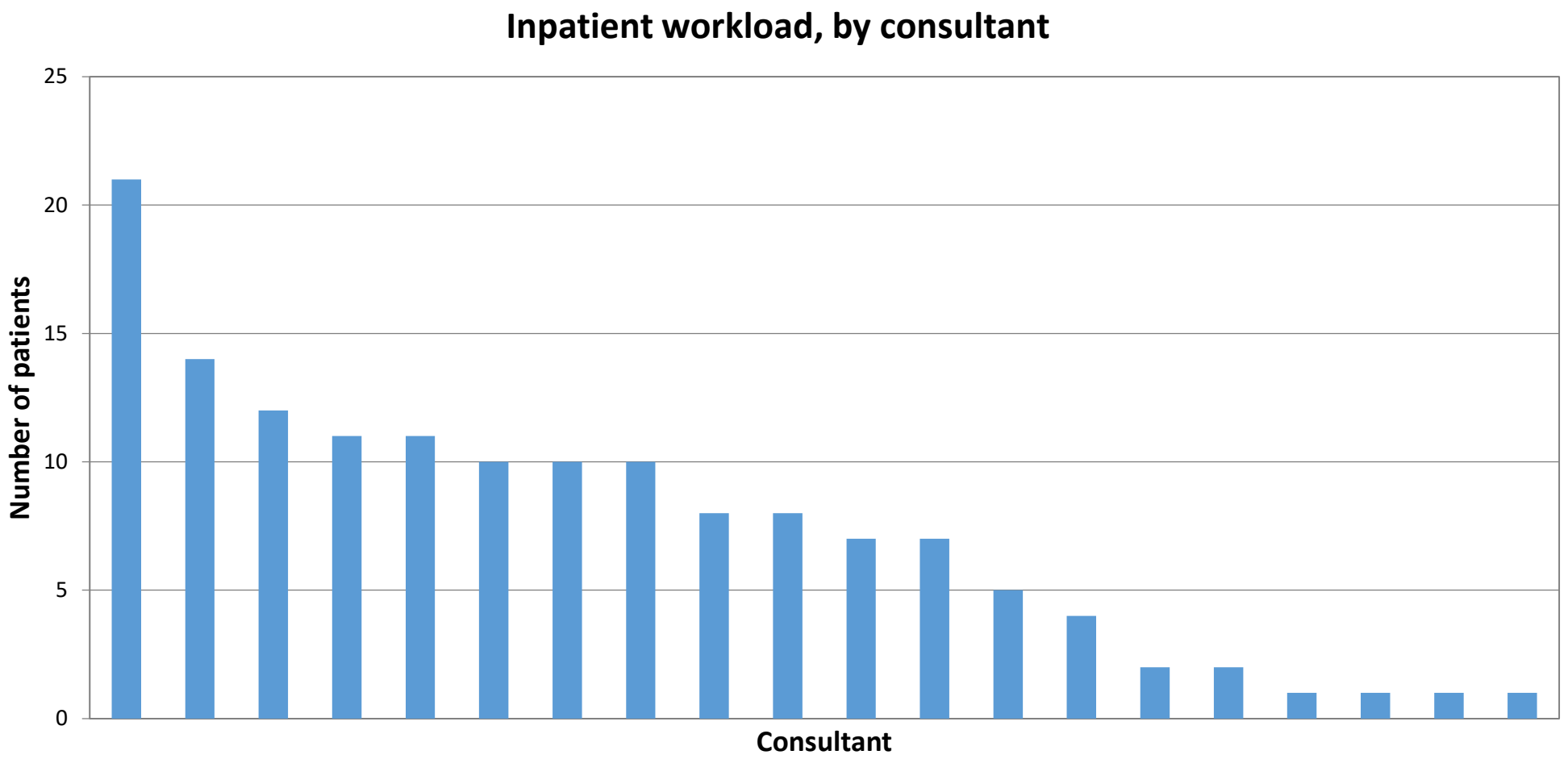
Caring for People, Keeping People Well

Day of care survey Hafan Y Coed



Caring for People, Keeping People Well

Day of care survey Hafan Y Coed

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

REPORT TITLE:	**Tawel Fan Independent Inquiry**								
MEETING:	Quality Safety and Experience Committee						**MEETING DATE:**	**18.12.18**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	**Head of Patient Safety and Quality Assurance**								

PURPOSE OF REPORT:

Please set out why this report is being provided to the meeting.

SITUATION:
The paper gives a high level overview of the themes of the Independent Investigation into the Care and Treatment provided on Tawel Fan Ward and the UHB position against these findings.

REPORT:

BACKGROUND:

An Independent Investigation into the care and treatment provided on Tawel Fan ward was commissioned by Betsi Cadwaladr University Health Board (BCUHB) in response to concerns raised by 23 families about the care received by their relatives on the ward.

In 2013 a series of events occurred which brought several issues regarding Tawel Fan to the attention of senior management within BCUHB and led to the ward being closed.
These included:

- A number of concerns raised under the Protection of Vulnerable Adults (POVA) Process
- Growing management difficulties in relation to the levels of aggression and disruption experienced by nursing staff from the relatives of some patients
- Challenges in managing patient acuity as a result of bed shortages
- Concerns around professionalism of nursing handover following the review of covert recording
- Concerns raised by a member of staff regarding the witnessed restraint of a patient
- Difficulties in maintaining safe staffing levels

ASSESSMENT:
BCUHB have developed a Clinical Programme Group (CPG) model that cuts across the complex and challenging geographical boundaries that exist in North Wales. It was envisaged that the structure would mean that CPGs would run with a high level of autonomy. The independent investigation identified that there were weaknesses in the governance that

surrounded this structures and found that the committee structure of the health board did not dovetail into that of the CPGs. The structure of BCUHB is unique to North Wales; despite this there are a number of themes emerging from the independent Inquiry that should be considered in relation to service provision within Cardiff and Vale and where it is appropriate to seek assurance about local service provision.

These findings include:

The Planning of Services in line with the National Dementia Plan
The review concluded that there was a lack of strategic direction and the operational process in relation to acute and inpatient mental health service provision for older adults across North Wales was convoluted and muddled.

Monitoring of available Care home Placements
It was identified that a significant number of care home beds were lost across North Wales, this had resulted in several patients being accommodated inappropriately in older people's inpatient care settings, increased crisis admissions from care homes and delayed transfers of care.

Clinical Governance
The Inquiry identified that the traditional pillars of Clinical Governance were not implemented or monitored. One quote from a witness stated "we didn't talk about quality, we didn't talk about audit and we didn't talk about effectiveness."

Clear processes to ratify policies were inefficient; there were examples of clinical policies that had been developed within the Mental Health CPG that were not evidence based. Processes for removing old policies and procedures from circulation and for effectively disseminating changes to policies and procedures were ineffective and there was no auditable trail to establish which staff had read policy updates.

There was no effective clinical audit programme designed to support the patient safety and quality agenda. Audit activity was not aligned to Datix reporting and quality and safety themes and it was not possible to track service improvement initiated as a result.

The CPG was consistently not meeting the 30 day response requirements of the Putting Things Right (PTR) regulation. There were also confused escalation processes when a complainant was not content with a complaint response and this led to confusion and in some cases contradiction. Finally complaint responses remained within the CPG and themes and potential for learning lessons never reached The Board.

Safeguarding
The safeguarding systems set up by the CPG were poorly aligned to the Six Local Authority Areas. There were insufficient systems to record and save safeguarding information, as a result ensuring that the information was available to those that were required to see it was often not possible. The processes to monitor safeguarding training were inadequate.

Antipsychotic prescribing
While the Inquiry team found that the use of psychotropic medication fell within good practice with physical examinations undertaken prior to prescribing, there were occasions when prescribing and administration processes could have been more robust.

End of Life care
There was no reliable availability of hospice beds to provide end of life care for patients with dementia and as a result psychiatric wards were increasingly providing end of life care.

Diagnosis
A number of families raised concerns about the diagnostic process and subsequent support and follow up that was made available to them.

A baseline position for Cardiff and the Vale UHB is attached at Appendix 2.

RECOMMENDATION:
The committee is asked to review baseline assessment and to note the health board's position and planned actions relating to the themes of the Independent Review.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration		Collaboration		Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Appendix 2 - Baseline Line Assessment of the Themes Identified in the Tawel Fan Independent Review

Theme	UHB Position	Lead	Action/by when/by whom
The National Dementia Strategy should be underpinned by a local strategy and action plan with adequate monitoring and reporting arrangement around the progress	The Cardiff and Vale 2018/21 Dementia Strategy has been co produced by a range of stakeholders and sets out the vision for Cardiff and the Vale of Glamorgan including eight strategic objectives. The Cardiff and Vale 2018/21 Dementia Action Plan details the actions that sit under each of the eight strategic objectives in the local dementia Strategy including the leads and timescales. Embedding person Centred Care is a central element in the Dementia Action Plan and includes the implementation of the Team Around the Individual which identifies a care worker to each individual from diagnosis until the end of life The Cardiff and Vale Dementia Action Plan incorporates actions relating to assessment and diagnosis, post diagnosis information and follow up support as well as a 3% target for increase in diagnosis rates.	Public Health	• Continue to implement the recommendations from the memory team assessment services audit. • Continue to implement and monitor the C&V Dementia Action Plan Progress against the action plan is reported to Welsh Government 6 monthly. Review June 2019/DoN Mental Health Clinical Board
An integrated approach to care home provision and quality monitoring should be in place.	The availability of Care Home Placements is monitored by the Primary Community and Intermediate Care Clinical Board and through the processes to manage Funded Nursing Care and Continuing Health Care arrangements. UHB Nurse Assessors are integral in monitoring the quality and appropriateness of care delivery in care homes.	Mental Health/Primary Care	There are robust arrangements in place within the UHB to monitor this.

Appropriate governance arrangements should be in place including : • audit designed to give assurance around patient safety themes • A robust system of quality control around clinical policies and procedures • Timely management of concerns	Mental Health Clinical Board have developed a clinical audit plan incorporating national Clinical audits and local audits designed to address their quality and safety priorities. An update of all Clinical Board Clinical Audit Plans will be reported to QSE in June 2019. There is a Policy for the Management of Policies, Procedures and Other Written Control Documents which was ratified in 2010 and updated in 2011 to ensure the governance around the management of controlled documents. Assurance was provided to the QSE committee in 2017 and 2018 with regards the progress being made to address outdated policies. Concerns are managed in line with the regulations and performance is reported and monitored via the quality and safety dashboard that is reported at the Clinical Boards Executive Performance reviews. Emerging themes around concerns and patient safety incidents are discussed weekly with the Executive Nurse Director and reported to the Management Executive as required.	Patient Safety and Quality/ Patient Experience / Mental Health	• Report Audits through the appropriate forum and monitor actions undertaken to address requisite There are robust arrangements in place within the UHB to monitor this. Review June 2019/DoN Mental Health Clinical Board
Safeguarding training should be monitored and adequate compliance maintained	Safeguarding training at Level 2 is mandated for all staff. Compliance is monitored and reported at Clinical Board level at Quality Safety and experience Committee. Clinical Board compliance is monitored and reported through the Clinical Board Executive Performance reviews. Across the UHB Designated Lead Managers (DLM) who have undertaken enhanced safeguarding training are appointed to support the safeguarding process . Within the Mental Health	Safeguarding / Mental health	• Ongoing Monitoring of Compliance There are robust arrangements in place within the UHB to monitor this.

	Clinical Board there is a safeguarding Nurse Advisor aligned to the Clinical Board and available who reports to QSE meetings. Safeguarding supervision is provided to CMHTs and to the Designated Lead Managers. Head of safeguarding has regular meetings with Lead Nurse for Acute MH services and DON.		Review June 2019/DoN Mental Health Clinical Board
A process should be in place to record safeguarding information including protection plans, Strategy meetings, formal monitoring and review plans	Recording of protection plans and strategy meetings for health led cases are led by the health Designated Lead Manager within the Clinical Board/ Directorate. All information is saved in the DLM folder on the shared drive. This folder is accessible to all DLMs within the specific CB as well as the Director of Nursing. Key safeguarding issues are reported to the weekly Management executive as appropriate and monitored. A Safeguarding update is provided to every private session of the UHB Quality, Safety and Experience Committee. There is a well embedded Safeguarding Group in place.	Safeguarding / Mental Health	• Clinical Board to monitor compliance of up to date recording through audit. There are robust arrangements in place within the UHB to monitor this. Review June 2019/DoN Mental Health Clinical Board
A robust process should be in place to allow appropriate sharing of safeguarding information and the tracking of safeguarding documentation	All safeguarding information is saved and accessible on PARIS and in the Shared Safeguarding Folder PARIS has the capability to track safeguarding cases. Current work to develop the electronic patient record to allow all staff to be able to access safeguarding information is underway.	Safeguarding / Mental Health	• PARIS development to ensure safeguarding information is accessible to all staff Review June 2019/DoN Mental Health Clinical Board

Deprivation of Liberty performance should be monitored and reported	There is a process for reporting and monitoring of Deprivation of Liberty (DoLs) application and assessments within the UHB . Compliance of timely management of DoLs is audited and reported at the Quarterly Partnership Board. Additional funding has been made available at the beginning of 2018 /19 financial year to manage the demand in response to audit results. Application of DoLS is monitored via the Mental Health and Capacity Legislation Committee	Deprivation of Liberty Team	• Ongoing audit and reporting There are robust arrangements in place within the UHB to monitor this. Review June 2019/DoN Mental Health Clinical Board
All older adults and those with dementia must be in receipt of lawful and safe restrictive practice.	All inpatients in Mental Health Services for Older People are subject to either DOLs or the Mental Health Act as ward doors are locked.	Mental Health	NA
Antipsychotic prescribing should be monitored and reviewed where necessary.	The UHB participates in the National Audit of Psychosis and has a robust process for reviewing prescribing including the monitoring of patients prescribed in excess of the maximum BNF recommended dose.	Mental Health	• Continued monitoring and audit Review June 2019/DoN Mental Health Clinical Board
All older adults and people with dementia should have the same access to end of life care as any other individual	End of Life Care and Treatment Plans are in use to support decision making. Access to the Palliative Care team is equitable across all Clinical Boards including Mental Health. There is consultant cover out of hours as well as Out of Hours GP provision to ensure 24 hour care for end of life patients.	Mental Health	• Use of advance care directives to be evaluated • Evaluation of end of life care training provision in Mental Health Clinical Board. Review June 2019/DoN

			Mental Health Clinical Board

Reference Number: 291 **Version Number: 2**	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number: 291**

Being Open Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we are committed to Being Open with patients and staff following adverse events.

The Policy defines Being Open in line with the framework introduced to the NHS by the former National Patient Safety Agency (NPSA) in 2005, with updated guidance in 2009.

Being Open broadly involves:-

- acknowledging, apologising and explaining to patients, their families and carers when things go wrong;
- when appropriate, conducting a thorough investigation into adverse incidents and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring;
- providing support for those involved to cope with the physical and psychological consequences of what happened.

The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013 chaired by Robert Francis QC, made many significant recommendations; recommendation 181 was that a statutory duty of candour be introduced for health and care providers. The following definitions were referred to the Report and are adopted by the UHB.

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

We encourage an open and just culture. The aim of reporting and investigating adverse incidents is not to blame but rather learn from the event and to minimise risk of recurrence. A critical component of the learning process is to be open with those affected by the event, including conveying an apology. It is important to remember that saying sorry is not an admission of liability and is the right thing to do when an adverse incident has occurred.

The way a concern is initially handled can have an impact on everything that follows, so a robust approach to Being Open by providing a sympathetic, genuine and listening approach is crucial.

Policy Commitment

To ensure that all staff, regardless of seniority or permanency, understand the responsibility to be open and transparent in their communication with relevant persons following an adverse incident.

To promote a culture that encourages candour, openness and honesty at all levels. This is an integral part of a culture of safety that supports organisational and personal learning.

To enable the UHB to be compliant with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Safe Care, Compassionate Care: A National Governance Framework.

To enable individual members of staff who are registered with professional bodies to fulfil the obligations of their professional duty of candour.

Supporting Procedures and Written Control Documents

- Incident, Hazard and Near Miss Reporting Procedure

Scope

This policy applies to all staff in all locations, including those with honorary or temporary contracts.

The policy applies when harm to patient/s at moderate, major or catastrophic level has been identified. This is irrespective of whether the harm is identified by patients, their family or carers, for example, through the concerns process or by staff through incident reporting procedures. Any decision to discuss near miss / low harm incidents with patients, their families and carers will be on an individual patient basis.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact
Policy Approved by	Quality, Safety and Experience Committee
Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures	Clinical Board Quality, Safety and Experience Groups

written to explain how this policy will be implemented	

Accountable Executive or Clinical Board Director	Executive Nurse Director
Author(s)	Head of Patient Safety and Quality

Disclaimer

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

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
	Date of Committee or Group Approval	*TBA*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*
2			Policy and Procedure have been separated into different documents. Updated reference to National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Safe Care, Compassionate Care: A National Governance Framework is made.

Equality & Health Impact Assessment for

BEING OPEN POLICY

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Being Open Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive Nurse Head of Patient Safety and Quality – 46387
3.	Objectives of strategy/ policy/ plan/ procedure/ service	• To ensure that all staff, regardless of seniority or permanency, understand the responsibility to be open and transparent in their communication with relevant persons following an adverse incident. • To promote a culture that encourages candour, openness and honesty at all levels. This is an integral part of a culture of safety that supports organisational and personal learning. • To enable the UHB to be compliant with the National Health

		Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Safe Care, Compassionate Care: A National Governance Framework. • To enable individual members of staff who are registered with professional bodies to fulfil the obligations of their professional duty of candour.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages	The Being Open framework was introduced to the NHS by the former National Patient Safety Agency. The framework specifically considered the needs of patients in particular circumstances, for example, those who are children, those with mental health issues, those with cognitive impairment, different language, communication or cultural considerations. The associated Procedure considers these issues in turn. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013 chaired by Robert Francis QC, made many significant recommendations; recommendation 181 was that a statutory duty of candour be introduced for health and care providers. The Report can be accessed here. This has been introduced by the Care Quality Commission in NHS England into their regulatory framework. In NHS Wales, it is underpinned by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011

	Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	(more information is here) and Safe Care, Compassionate Care: A National Governance Framework (more information is here).
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This policy applies to all staff in all locations, including those with honorary or temporary contracts.

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

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

BEING OPEN PROCEDURE

Introduction and Aim

It is the policy of the UHB to be open with patients and staff following adverse events.

The Being Open framework was introduced to the NHS by the former National Patient Safety Agency (NPSA). It broadly involves:

- acknowledging, apologising and explaining to patients, their families and carers when things go wrong;
- when appropriate, conducting a thorough investigation into adverse incidents and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring;
- providing support for those involved to cope with the physical and psychological consequences of what happened.

The need for openness, transparency and candour was reinforced by Robert Francis QC in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013 which recommended that a statutory duty of candour be introduced for health and care providers.

The following definitions were referred to the Report and are adopted by the UHB.

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Objectives

This procedure outlines the UHB's responsibilities following a patient safety incident occurring or a concern being raised, in accordance with the principles of Being Open, as established by the NPSA. This 10 principles are as follows:

1. Acknowledgement

2. Truthfulness, timeliness and clarity of communication
3. Apology
4. Recognising patient and carer expectations
5. Professional support
6. Patient safety, risk management and systems improvement
7. Multidisciplinary responsibility
8. Clinical governance
9. Confidentiality
10. Continuity of care

Supporting information behind these principles is defined in the body of this procedure to assist staff to consistently apply these principles.

The procedure assumes the former NPSA's definition of a patient safety incident which is 'any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care'.

The Putting Things Right guidance for NHS Wales states that where an incident occurs and there has been moderate, severe harm or death, the UHB must advise the patient to whom the concern relates, or his or her representative, of the concern and involve them in the investigation of the matter. This should be managed in accordance with advice set out in the Being Open framework. The exception to this is if informing the patient or their representative could cause a deterioration in their physical or mental health. Such decisions must be taken with careful consideration and the rationale documented fully in the medical records. If a person lacks capacity, any decisions must be taken in accordance with the Mental Capacity Act (2005).

The following severity grading is adopted from the Putting Things Right guidance and applies as indicated to Being Open.

Severity grading / Level of harm	Potential for qualifying liability / Redress	Does Being Open apply?
1 / No harm	Highly unlikely	Not mandated
2 / Low harm	Unlikely	Not mandated
3 / Moderate harm	Possible	Yes
4 / Major harm	Likely	Yes
5 / Catastrophic harm	Very likely	Yes

Scope

This procedure applies to all staff in all locations, including those with honorary or temporary contracts.

The procedure applies when harm to patient/s at moderate, major or catastrophic level has been identified. This is irrespective of whether the harm is identified by patients, their family or carers, for example, through the concerns process or by staff through incident reporting procedures. Any decision to discuss near miss / low harm incidents with patients,

their families and carers will be on an individual patient basis.	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact.
Documents to read alongside this Procedure	• Incident, Hazard and Near Miss Reporting Policy and Procedure • Welsh Government Putting Things Right Guidance November 2013 (which includes Serious Incident Reporting) • Never Events, updated April 2018 • UHB Serious Incident process which includes Never Event processes • All Wales Root Cause Analysis (RCA) toolkit • Just Culture guide from NHS Improvement
Approved By	Quality, Safety and Experience Committee
Group with authority to approve procedures	Clinical Board Quality, Safety and Experience Groups
Accountable Executive or Clinical Board Director	Executive Nurse Director
Author(s)	Head of Patient Safety and Quality

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Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
	Date of Committee or Group Approval	*TBA*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*
1			New Procedure document devised as Policy and Procedure documents have been separated.

1 Roles and Responsibilities

1.1 **Board members** have a crucial role to play in ensuring the Being Open principles are embedded in the UHB. Being Open should be at the core of the organisation's values and culture of working with patients, the public and staff.

The Being Open procedure is a demonstration of the Board's commitment to publicly endorse the principles of Being Open, setting out the duty of all staff to follow the Being Open principles and reinforcing the organisation's full support of an open, honest and fair culture.

1.2 The **Chief Executive** has overall responsibility for ensuring that there are arrangements in place for the UHB to comply with its obligations for Being Open.

1.3 The **Executive Nurse Director** has delegated responsibility from the Board for the management of patient experience, patient safety and quality. As such, the implementation of the Being Open procedure sits within the remit of the Executive Nurse Director.

1.4 The **Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality** are responsible for ensuring that systems and processes for the operational management of concerns are established and consistently applied with the support of the Concerns Department, Patient Experience Team and Patient Safety Team.

1.5 **Clinical Board Management Teams** are responsible for ensuring the Being Open procedure is communicated to staff and implemented in their clinical/service areas. They must ensure they have sound mechanisms in place for recognition and escalation of untoward incidents that may have caused patient harm.

1.6 **Directorate Management Teams** are responsible for ensuring the Being Open procedure is communicated to staff and implemented in their clinical/ service areas. They must ensure they have sound mechanisms in place for recognition and escalation of untoward incidents that may have caused patient harm.

1.7 The **identified person nominated to be the patient/family contact lead person** is responsible for ensuring that communication with patients, family or carers is timely; open and honest; meets their individual needs, for example, use of translators where necessary and is in accordance with the 10 principles of Being Open which are outlined within this procedure.

The contact lead person must ensure that full written records of communication with patients, family or carers are kept.

Staff are encouraged to use the electronic risk management database (Datix) to store the communication log that they maintain.

1.8 **Individual members of staff** are responsible for ensuring that they comply with the Being Open procedure and their associated Code of Conduct for registered healthcare professionals. It is imperative that staff recognise and escalate untoward incidents to their line manager or person in charge, especially where harm to patients has occurred. Staff must ensure that their communication with patients, families or carers is in accordance with the 10 principles of Being Open. Staff must identify if they require training and support in Being Open.

2 Foundations for Being Open

2.1 Open and effective communication with patients should begin at the start of their care and continue throughout their time within the healthcare system.

2.2 This should be no different when a patient safety incident occurs. Being open when things go wrong is key to the partnership between patients and those who provide their care. Openness about what happened and discussing patient safety incidents/concerns promptly, fully and compassionately can help patients and staff cope with the after-effects.

2.3 Concerns can incur extra costs through litigation and further treatment. Openness and honesty at an early stage can help prevent such events becoming formal concerns and litigation claims. Well managed concerns may allow for legal costs to be minimised.

2.4 Being open involves:

- Acknowledging, apologising and explaining when things go wrong;
- Conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring;
- Providing support for those involved to cope with the physical and psychological consequences of what happened.

2.5 Saying sorry is not an admission of liability and is the right thing to do. Patients have a right to expect openness in their healthcare.

2.6 To implement Being Open successfully, healthcare organisations need to have the following foundations in place:

- A culture that is open and fair where patient safety and quality of

care is the key priority;

- A strong focus on clinical leadership and direction for patient safety;
- Integrated risk management systems that are mature, proactive and responsive when necessary;
- Staff are encouraged to report incidents and the organisation complies with external reporting requirements;
- Developed mechanisms to involve and communicate with patients and members of the public about the UHB's business;
- Use of recognised investigation methodology to learn how and why incidents happen;
- Processes to embed lessons learnt through changes to practice and appropriate monitoring mechanisms.

3 10 Principles of Being Open

3.1 Principle 1 - Acknowledgement

All concerns should be reported and acknowledged as soon as they are identified. In cases where the patient, their family or carers inform healthcare staff that something untoward has happened, it must be taken seriously from the outset and escalated promptly to an appropriate senior person. Any concerns should be treated with compassion and understanding by all healthcare professionals.

3.2 Principle 2 - Truthfulness, timeliness and clarity of communication

Information about a concern must be given to patients, their families and carers in a truthful and open manner by an appropriate person. Patients should be provided with a step-by-step explanation of what happened, that considers their individual needs and is delivered openly. Communication should also be timely. Patients, their families and carers should be provided with information about what happened as soon as practicable.

It is essential that any information given is based solely on the facts known at the time. Healthcare professionals should explain that new information may emerge as the investigation is undertaken, and that patients, their families and carers will be kept up-to-date with the progress of an investigation.

Patients, their families and carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of medical jargon which they may not understand must be avoided.

3.3 Principle 3 - Apology

Patients, their families and carers should receive a meaningful apology. It must be a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident or for the experience which has led them to raise the concern. This should be in the form of an appropriately worded and agreed apology as early as possible.

It is important to identify the most appropriate person to express an apology to the patient, their family and carers. A Serious Incident meeting provides a suitable forum for this discussion to take place. However, there may be an urgent need to disclose to a patient, their family and carers that a patient safety incident has occurred. This may occur out of hours, in which case support from appropriate management staff may be necessary.

Where it is possible to plan and prepare for the disclosure and apology, the decision should consider the seniority of the person to lead the process; their relationship with the patient and their experience and expertise in the type of patient safety incident that has occurred.

Verbal apologies are encouraged because they allow face-to-face contact between the patient, their family and carers and the healthcare team. This should be given as soon as practicable once staff are aware an incident has occurred. A written apology should follow which clearly states that the UHB is sorry for the suffering and distress resulting from the incident. Written apologies should be issued following advice and input from relevant senior managers.

Corporate departments such as the Concerns Department and Patient Safety Team must also be consulted.

An initial meaningful apology should not be delayed as there is evidence that delays are likely to increase the anxiety, anger or frustration experienced by patients, their families and carers. Focus groups on this matter have reported that patients were more likely to seek legal advice if verbal and written apologies were not delivered promptly.

3.4 Principle 4 – Recognising patient and carer expectations

Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident and its consequences, in a face-to-face meeting with representatives from the UHB. They should be treated sympathetically, with respect and consideration. They should also be provided with support in a manner appropriate to their needs – e.g. a translator or advocate where necessary.

Where appropriate, information on support available from Community

Health Councils (CHC) and other relevant groups like Cruse Bereavement Care and Action against Medical Accidents (AvMA) should be given to the patient or their family and carers as soon as possible.

3.5 Principle 5 – Professional support

The UHB must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. Staff should feel supported throughout the incident investigation process because they too may have been traumatised by being involved. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration.

To ensure a robust and consistent approach to incident investigation and management of staff involved, managers are encouraged to use the Just Culture guide, published by NHS Improvement which can be accessed here

Where there is reason for the UHB to believe that a member of staff has committed a punitive or criminal act, the UHB must take appropriate steps in conjunction with advice from Workforce and Development. In such circumstances, the staff member(s) should be advised that separate legal advice and/or representation may be appropriate.

The UHB encourages staff to seek support from relevant professional bodies following significant adverse events. Occupational Health referral and use of services available from the Employee Assistance Programme may be beneficial.

Appropriate support mechanisms must also be in place for the Being Open lead.

3.6 Principle 6 – Risk management and systems improvement

Root Cause Analysis (RCA), Significant Event Audit (SEA) or other recognised investigation methodology must be used to uncover the underlying causes of a patient safety incident. The investigation should focus on identifying care and service delivery problems in order to develop solutions that will make improvements to systems and minimise the risk of recurrence.

The Being Open procedure is integrated into the UHB's incident reporting and risk management policies and procedures. It is embedded within the UHB's overarching Quality, Safety and Improvement Framework.

3.7 Principle 7 – Multidisciplinary responsibility

Managers and senior clinical staff are expected to support and guide their teams through investigations and the resulting risk management processes. Most healthcare provision is delivered through multidisciplinary teams and this should be reflected in the way that patients, their families and carers are communicated with following a patient safety incident. This will ensure that the Being Open process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual. Generating solutions following adverse events should be a multidisciplinary process to maximise the chance of successfully embedding change.

3.8 Principle 8 – Clinical governance

The Being Open process requires sound quality and safety improvement procedures, underpinned by a robust clinical governance framework. Within this framework, patient safety incidents and concerns will be investigated and analysed in order to prevent their recurrence. The findings from the investigations will be disseminated to healthcare professionals so that they can learn from patient safety incidents.

This principle requires a system of accountability where all staff take personal responsibility to ensure that necessary changes are implemented with audit programmes in place to monitor effectiveness. Mechanisms to feedback to staff widely across the UHB and more broadly where appropriate must be in place.

It is imperative therefore, that Directorate and Clinical Board quality and safety arrangements are sufficiently mature to ensure that robust clinical governance is in place.

Likewise, various committees of the Board have a crucial role in ensuring that accountable systems are in place, for example, Quality, Safety and Experience Committee.

Other means by which the effectiveness of governance is assessed include Internal Audit; Welsh Risk Pool claims assessments; Welsh Government Serious Incident reporting and monitoring mechanisms.

3.9 Principle 9 – Confidentiality

Patient confidentiality and the right to privacy for the patient, their family and carers must be respected. All staff involved in a patient safety

incident also have the right to confidentiality. Communication with parties outside of the immediate people involved should be on a strictly need-to-know basis.

In the majority of cases, the investigation of a concern will require access to medical records and so the issue of consent will need to be considered. Further information is contained with the Welsh Government's *'Guidance on dealing with concerns about the NHS from 1 April 2011'* which can be accessed here

3.10 **Principle 10 – Continuity of care**

Patients are entitled to expect that they will continue to receive their usual treatment and continue to be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, this should be arranged where possible.

4 The Being Open Process

4.1 Stage 1: Incident detection or recognition

The Being Open process begins with the recognition that a patient has suffered harm or has died as a result of a patient safety incident. It may be identified by:-

- a member of staff at the time of the incident;
- a member of staff retrospectively when an unexpected outcome is detected;
- a patient, their family or carers express concern or dissatisfaction with the patient's healthcare either at the time of the incident or retrospectively;
- incident detection systems such as incident reporting, medical records reviews or mortality reviews;
- external processes such as via Her Majesty's Coroner.

As soon as a patient safety incident is identified, the key priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required, this should occur whenever reasonably practicable after a discussion with the patient and with appropriate consent.

The UHB's processes for incident reporting must be followed in order to ensure compliance with clinical governance procedures and other onward reporting requirements.

4.1.1 Patient safety incidents occurring elsewhere

A patient safety incident may have occurred in an organisation other

than where it is detected or it may involve care provided across multiple providers. In these situations, the UHB will need to liaise with the other organisation(s) involved and agree roles and responsibilities, including the Being Open arrangements.

4.1.2 **Criminal or intentional unsafe acts**

Patient safety incidents are almost always unintentional. However, if at any stage it is determined that harm may have been the result of a criminal or intentional unsafe act, the matter must be escalated to a line manager immediately. The Executive Nurse Director or designated deputy must be informed as soon as practically possible. Out of hours, the on call Executive must be informed. The Just Culture guide from NHS Improvement should be referred to.

Additional notification

4.1.3 In addition, the following notifications should be considered where appropriate:

- Contacting the patient's GP where there are implications for care;
- All cases of untimely, unexpected or unexplained deaths and suspected unnatural deaths must be reported to Her Majesty's Coroner. Any restrictions or requests from the Coroner to the UHB must be heeded whilst his/her investigations take place. This should not preclude a verbal and written, meaningful apology or expression of regret being given to the family or carers of the patient. It should be made clear to the family how internal investigation arrangements will correlate with the Coroner's procedures. The Coroner often finds internal investigation reports to be useful as part of the inquest process. To that end, it is not uncommon for the UHB to provide the Coroner, family/carers and staff with an interim investigation report, pending any additional information that may come to light during the inquest process. Coroner's investigations and inquests can often be stressful for families/carers and healthcare professionals. Individuals should be signposted to appropriate support mechanisms from the outset, for example, bereavement support; Employee Assistance Programme.
- The UHB must ensure it complies with national incident notification requirements for reporting adverse incidents - for example, Serious Incident reporting to Welsh Government, Health and Safety Executive, Medicines and Healthcare Products Regulatory Agency.

4.2 **Stage 2: Preliminary team discussion**

4.2.1 The UHB has flowcharts in place to guide senior clinical staff and managers following a significant patient safety incident. They can be accessed here

4.2.2 Directorate and Clinical Board management teams should host an initial Serious Incident meeting. In the case of a Never Event, the Executive Nurse Director will usually chair the meeting but may delegate this to another person for example, the Assistant Director of Patient Safety and Quality.

4.2.3 The staff involved in the care of the patient at the time of the patient safety incident will not usually be present at the initial meeting. The purpose of the meeting is to establish an appropriate response to the incident. For example, investigation arrangements; liaison with the patient and their family; staff support. The consultant responsible for the care of the patient may be required to attend the initial meeting to provide information and background. Due consideration will be needed if the consultant was personally involved in the patient safety incident.

Timing of the initial discussion with the patient, family and carers

4.2.4 The initial Being Open discussion with the patient, their family and carers should occur as soon as possible after recognition of the patient safety incident. Factors to consider when timing this discussion include:

- clinical condition of the patient;
- patient preference (in terms of when and where the meeting takes place, whether they wish family/friends to be present and which healthcare professional leads the discussion);
- privacy and comfort of the patient;
- availability of the patient, their family and/or carers;
- availability of key staff involved in the incident and in the Being Open process;
- availability of support staff, for example - a translator or independent advocate, if required;
- arranging the meeting in an appropriate location – for example, at the patient's home;
- some patients, families/carers may require more than one meeting to ensure that all the information has been communicated and understood by them.

Choosing the individual to communicate with patients, their families and carers

4.2.5 The most suitable person to be the main contact with the patient/family will depend on the facts of each case. It may be that the most senior person responsible for the patient's care is the most suitable person or it could be someone with experience and expertise in the type of incident that has occurred. Ideally, the person should have received training in communication after patient safety incidents or have experience in managing patient safety incidents.

Other factors to consider when choosing the main contact person are that the

person should :

- be known to, and trusted by, the patient, their family and carers or have an ability to develop a professional relationship in difficult circumstances;
- have a good grasp of the facts relevant to the incident;
- be senior enough or have sufficient experience and expertise in relation to the type of patient safety incident to be credible to patients, their families and carers, and colleagues;
- have excellent interpersonal skills, including being able to communicate with patients, their families and carers in a way they can understand, and avoiding use of medical jargon;
- be willing and able to offer a meaningful apology, reassurance and feedback to patients, their families and carers;
- be able to maintain a medium to long-term relationship with the patient, their family and carers, where possible, and to provide continued support and information;
- be culturally aware and informed about the specific needs of the patient, their family and carers.

4.2.6 In exceptional circumstances, if the allocated lead cannot attend the initial meeting with the patient/family, the responsibility may be delegated to another appropriately trained clinician.

4.2.7 If it becomes clear during the Being Open process that the patient, family or carers would prefer to speak to a different healthcare professional, this should be respected and alternative arrangements should be made.

4.2.8 Junior staff or those in training would not generally lead the Being Open process except when all of the following criteria have been considered:

- the incident resulted in low harm;
- they have expressed a wish to be involved in the discussion with the patient, their family and carers;
- the senior healthcare professional responsible for the care is present for support;
- the patient, their family and carers agree.

4.2.9 Where a junior healthcare professional asks to be involved in the Being Open discussion, it is important that they are accompanied and supported by a senior team member.

4.2.10 In situations where a healthcare professional wishes to contribute to Being Open discussions to personally apologise to the patient, family or carers, they should be provided with support from senior colleagues unless a preference from the patient, family or carers is expressed for that person not to be present. In such circumstances, a personal written apology can be offered as an alternative.

4.3 Stage 3 – Initial Being Open discussion

4.3.1 The patient, their family and carers should be advised of the identity and role of all people attending the Being Open discussion before it takes place. This allows them the opportunity to state their own preferences about which healthcare staff they want to be present.

4.3.2 If for any reason it becomes clear that the patient, family or carers would prefer to speak to a different healthcare professional, their wishes should be respected. A substitute with whom they are satisfied should be provided.

4.3.3 It must be acknowledged that patients, their families and carers may be anxious, angry and frustrated, even when the discussion is conducted appropriately. The discussion must not speculate, attribute blame, deny responsibility or provide conflicting information.

4.3.4 The initial discussion should cover:

- An expression of genuine sympathy, regret and a meaningful apology for the harm that has occurred.
- The facts that are known as agreed by the multidisciplinary team. Where there is disagreement or lack of clarity about the facts, communication about them must be deferred until such time as they are confirmed through the investigation process.
- The patient, family and carers are informed that an investigation is to be completed and more information will become available as it progresses.
- The patient, family and carers' understanding of what happened is taken into consideration, as well as any questions they may have.
- Formal noting of the patient, family and carers' views and concerns demonstrates that these are being heard and taken seriously.
- Appropriate language and terminology are used when speaking to the patient, family and carers. If their first language is not English, arrangements must be made to communicate in their language of choice.
- An explanation about what will happen in terms of the short through to long-term treatment plan, sharing of incident investigation findings and improvement plan arrangements.
- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known.
- An offer of practical and emotional support for the patient, family and carers. This may involve support from third parties such as voluntary organisations or the Community Health Council. Information about the patient and the incident must not be disclosed without consent.
- It should be explained to the patient that they are entitled to

continue to receive all their usual treatment and continue to be treated with respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made where possible.

- The patient, their family or carers should be given information about Putting Things Right.

4.4 Stage 4 – Follow-up discussions

4.4.1 Follow-up discussions with the patient, family or carers are an important step in the Being Open process. Depending on the incident and the timeline for the investigation, there may be more than one follow-up discussion.

4.4.2 The following guidance is offered in order to make the communication effective:

- The discussion occurs at the earliest practical opportunity when there is additional information to report.
- Consideration is given to the timing of the meeting, based on both health and wellbeing and personal circumstances of the patient, family or carers.
- Consideration is given to the location of the meeting – it may be appropriate to be held at the family's home, for example.
- Appropriate attendees need to be invited, for example, Community Health Council representative where appropriate, in addition to UHB staff and the patient, family and carers.
- Feedback is given on progress to date and information provided on the investigation process.
- There should be no speculation or attribution of blame. The healthcare professional communicating the incident must not criticise or comment on matters outside of their expertise.
- A written record of the discussion is kept and shared with the patient, their family and carers.
- All queries are responded to appropriately.
- If completing the process at this point, the patient, their family and carers should be asked if they are satisfied with the investigation and a note made of this in the record of the discussion. The patient should be provided with contact details of an appropriate person so that there is a defined route for them to return to the UHB at a later date, should the need arise.

4.5 Stage 5 – Process completion

4.5.1 Communication with the patient, family and carers

On completion of the investigation, feedback to the patient, family and carers should take the form most appropriate and acceptable to them. It must include the following information:

- The chronology of clinical and other relevant facts;
- Details of the patient, family and carer concerns;
- A repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety incident;
- A summary of the factors that contributed to the incident;
- Information on what has and will be done to avoid recurrence of the incident and how these improvements will be monitored.

4.5.2 It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases, information may be withheld or restricted if there are legal requirements that preclude disclosure for specific purposes. In these circumstances, the patient, family and carer must be informed of the reasons for the restrictions.

4.5.3 Sometimes patients, family and carers may request investigation reports be shared with them in order that they can digest the content before meeting with UHB representatives. Care must be taken to avoid untimely arrival of the report, for example, over a weekend. Follow up arrangements may be required to make contact with the patient, family and carers following their receipt of the report in case immediate additional support is required.

4.5.4 Continuity of care

When a patient has been harmed during the course of treatment and requires further therapeutic management or rehabilitation, the clinical management plan must be discussed and agreed with them. Patients, family and carers must be reassured that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the healthcare team. They should be advised that they have the right to continue their treatment elsewhere if they prefer and the UHB will assist them with this request wherever possible. If the patient, family or carer request that care be transferred, advice should be sought from Directorate and Clinical Board management teams in the first instance.

Communication with the GP and other community care service

providers when patient safety incidents did not occur in primary care

4.5.5 Wherever possible, it is advisable to send a brief communication to the patient's GP, prior to discharge from secondary care, describing what happened. It may be necessary to share information with appropriate community care services who will have ongoing contact with the patient. Consideration will be needed as to whether consent to share information will be required from the patient.

4.5.6 Such communication should contain summary details of:

- The nature of the patient safety incident and the continuing care and treatment;
- The current condition of the patient;
- Key investigations that have been carried out to establish the patient's clinical condition;
- Recent results;
- Prognosis.

4.5.7 It may be valuable to consider including the GP in a follow-up Being Open discussion if deemed appropriate and if the patient agrees.

Monitoring

4.5.8 Any recommendations for systems improvements and changes should be monitored for effectiveness in preventing a recurrence. Directorates and Clinical Boards must ensure they have processes in place to monitor compliance with improvement action plans.

Communicating changes to staff

4.5.9 Effective communication with staff is a vital step in ensuring that the recommended changes are fully implemented and monitored. It will also facilitate the move towards increased awareness of patient safety issues and the value of Being Open.

5 Documentation

5.1 Throughout the Being Open process it is important to record discussions with the patient, family and carers. Written notes should be made and shared with the relevant parties. Alternatively, voice recordings can be made and downloaded for electronic storage if all parties are in agreement that the meeting be recorded. The Concerns Department and Patient Safety and Quality Department have access to voice recording equipment.

5.2 The incident report, record of the investigation and Being Open process should be filed separately to the patient's medical records. Information can be uploaded to the relevant record on the UHB's risk management database (Datix).

Written records of the Being Open discussions

5.3 There should be documentation of the following:

- the time, place (note: these may be telephone calls as well as face to face meetings), date; the name and role/relationships of all attendees;
- plans for providing further information to the patient, their family and/or their carers;
- offers of assistance, and the patient's, their family and/or their carers' response;
- questions raised by the patient, family, carers or their representatives, and the answers given;
- plans for follow-up as discussed;
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient, their family and/or their carers;
- copies of letters sent to the patient, their family and/or their carers and the GP for patient safety incidents involving the GP but originating in secondary care;
- copies of any documents gathered in the investigation process will be shared at an appropriate time, for example, when the investigation report is shared. Documents may include statements taken in relation to the patient safety incident, the incident form, policies and procedures referred to in the report etc.

5.4 The records of the Being Open discussions should be shared with the patient, their family and/or carers.

6 Patient issues to consider

Advocacy and support

6.1 Patients, their families and carers may need considerable practical and emotional help and support after experiencing a patient safety incident. It is important to discuss their needs with the relevant individuals. Support may be provided by patients' families, social workers, religious representatives, advocates and the Community Health Council.

Where the patient, their family and/or their carers require long-term support, advice can be sought from charitable organisations such as Cruse Bereavement Care or via the GP.

Particular patient circumstances

6.2 When a patient dies

6.2.1 When a patient safety incident has resulted in a patient's death, it is even more

crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The patient's family and carers may need information on the processes that will be followed to identify the cause(s) of death in addition to needing emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counselling or assistance at any stage.

Usually the Being Open discussion and any investigation occurs before the Coroner's inquest. In some circumstances it may be appropriate to wait for the Coroner's inquest before holding the Being Open discussion with the patient's family and carers. The Coroner's post mortem report may be a key source of information that will help to complete the picture of events leading up to the patient's death and help the UHB determine if Being Open disclosure is required. In any event, an apology should be issued as soon as possible after the patient's death, together with an explanation that the Coroner's process has been initiated and a realistic timeframe of when the family and carers will be provided with more information.

Children

6.2.2 Where a child under the age of 16 is judged to have the intelligence and maturity to understand the information provided, he/she should be involved directly in the Being Open process after a patient safety incident, unless they decide that they don't want to be involved. The opportunity for parents to be involved should be provided unless the child expresses a wish for them not to be. Where children are assessed not to have sufficient intelligence or maturity, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought. In general though, children should be as involved in the process as they wish to be.

Patients with mental health or learning disability issues

6.2.3 Being Open for patients with mental health or learning disability issues should follow normal procedures unless the patient also lacks mental capacity to decide whether or how to participate in the process (see section 6.2.4). The circumstances in which it is appropriate to withhold patient safety incident information from a patient with mental health issues is when advised to do so by a consultant psychiatrist who considers it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient. Apart from in exceptional circumstances, it is never appropriate to discuss patient safety incident information with a carer or relative without the express permission of the patient.

Patients with cognitive impairment

6.2.4 Some patients have conditions that limit their ability to understand what is happening to them. However, they may have authorised a person to act on their behalf by executing a Lasting Power of Attorney (LPA). In these cases, steps must be taken to ensure that the LPA covers the relevant medical care and treatment of the patient and (where relevant) making complaints on their behalf. Patients may also have had a deputy appointed for them by the court, although deputies covering health and welfare decisions are rarely appointed. The Being Open discussion would be conducted with the attorney of the Lasting power of attorney (if the patient is assessed to lack mental capacity to make decisions about their participation in the process) or deputy. Where there is no such person and the patient is unable to determine who they would like to be involved, the clinicians may act in the patient's best interests, in accordance with the Mental Capacity Act 2005 in deciding who (if anyone) the appropriate person is to discuss incident information with. Care must be taken not to breach the patient's confidentiality, unless it is in the patient's best interests to do so. However, patients with cognitive impairment should, wherever possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the patient to assist in the communication process.

<u>Patients with different language or cultural considerations</u>

6.2.5 If a patient and/or family/carers' first language is not English, or there are other communication barriers, their needs should be addressed using available services and aids. The need for translation and advocacy services, and consideration of special cultural needs (such as for patients from cultures that make it difficult for a woman to talk to a male about intimate issues), must be taken into account when planning to discuss patient safety incident information. It is advisable to obtain guidance from an advocate or translator before the meeting on the most sensitive way to discuss the information. The use of 'unofficial translators' such as the patient's family or friends must be avoided wherever possible so as to reduce the risk that they may distort information by editing what is communicated and also to avoid breaching the patient's confidentiality.

<u>Patients with different communication needs</u>

6.2.6 Patients may have particular communication difficulties, such as a hearing impairment. Plans for any meetings must take these sensory needs fully into account.

<u>Patients who do not agree with the information provided</u>

6.2.7 Sometimes, the relationship between the patient, their family and carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the Being Open process. In this case, following strategies may assist:

- deal with the issue as soon as it emerges;

- where the patient agrees, ensure their family and carers are involved in discussions from the beginning;
- ensure the patient has access to support services including advocacy – e.g. Community Health Council;
- where the senior health professional is not aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team;
- offer the patient, their family and carers another contact person with whom they may feel more comfortable; this could be another member of the team or senior manager;
- use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution;
- ensure the patient, their family and carers are fully aware of the formal complaints procedures;
- write a comprehensive list of the points that the patient, their family and carers disagree with, reassure them you will follow up these issues and report the outcomes back to them.

7 Strengthening Being Open by supporting staff

7.1 When a patient safety incident occurs, healthcare professionals involved in the patient's clinical care may also require emotional support and advice. Professionals who have been involved directly in the incident, those with the responsibility for Being Open discussions and those who support the Being Open process (people who can provide mentoring and support to their colleagues, e.g. staff within the Concerns department and Patient Safety Team) should be given access to assistance, support and any information they need to fulfil their roles.

7.1.1 To support healthcare staff involved in patient safety incidents, the UHB will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The UHB will continue to work towards a just culture where human error is understood to be a consequence of flaws in the healthcare system, not necessarily the individual.
- Opportunities to educate staff about Being Open will be taken, ensuring that staff understand that apologising to patients, their families and carers is not an admission of liability and is the right thing to do;
- Will promote the value of debriefing of the clinical team involved in the patient safety incident. This will be separate from the requirement of staff to contribute to the investigation process which may require additional support for staff, such as statement writing. Feedback to staff regarding the outcome of the investigation process is essential. Involving staff in generating solutions is also encouraged.
- Offer specific systems of support for staff via line management routes,

Occupational Health and the Employee Assistance Programme.

- Provide advice and training on the management of patient safety incidents via the Patient Safety Team.

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

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

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

8 Training

8.1 Being Open is embedded and promoted as part of all existing training on incident reporting and concerns management offered by the Concerns Department and Patient Safety Team.

8.1.1 E-learning opportunities are available on the following websites:

Royal College of Surgeons – Duty of Candour e-learning:
http://vle.rcseng.ac.uk/course/view.php?id=321

NHS e-learning repository – Being Open e-learning: (create an account with a valid NHS email address)
https://www.elearningrepository.nhs.uk//

9 IMPLEMENTATION

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

10 EQUALITY

10.1 We have undertaken an Equality Impact Assessment and received feedback on this policy and procedure and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil

partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no adverse impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

11 MONITORING

11.1 It will be necessary to ensure that Clinical/Service Boards are adhering to the requirements of this procedure. This will be monitored via a number of performance indicators such as local audit of compliance by Directorates and Clinical Boards; corporate arrangements such as by the Concerns Department and Patient Safety Team; formal assessments including Health and Care Standards, Internal Audits.

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

12 DISTRIBUTION

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

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

13 REVIEW

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

AGENDA ITEM *to be inserted*

Insert Meeting Date –

APPROVAL OF CONFIRMATION OF AN EXPECTED DEATH POLICY

Report of: Kay Jeynes - Director of Nursing Primary Community and Intermediate Care (PCIC)
Paper prepared by: Helen Earland **-** Senior Nurse Primary Care / Clinical Lead GP OOH
Executive Summary This policy and associated guidance identifies the process to be followed by healthcare professionals when confirming an expected death of an adult. All expected deaths may be confirmed by any suitably trained healthcare professional e.g. doctor, paramedic, registered nurse and midwife. The requirement to have a policy for undertaking the confirmation of death arose due to a general lack of clarity and understanding with regard to the doctors role in confirming death, and changes in the General Practitioner contract / and European Working Time Directive which has resulted in General Practitioners / Hospital Based Doctors no longer being responsible or able to provide this service in a timely manner. Specifically within Cardiff and Vale trained health care professionals are undertaking the role of 'confirmation of expected deaths' within some of the Clinical Boards, but there is no overarching policy for the Health Board therefore this will be a new Cardiff and Vale UHB Policy and requires Board approval. The policy incorporates guidance from the British Medical Association, Nursing and Midwifery Council and Joint Royal Colleges Ambulance Liaison Committee to highlight a structured approach to 'confirmation of death' within the Primary. Community and Hospital settings – 'in hours'

and ‘out-of-hours’. Action required following the ‘confirmation of death’ is also discussed as is the appropriate documentation.

A training package has been developed identifying all the key clinical and theoretical competencies required to ensure the individual healthcare professional is skilled within this area of care. Additionally the appendix provides documentations that will support the health care professional undertaking this task:

- Confirmation of Death Process
- Procedure for Confirming Death
- Confirmation of the Fact of an Expected Death
- Deaths which should be Reported to HM Coroner
- Confirmation of Death Competency Assessment

The Board is requested to:

- **APPROVE** the full publication of the Confirmation of an Expected Death Policy in accordance with the UHB Publication Scheme

The policy has financial consequences:
Yes.
Staff training to undertake Confirmation of Death Procedure – funding required from training budgets within individual Clinical Boards as required

Board Assurance Framework:
The policy provides assurances against Standards:
2.1, 2.7, 3.5, and 4.2

APPROVAL OF:
'CONFIRMATION OF AN EXPECTED DEATH POLICY'

1. INTRODUCTION

This policy and associated guidance is concerned with the process to be followed by healthcare professionals when confirming death of an adult. All expected deaths may be confirmed by any suitably trained healthcare professional e.g. Doctor, Paramedic, Registered Nurse and Midwife. The requirement to have a policy for undertaking the confirmation of death has arisen due to a general lack of clarity and understanding with regard to the Doctors role in confirming death, and changes in the General Practitioner contract / and European Working Time Directive which has resulted in General Practitioners / Hospital Based Doctors no longer being responsible or able to provide this service in a timely manner.

In April 1999 the General Practitioner's Committee (GPC) of the British Medical Association published guidance for general practitioners on confirmation of death (Appendix 1). This included advice that there was no requirement, either legally or under the NHS Terms of Service, for a general practitioner /responsible medical practitioner to confirm the fact of death. The GPC Guidance was issued to inform general practitioners of their obligations and also good practice. Its rapid dissemination was necessary because of changes in the organisation of general practice, especially out of hours, which make it increasingly likely that a doctor called to confirm death may not be the patient's own doctor. Because of this the confirmation of death and its certification have become separated. This guidance recognises that it is unlikely that any useful purpose will be served by an 'on call' doctor attending. This is particularly true where they are not known to the family and will not play any part in the ongoing care of the family.

NMC Guidance, issued in 2012 –states that in the event of a death, a Registered Nurse may confirm or verify death has occurred, providing there is an explicit local protocol in place to allow such an action....nurses undertaking this responsibility must only do so providing they have received appropriate education and training, and have been assessed as competent.

Recognition of life extinct by ambulance clinicians is highlighted in 'Cardiac Arrest and Arrhythmias' (2006) and Services are encouraged, in conjunction with their coroner's service, to develop a local procedure for handling the body once death has been confirmed by ambulance personnel

2. SCOPE OF THE POLICY

UHB wide including the primary and community settings 'in and out of hours'

3. THE AIM OF THE POLICY

The aim of the document 'Confirmation of an Expected Death' is to ensure that:-

- Quality of care provision to the deceased and bereaved by promoting a consistent approach to the confirmation of death procedures across Cardiff and Vale UHB.

- Staff who undertake the procedure are trained and competent

The expected outcomes of this policy are as follows:

- For the death of the patient to be dealt with in a timely, sensitive and caring manner;
- The death is dealt with in accordance with the law;
- The Registered Nurse / Midwife / Paramedic skills and competencies are used appropriately;
- The distress of relatives can be reduced by having parenteral medication devices disconnected promptly and appropriately following the death of a patient, once confirmation of death has been established;
- All religious and cultural needs of the patient will be clearly identified and recorded in the patients nursing documentation prior to death.

4. TERMINOLOGY

Confirmation & Certification - *Confirmation of death* is the procedure of determining whether a patient is actually deceased. All deaths should be subject to professional confirmation that life has ended (Secretary of State for the Home Department, 2003). Confirmation can be undertaken by a medical practitioner or a suitably qualified health care professional. It is separate to the *certification* process which is an obligation on the doctor who attended the deceased during his or her last illness. *Certification of Death* can only be carried out by a medical practitioner or a coroner. Certification of death is to establish cause of death.

Expected Death - A death where the patient was expected to die or their friends or family had been informed was terminally ill or likely to die where there is a Do not attempt resuscitation order in place (DNA CPR Welsh Government Policy 2017) . These are usually determined by the fact that the patients own GP / responsible medical practitioner will be able to complete a certification of death. If the expected death is precipitated by an unexpected incident such as a fall or accidental harm a GP or responsible medical practitioner may be required to attend the deceased.

Unexpected Death - A death where there was no expectation that the patient was terminally ill or likely to die. This should include *suspicious death*, where there is suspicion or signs of violence, accident, poisoning or suicide or *unexplained death* where there is insufficient evidence available to assist in determining the likely cause of death.

5. WHO CAN CONFIRM DEATH

All suitably trained nurses, midwives and paramedics, following formal training in undertaking confirmation of death, can confirm death in their working environment. The procedure to be followed by nurses midwifes and paramedics who work within the Health Board and are appropriately trained is outlined in Appendices 2 & 3.

6. TRAINING

A training package has been developed within the PCIC Clinical Board – moving forward all Clinical Boards across the Health Board will either adapt the developed training package and provide in-house training / or / will be able to access the training via the PCIC Education Team.

Training in the confirmation of death should as a minimum cover the following:

- An understanding of the legal implications and requirements;
- The procedure to follow when confirming death (Appendix 3);
- Clarification of the differences between certification and confirmation;
- Explanation of Health Board Policy
- Clarification of expected death and unexpected death;
- The procedures for expected, unexpected, suspicious and unexplained death;
- Documentation of the fact of death;
- Awareness of related health board policies & procedures;
- The role of the Funeral Director;
- The role of the Coroner;
- Contacting the Police.

Training will include a half day theory supported by supervised competency based assessment (appendix 4). Competency will be assessed by a health care professional who is competent and confident to confirm death. Time frame to achieve competence is dependent on individual's confidence and not a pre-determined number of assessments. **Two signatures will be required on Confirmation of death form until an individual's competency has been achieved**. Individuals must recognise their responsibility to work within limits of own competence and keep skills and knowledge up to date to maintain competence and performance.

The Registered Nurse / Paramedic should also be aware of the legal issues and related accountability to this extended scope of professional practice (RCN / HCPC).

7. DOCUMENTATION ON THE FACT OF DEATH

A legible, signed entry must be made in the patients record indicating the time and date that death was confirmed. Additionally a form indicating that confirmation of death has occurred must be completed (Appendix 5) and kept with the patient record. This form should clearly state full name of health care professional who has confirmed death (required for cremation form 4). This form may be required by HM Coroner should the responsible doctor find that they are in fact unable to complete certification of death. Healthcare professional (nurses midwives and paramedics) should also ensure all necessary documentation is completed as per Health Board policies & procedures.

8. ACTION TO BE TAKEN FOLLOWING CONFIRMATION OF DEATH

Expected Deaths - All deaths may be confirmed by any suitably trained health professional, e.g. a doctor, paramedic, a registered nurse or midwife working in the hospital, primary and community setting, community hospital or a nursing home – 'in and out of hours'. When a patient is expected to die, it is good practice for the healthcare professional that is caring for the patient to discuss with the patient's doctor who will be the most appropriate person to confirm death. This should be recorded within patient's medical records / documents.

The action to be taken in this circumstance is as follows:

- Confirm Death (appendix 2 +5);
- Advise relatives/carers that the patient has died and give information on what to do after a death;

<u>If 'in hours'</u> contact the Responsible Doctor / General Practitioner:

- advise that the patient has died;
- ascertain arrangements for certification;
- ascertain whether doctor / GP intends to visit before removal of body;
- advise those present of the outcome of these discussions.

If 'out of hours' it is the responsibility of the person who confirms the death to ensure the patients responsible doctor / GP is informed of the death on the next day (by phone).

If the responsible doctor / GP is not attending before the removal of the body, advise the ward or care home staff /relatives that they can transfer the body to the Mortuary or contact undertaker for removal of body.

On no account should a body be moved until a trained person has confirmed that death has occurred.

Medical certification of death can take place in the mortuary; however, there is no legal requirement for a GP/ responsible medical practitioner to see the body to certify death (appendix 1).

9. EXPECTED DEATH WHERE THE CORONER NEEDS TO BE INFORMED

The Coroner usually needs to be informed if the death is due to industrial disease such as Mesothelioma or asbestos related disease. Also if there has been an accident of any kind in the final illness. For a comprehensive list of deaths that should be reported to HM Coroner refer to Appendix 6.

Primary and Community Setting:
If the death is expected but HM Coroner needs to be informed because an inquest is required then the Police will have to attend, e.g. someone dying following an injury received after a fall. In these cases the death will be reported to HM Coroner by the Police, once a qualified person has confirmed the death (Police Officers are not qualified to confirm deaths).

If out of hours the Coroner's office should be contacted through the police station and the situation discussed – for an unexpected death that is suspicious phone 999 (NB this may be classed as a crime scene), for an unexpected death that is not suspicious phone 101.

Hospital Setting:
Sometimes it is necessary to report a death to the Coroner before the medical certificate of cause of death can be given. Some of the circumstances include where:

- the cause of death is unknown;
- the cause of death is unnatural e.g. possible suicide, homicide, neglect, accident (including road traffic collision and inpatient incidents) or poisoning;
- death occurred within 24 hours of admission to hospital, during or after surgery or a medical procedure;
- death occurred during or immediately after detention in police custody.

The Coroner will decide either that:

- a post-mortem examination does not need to take place, in which case they will notify the Registrar of this, using a Form A and a death certificate will be issued; or
- a post-mortem examination will need to take place, in which case they will instruct a Pathologist (a highly trained doctor) to perform this.

After a post-mortem examination has been carried out, the Coroner will decide either that:

- no further action is necessary, in which case they will notify the registrar of this, using a form B: or
- that they need to hold an inquest; in which case, the coroner's officer will tell you of what happens next.

A coroner's post-mortem is a legal obligation and not subject to the permission of the deceased's family. If there is time to organise it in advance, relatives may be represented at the examination by their own doctor.

10. SUDDEN, VIOLENT OR UNEXPECTED DEATH – SIGNS OF SUSPICIOUSS / UNEXPLAINED DEATH

Where death is unexpected and where no explicit advance decision has been made about the appropriateness or otherwise of attempting cardiopulmonary resuscitation prior to a patient suffering cardiopulmonary arrest, and the expressed wishes of the patient are unknown and cannot be ascertained, it is presumed that healthcare professionals will make all reasonable efforts to resuscitate the patient and in community an emergency ambulance will be called.

However, it is possible in these circumstances to identify patients in whom there is absolutely no prospect of survival, and where an attempt at cardiopulmonary resuscitation would be futile. In such cases it would not be in the patients' best interest to commence Cardiopulmonary Resuscitation. In these circumstances it would be appropriate to perform confirmation of death. In these circumstances a Cardiopulmonary Arrest Audit form must be completed.

Healthcare professionals (nurses midwives and paramedics) should proceed with confirmation of death and if not a suspicious death bodies can be transferred to mortuary/undertaker.

11. CONDITIONS UNEQUIVOCALLY ASSOCIATED WITH DEATH

The conditions listed below are unequivocally associated with death in all age groups and cardiopulmonary resuscitation should not be attempted. If a relative or carer insists on cardiopulmonary resuscitation, careful explanation of the circumstances and the reason for not undertaking cardiopulmonary resuscitation should be given.

***Hypostasis*:** the pooling of blood in congested vessels in the dependent part of the body in the position in which it lies after death. Initially hypostatic staining may appear as small round patches looking rather like bruises but later these coalesce to merge as the familiar pattern. Above the hypostatic engorgement there is obvious pallor of the skin. The presence of hypostasis is diagnosis of death- the appearance is not present in a living person.

***Rigor mortis*:** the stiffness occurring after death from the post mortem breakdown of enzymes in muscle fibres. Rigor mortis occurs first in the small muscles of the face, next in the arms and then in the legs (30 minutes to 3 hours).

If called upon to confirm a death and the healthcare professional has any cause for concern, or observes anything untoward the following action should be taken if resuscitation is not to be undertaken.

- Contact the police and request the attendance of a police officer;
- Do not move the body or disturb the scene of death. It is the responsibility of the police to inform HM Coroner and to arrange the attendance of the police surgeon/forensic medical examiner if appropriate;
- Advise the relatives/carers of the action taken explaining that the police have been called and they will deal with further information.

If 'in hours' also contact the responsible doctor / GP:

- advise that the patient has died and that the police have been contacted;
- ascertain whether responsible doctor /general practitioner intends to visit;
- advise those present of the outcome of these discussions.

Complete all documentation and, if safe to do so, remain at the scene with the body until the police arrive - aiding preservation of the scene and ensuring continuity of evidence.

In these circumstances healthcare professionals must inform their line manager of the situation and ensure an adverse incident form is completed to capture the circumstances of the event as per the policy.

12. THE ROLE OF THE RESPONSIBLE DOCTOR / GENERAL PRACTITIONER

The responsible doctor / general practitioner will at all times consider the needs of living persons and these include the relatives, carers of the deceased as well as other patients. If the responsible doctor / general practitioner will be the Certifying doctor it is good practice to arrange to see the deceased as soon as practicable.

This need not delay the removal of body to the mortuary /undertaker. Where the certifying doctor is not available another doctor should assess whether a visit is needed to meet the needs of living patients (e.g. bereaved relatives).

13. GUIDANCE FOR OUT OF HOURS ORGANISATIONAL / DEPUTY DOCTOR

If a deputy general practitioner or out of hours organisation is contacted about a death an assessment should be carried out to decide whether a visit is appropriate. The deputy doctor will not be the certifying doctor and is unlikely to have any connection with the relatives or any access to the medical records. A visit will be appropriate when:

- There is no other health care professional competent to undertake the procedure for the confirmation of death.
- There is uncertainty about the fact of death.
- The needs of living patients (e.g. bereaved relatives) are required to be met.

14. BEST PRACTICE GUIDANCE FOR STAFF CARING FOR THE TERMINALLY ILL

When a death is anticipated it is helpful if clear information is given to relatives/carers with regard to what action to take when a death occurs either in or out of hours.

Where it is appropriate, it is good practice to discuss and document 'Do not cardiopulmonary resuscitate' issues as part of advanced care planning. (See Cardiff and Vale University Health Board Do Not Attempt to Cardiopulmonary Resuscitate Policy – http:www.cardiffandvaleuhb.wales.nhs.uk/opendoc/251418).

Additionally when a death is anticipated and the patients preferred place of care is at home it is important that the out of hour's doctor service is informed of this fact by the Primary Health Care Team.

15. CONSULTATION ARRANGEMENTS

Postholders/ Groups/Organisations Consulted	Date Consulted/ Rationale for not Consulting	Comments Received: Y/N
Executive Directors*	√	
Clinical Board Medical Directors*	√	Y
Clinical Board Directors of Nursing*	√	Y
Clinical Board Managers – Head of Operations*	Clinical practice issue	N
Staff Representatives*	No Staff side issues identified through the stakeholder engagement	N
Appropriate Subject Committee/Group(s) (please specify)	NMB October 2018	Y
Relevant Professional Group(s) / Subject Specialist(s) (please specify)	DON, Lead and Senior Nurses, Resus Officer	Y
Service User Representatives/ Stakeholder Groups (please specify)	2018	Y
Third Sector/Partner Organisations (please specify)	2018	Y
Other (please specify)		

16. EQUALITY HEALTH IMPACT ASSESSMENT

Following assessment, this procedure is **not** felt to be discriminatory or detrimental in any way with regard to the following equality strands:
Gender; Race; Disability; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human Rights (Appendix 9)

17. IMPLEMENTATION OF THE POLICY

Each Clinical board is responsible for their implementation of this policy.

This Policy will be posted on the UHB Intranet.

18. PUBLICATION AND DISSEMINATION

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

19. CONCLUSION

E.g. The approval of the Confirmation of an Expected Death Policy will promote quality of care provision to the deceased and bereaved by promoting consistent approach to the confirmation of death procedures across Cardiff and Vale UHB – in and out of hours

20. RECOMMENDATION

The Board is asked to:

- **APPROVE** the ''Confirmation of an Expected Death Policy''

Appendix 1 *– Guidance for GPs in England and Wales Confirmation* **and Certification of Death**

GENERAL PRACTITIONERS COMMITTEE

1. INTRODUCTION

This guidance aims to clarify the distinction between confirming and certifying death in relation to GP's obligations.

English law:

- *does not* require a doctor to confirm death has occurred or that "life is extinct";
- *does not* require a doctor to view the body of a deceased person;
- *does not* require a doctor to report the fact that death has occurred;
- *does* require the doctor who attended the deceased during the last illness to issue a certificate detailing the cause of death.

(i) Expected deaths of patients

If the death occurs in the patient's own home, it is wise to visit as soon as the urgent needs of living patients permit.

If the death occurs in a residential or nursing home and the GP who attended the patient during the last illness is available, it is sensible for him/her to attend when practicable and issue a death certificate.

If an 'on-call' doctor is on duty, whether in or out of hours, it is unlikely that any useful purpose will be served by that doctor attending.

In such cases we recommend that the GP advises the home to contact the undertaker if they wish the body to be removed and ensures that the GP with whom the patient was registered is notified as soon as practicable.

(ii) Unexpected ('sudden') deaths

If death occurs in the patient's home, or in a residential or nursing home, we recommend a visit by the GP with whom the patient was registered to examine the

body and confirm death, although this is not a statutory requirement. The GP should then report the death to the coroner (usually through the local police).

In any other circumstances, the request to attend is likely to have come from the police or ambulance service. It is usually wise, and especially in the case of an "on-call" doctor to decline to attend and advise that the services of a retained police surgeon be obtained by the caller.

2. LEGAL REQUIREMENTS

The law requires a doctor to notify the cause of death of any patient whom he/she has attended during that patient's last illness to the Registrar of Births and Deaths. The doctor is required to notify the cause of death as a certificate, on a form prescribed, stating to the best of his/her knowledge and belief, the cause of death. It should be noted that the strict interpretation of the law is that the doctor shall notify the cause of death, not the fact. Thus, a doctor does not certify that death has occurred, only what in his/her opinion was the cause, assuming that death has taken place. Arising out of this interpretation there is no obligation on the doctor even to see, let alone examine the body before issuing the certificate.

The Broderick report recommended that a doctor should be required to inspect the body of a deceased person before issuing the certificate but this recommendation has never been implemented. Thus there is no requirement in English law for a general practitioner or any other registered medical practitioner to see or examine the body of a person who is said to be dead.

General practitioners as a body would not, and as individuals should not, seek to use this quirk of English law to avoid attending upon an apparently deceased patient for whom the GP is responsible. However, the fact that there is no legal obligation upon a GP to attend a corpse should be remembered and if necessary, quoted when organisations such as the emergency services ask general practitioners either in or out of hours, to attend a corpse as a matter of urgency. If a patient is declared to be dead a relative, a member of staff in a nursing home, ambulance personnel or the police, GPs would be right to explain that the needs of the living must take priority over the requirements of the dead.

On a parallel basis, case law exists to confirm that a NHS general practitioner does not have a contractual obligation to attend upon the body of a patient declared to be dead. Once again the fact that a contractual obligation does not exist should never be used by GPs to avoid the ethical and moral responsibility to make the experience of bereavement as gentle and easy as possible for relatives and friends.

3. SUDDEN OR UNEXPECTED DEATHS

These fall into two main categories:

I. deaths where there is prima facie evidence of violence or other unnatural causes, including deaths in road traffic accidents, falls from high places, suicides and those apparently involving criminal violence; and

II. sudden or unexpected death where there is no prima facie evidence of violence or unnatural causes.

GPs are advised to be cautious in making or attempting to make this distinction unless they are forensically trained and experienced in clinical forensic medicine. It is too easy to wrongly classify a sudden or unexpected death.

As a citizen, a doctor has an obligation to inform the police if he/she becomes aware of a serious crime but English law, contrary to popular belief, does NOT place an obligation upon a doctor to report all sudden deaths to the coroner. In practice, the wise practitioner will report a sudden death to the coroner, normally through the agency of the local police.

The most likely circumstances in which GPs may be requested to attend upon the body of a victim of sudden death are:

I. A call from a relative carer or a nursing or residential home, about a registered patient who has been found to be dead, unexpectedly, but apparently in circumstances which are not suspicious.

The doctor should respond as quickly as the urgent needs of their living patients permit.

On arrival the doctor should carry out an adequate examination to confirm death and then consider whether HM Coroner should be informed. In all but very exceptional circumstances, even where there appear to be no suspicious circumstances, the doctor would be wise to notify HM Coroner. The GP should be mindful of the considerable distress this may cause to relatives, carers and friends and explain why the police will attend and the likely course of events subsequent to the attendance of the police.

II. A request from the police, or ambulance service that the GP attend upon a body found in a public place, a deserted building or as the result of a road or other form of accident or other situation.

In these circumstances there is no obligation upon the GP to attend. Under paragraph 4 (1) (h) (iii) of the terms of service, a NHS GP is required to provide treatment to persons not registered but requiring immediate treatment due to an accident or other emergency only if “he is available to provide such treatment”. If the request is to attend upon a dead person or persons there is no question of a GP being requested to provide treatment, therefore there is no obligation to attend.

If the request is to attend to treat a person as a result of an accident it may be that the GP, whether the call is in working hours or out of working hours, is available and considers it would not endanger the other patients for whom he/she is responsible to attend the emergency. It would then be right and reasonable for the doctor to attend.

However, if the doctor is on call and dealing with numerous calls as when on duty for a co-operative or dealing with patients attending a surgery session, then it is reasonable to give a reply which indicates that the doctor is not available to provide such treatment.

If the police request a GP to attend a sudden death, unless that doctor is trained and experienced in clinical forensic medicine and the police offer the appropriate fee for the service, then the GP would be well advised to refuse to attend and advise the police to obtain the services of a retained police surgeon. If the request comes from the ambulance service then the response should be to advise the ambulance service that a doctor is not available and suggest that they ask the police to enlist the services of a retained police surgeon.

4. EXPECTED DEATHS AT HOME OR IN NURSING OR RESIDENTIAL HOMES

Calls during normal working hours
A doctor who has been treating the patient during their current illness should indicate that he/she will attend as soon as the urgent needs of any living patients have been satisfied. The doctor should then attend to confirm death and issue the Medical Certificate of Cause of Death. If the doctor who has been treating the patient is not immediately available, a colleague should attend and then ensure that the doctor of the deceased patient is informed of the death as soon as possible.

Calls out of hours
The likelihood is that the doctor on call is not the doctor who has been attending the deceased person during their last illness, and cannot therefore initiate the death certification process. If the death is in a nursing or residential home it is unlikely that any useful purpose can be served by a duty doctor attending during the out of hours period unless there is a genuine doubt as to whether the person is dead.

The obligation upon the on-call doctor or the co-operative, in those circumstances, is to ensure that the deceased's registered GP is notified at the first possible opportunity in the next period of normal working hours. It is then the responsibility of the doctor with whom the deceased was registered to deal with the death certification procedure. If the home so requests, normally undertakers will remove the deceased under these circumstances. Circumstances are similar if the person has died at home but, on those occasions, it may well be that there is a distressed relative, carer or friend who reasonably requires the attention of the doctor. If, however, the relative, carer is content to make arrangements with an undertaker, without the doctor attending, then there is certainly no need for a duty doctor to attend.

Within the hospital setting it has to be the treating doctor who writes the medical certificate certifying death.

6. PROBLEM SITUATIONS

It is inevitable that on occasion expected deaths will occur at times when the general practitioner who has been treating the patient during the last illness is not available at

the time or during the next period of normal working hours. Whilst partners sometimes take what they deem to be the kindest action to deal with the situation and issue the Certificate of Cause of Death, the proper course of action and very much the wisest is for the partner or colleague of the absent practitioner to notify HM Coroner personally in those circumstances. Coroners are understanding of the doctor's position and sympathetic to the relatives" situation and will, normally, issue appropriate instructions to allow the funeral arrangements to proceed without unnecessary bureaucratic delay

Appendix 2 – Confirmation of Death by a Healthcare Professional

INTRODUCTION

This policy is for the confirmation of death by a healthcare professional (nurse midwife or paramedic) employed within Cardiff and Vale University Health Board, who as part of their role, may be required to confirm death. Training must be undertaken in the use of this protocol and the healthcare professional deemed to be competent before they undertake this expansion to their role.

CONFIRMATION OF DEATH

CONFIRM THE PATIENT IS UNRESPONSIVE	• Check that there is no response to a painful stimulus
CONFIRM THE ABSENCE OF BREATHING	• Look at the chest for signs of movement for at least one minute • Check for the absence of breath sounds with a stethoscope for at least 1 minute
CONFIRM ABSENCE OF CIRCULATION	• Inspect patient for any signs of circulation (e.g. movement, pallor) • Palpate the carotid pulse for 1 minute • Listen for the absence of heart sounds – at least 1 minute
PUPIL REACTION	• With a bright source of light (i.e. pen torch) shine torch in each eye • Observe that both pupils are fixed

If there are no signs of respiration, no heart sounds and pupils are un-reactive – death can be confirmed.

It is not uncommon for there to be occasional spontaneous gasping sounds or occasional intermittent audible heart sounds soon after death and if this is the case the patient should be left for 15 minutes and the full procedure repeated.

Appendix 3 – Procedure for Confirming Death

Procedure for confirmation of expected death by a Registered Nurse / Paramedic

- Ensure all nursing staff / paramedic are aware of expected death i.e. record within care plan / care pathway;
- Following expected death of patient. Ensure the appropriate equipment is available:
    1) Stethoscope;
    2) Torchlight / pen torch / ophthalmoscope;
    3) Sharps box for disposal of parenteral / subcutaneous medication administration equipment.
- Check for clinical signs of death over a 5minute period, using a stethoscope and penlight. The following are recognised clinical signs used for confirmation of death, all the signs should be apparent before death is confirmed and recorded on the relevant paperwork.
    1) Unresponsive and there are no vital signs of life e.g. movement, coughing, swallowing, for over one minute;
    2) Absence of carotid pulse over one minute;
    3) Absence of heart sounds over one minute using stethoscope;
    4) Absence of respiratory movement and breath sounds over one minute;
    5) Fixed, dilated pupils (unresponsive to pen torch) in both eyes;
    6) No response to painful stimuli, verified by application of pressure to nail bed for 10 seconds;
    7) Any spontaneous return of cardiac or respiratory activity during the period of observation should prompt a further 5 minute observation from the next point of cardio-respiratory arrest.
- Record the clinical observations within nursing notes / using template (see appendix 2):
    1) The date of death;
    2) The time of death (ascertained if necessary from relative / carer);
    3) Identity of any person present at the death or, if the deceased was alone, the person who found the body;
    4) Time of confirmation;
    5) Place of death;
    6) Clinical signs of death (listed above);
    7) Name of Doctor informing, time and date this took place;
    8) Signature of Nurse / Paramedic confirming death with the printed name of the Nurse underneath signature and designation.
    9) Contact family / next of kin, if not present;
    10) Perform laying out duties, if required and contact Funeral Director.

The record of the nurse / paramedic confirmation of death should be communicated to the patients GP as soon as possible following death by telephone message, secure fax or email .

If this is an expected death, the nurse / paramedic should advise the relatives that the patient's own Doctor will be able to issue a medical certificate of the cause of death within 24 hours of the patient death, except at weekends or bank holidays when the certificate should be made available the next working day.

Primary Care Death:

If a death occurs during the OOH period, weekend or bank holiday and the deceased requires burial within 24 hours for cultural reason – families of the bereaved are advised to contact their local religious leaders for guidance on the process.

`Hospital Death:

If the death occurs at the weekend /over the bank holiday period and the deceased requires burial within 24 hours for cultural reasons an information pack is available at the Bereavement Office offering guidance for medical / nursing staff regarding completing the medical certificate of cause of death/registering the death and release of the body.

If cremation is required a separate form (4&5) needs to be completed by medical staff.

The next of kin / relatives taking care of the funeral arrangements are required to phone the Bereavement Office the next working day to make arrangements to collect the medical certificate of cause of death. Not all certificates are issued from the hospital e.g. if the death has been reported to the Coroner and a Coroner's post mortem examination is taking place then there will be no certificate issued from the hospital. The Coroner's Officers will issue the relevant paperwork to the relatives.

NB. Parental drug administration equipment should be removed after the confirmation of death.

Appendix 4 – Confirmation of Death Competency Assessment

Practitioners name ……

Assessors name ……

DATE ……

TIME ……

No.	Criteria	Practitioner Signature	Assessor Signature	Comments
1	**Professional is able to identify risks associated with the confirmation of death and actions required to eliminate or minimise risks**			
2	**Professional is able to describe the difference between the confirmation and the certification of death e.g. Completing the 'Medical Certificate of Cause of Death'**			
3	**Professional is able to describe when it would be appropriate to move the body to the mortuary or contact the undertaker**			
4	**Professional is able to state the factors that would classify the death as expected or unexpected and action based on this assessment**			
5	**Professional is able to state the unequivocal signs of death**			
6	**Applies appropriate painful stimuli and assesses response to confirm that there is no response to pain**			
7	**Visually confirms the absence of breathing movement. Using a stethoscope demonstrates appropriate auscultation of breath sounds for at least one minute**			
8	**Confirms the absence of circulation by demonstrating competence in palpation of the carotid pulse, cardiac auscultation (one min) with a stethoscope and observation for movement & pallor**			

9	**Using an appropriate light source, Demonstrate the correct technique in ensuring that pupils are fixed and dilated.**			
10	**Is able state the correct action/procedure required if any signs of life are found during the initial assessment**			
11	**Is able to state the correct action in relation to dealing with any IV medications during the confirmation of death procedure.**			
12	**Professional is able to list the indications required for notification of the coroner**			
13	**Professional is aware of other relevant LHB policy (such as last offices, cremation procedure, resuscitation policies and procedures)**			
14	**Professionals are able to identify any ICD / pacemaker / medical device on the body and can demonstrate a knowledge on how to proceed if any of these are present**			
15	**Professional has demonstrated throughout confirmation of death compassion and Dignity for patient / relatives and colleagues**			

Professional must recognise and work within limits of own competence and keep skills and knowledge up to date to maintain competence and performance NB**: Until Practitioner is assessed as competent two signatures**

Appendix 5 – Confirmation of the Fact of Death

CARDIFF AND VALE UHB

CONFIRMATION OF THE FACT OF AN EXPECTED DEATH

Date and Time Reported By Family/Care Home :	**Date and Time Confirmed by Practitioner :**
Patient's Name :	**DOB :**
Patient's Address :	**GP Name and Address :**
Patients NHS Number :	**History:** **There are no vital signs of life for a period in excess of ..... minutes**
1. Signs of spontaneous respiration (no respiratory effort observed / no breath sounds for 1 minute) **2. Signs of circulation (carotid or femoral pulses / heart sounds)** **3. Cessation of cerebral function – (the pupils are fixed and unresponsive to light/no reaction to painful stimuli)**	**Comments** **YES / NO** **YES / No** **YES / NO**
Comments :	**Life Extinct verified by (please print clearly):**
Signature:	**Does the patient have an ICD in situ** **YES / NO**
Verification of Death: **Date –** **Time -**	**Persons present at time of death:**
Information leaflets given to relatives: **YES / NO**	**Relatives informed if not present at time of death:** **YES / NO** **If YES – name of relative**
Has this case been referred to the Coroner: **YES / NO**	**Have the Police been informed:** **YES / NO**

CARDIFF AND VALE UHB

CONFIRMATION OF THE FACT OF AN EXPECTED DEATH
****IN A VENTILATED PATIENT****

Date and Time Reported By Family/Care Home / Ward :	**Date and Time Confirmed by Practitioner :**
Patient's Name :	**DOB :**
Patient's Address :	**GP Name and Address :**
Patients NHS Number :	**History:** **In the ventilated patient you must:** **1. Confirm the patients identity** **2. Confirm the decision to withdraw treatment**
After asystole confirm: **1. Signs of circulation (carotid or femoral pulses / heart sounds)** **2. Cessation of cerebral function – (the pupils are fixed and unresponsive to light/no reaction to painful stimuli)** **The ventilator can now be disconected** **Ascultate for:** **1. Signs of spontaneous respiration (no respiratory effort observed / no breath sounds for 1 minute)**	**Comments** **YES / NO** **YES / NO** **YES / NO**
Comments :	**Life Extinct verified by (please print clearly):**
Signature:	**Does the patient have an ICD in situ** **YES / NO**
Verification of Death: **Date –** **Time -**	**Persons present at time of death:**
Information leaflets given to relatives: **YES / NO**	**Relatives informed if not present at time of death:** **YES / NO** **If YES – name of relative**
Has this case been referred to the Coroner: **YES / NO**	**Have the Police been informed:** **YES / NO**

APPENDIX 6 – Death which should be 'reported' to HM Coroner

Referral of Deaths to HM Coroner
SOUTH WALES CENTRAL

GUIDANCE

By virtue of s.1 Coroners and Justice Act 2009, a Coroner has a duty to investigate a death where there is *reason to suspect* that the death is:-

- Violent
- Unnatural
- Of unknown cause
- Has occurred whilst in custody or state detention

There are no statutory guidelines which set out which deaths have to be reported to HM Coroner. The categories of cases set out below are therefore for guidance only and if there is any doubt whether a death should be referred, advice from the Coroners Office should be sought.

A death should be reported to HM Coroner when a doctor knows or has *reasonable cause to suspect* that:-

- the cause of death is unknown – (*probable* cause not certain cause). NB if the cause of death is known, on the balance of probabilities and is natural, there is no need to refer to the Coroner.
- the death has occurred as a result of trauma, violence or physical injury whether inflicted intentionally or otherwise – this includes deaths related to accidents.
- The death occurred as a result of poisoning, the use of a controlled drug, medicinal product or toxic chemical
- The death is due to a hospital acquired infection in circumstances in which it could be said to be unnatural.
- The death is related to any treatment or procedure of a medical or similar nature
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic.
- The death occurred as a result of self-harm (including a failure of the deceased to preserve his own life) whether intentional or otherwise
- The death occurred as a result of an injury or disease received

during or attributable to the course of the deceased persons work
- The death occurred a result of a notifiable accident, poisoning or disease
- The death occurred as a result of neglect or failure of care by another person or self-neglect
- The death has occurred or illness arisen during or shortly after the deceased has been in contact with the police
- The death is related to abortion (miscarriage or termination)

- The death occurred whilst in custody or state detention – whatever the cause of death (Mental Health Act Section, Imprisonment etc.) NB – there is no longer a legal requirement to automatically hold an inquest where there is a Deprivation of Liberty Safeguarding Order (DoLS) in place if the cause of death is natural and there is no other reason to refer to the Coroner.
- the identity of the deceased is not known
- where the Registration Regulations cannot be complied with i.e. The certifying Dr must have a*ttended patient in last illness and either such attendance was within last 14 days OR the Dr has viewed the body after death*
- the death was otherwise unnatural ie. Not due to natural causes.

NOTES

1. There is no longer a requirement to refer a death *just because* the deceased had in the past, worked as a miner *if* the cause of death is clearly not related to that occupation.
2. There is no longer a need to refer a death where death has occurred within 24 hours of admission to hospital *provided* the cause of death is known and it is natural.
3. Falls. Unless there is reason to suspect that a fall has caused or contributed to death, there is no need to refer the death to the Coroner. If there is any doubt, advice should be sought.
4. Deaths following surgery. Unless there is reason to suspect that the surgery or procedure has caused or contributed to the death, there is no need to refer the death to the Coroner. If there is any doubt, advice should be sought.
5. Deaths related to alcohol need not be referred if the cause of death is due to chronic alcohol related disease. It must be referred if it is due to acute alcohol poisoning. Remember also that if alcohol has played a role in an accidental death – the death should be referred.
6. Reporting doctors are reminded of their duty of candour when reporting deaths to HM Coroner – Good Medical Practice 2013 (General Medical Council) : http://www.gmc-uk.org/guidance
7. Reporting doctors are also reminded of their legal obligation under s.22 of the Births Deaths and registration Act 1953 to provide a cause of death – to the best of his / her knowledge and belief.

A.R. BARKLEY HM
Coroner October
2017

Appendix 7 – Nurse Midwifery Council

The NMC Code (2015) – contains the professional standards that registered nurses and midwives must uphold. UK nurses and midwives must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing and midwifery practice in other roles, such as leadership, education or research. While you can interpret the values and principles set out in the Code in a range of different practice settings, they are not negotiable or discretionary.

Registrants have a responsibility to deliver safe and effective care based on current evidence, best practice, and where applicable, validated research.

A nurse cannot legally *certify* death - this is one of the few activities required by law to be carried out by a registered medical practitioner. In the event of death, a registered nurse may *confirm or confirm life extinct*, providing there is an explicit local protocol in place to allow such an action, which includes guidance on when other authorities, e.g. the police or HM Coroner, should be informed prior to removal of the deceased.

Registered nurses undertaking this responsibility should only do so providing they have received appropriate education and training and have been assessed as competent. They must also be aware of their accountability when performing this role.

Appendix 8 – Further Information

NMC Code (2015) Professional Standards of Practice and behaviour for Nurses and Midwives - **www.nmc.org.uk/standards/code/read-the-code-online/**

NMC advice sheet on Accountability

Department of Health (England) **www.dh.gov.uk**

The Scottish Executive **www.scotland.gov.uk**

The Welsh Assembly **www.wales.gov.uk**

Department of Health and Social Services and Patient Safety of Northern Ireland **www.dhsspsni.gov.uk**

Health and Personal Social Services in Northern Ireland **www.n-i.nhs.uk**

Community and District Nurses Association **www.cdna-online.org.uk**

Community Practitioners and Health Visitors Association **www.amicus-cphva.org**

Royal College of Nursing **www.rcn.org.uk**

Royal College of Midwives **www.rcm.org.uk**

UNISON **www.unison.org.uk**

Appendix 9 – Equity Health Impact Assessment

Impact on population health	No impact
Quality and / or Safety implications	No impact
Patient / Carer Experience implications	No impact
Additional workforce requirements	No impact
Education and Training requirements	No impact
Financial implications	No impact
Legal implications	No impact
Equality impact	No impact
Communication / Consultation / engagement requirements	No impact
Affect one group less or more favourably than another on the basis of: **Race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age, or disability**	No Impact

References:

British Medical Association (1999) - Guidance for GPs in England and Wales: Confirmation and Certification of Death - BMA.

Joint Royal Colleges Ambulance Liaison Committee (2003) - Recognition of life Extinct (ROLE) by Ambulance Staff - The Joint Royal Colleges Ambulance Liaison Committee.

NMC Code (2015) Professional Standards of Practice and behaviour for Nurses and Midwives - **www.nmc.org.uk/standards/code/read-the-code-online/**

Nursing & Midwifery Council (2012) Confirmation of Death. A-Z advice sheet. NMC, London.

Referral of a Death to HM Coroner (2017) - **South Wales Central Guidance** – A R Barclay HM Coroner Oct 2017.

Welsh Government: A clinical Policy for Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) for Adults in Wales, 2017

Equality & Health Impact Assessment for

Confirmation of an Expected Death

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Confirmation of an Expected Death in Adults – (18yrs and over)
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Primary Community and Intermediate Clinical Board Kay Jeynes - Director of Nursing – 02921834521 Helen Earland – Senior Nurse Primary Care / Clinical Nurse Lead OOH – 02920 335287
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of the document 'Confirmation of an Expected Death' is to ensure that:- • Quality of care provision to the deceased and bereaved by promoting a consistent approach to the confirmation of death procedures across Cardiff and Vale UHB. • Staff who undertake the procedure are trained and competent. The expected outcomes of this policy are as follows - • For the death of the patient to be dealt with in a timely, sensitive and caring manner; • The death is dealt with in accordance with the law; • The Registered Nurse / Midwife / Paramedic skills and competencies are used appropriately;

		• The distress of relatives can be reduced by having parenteral medication devices disconnected promptly and appropriately following the death of a patient, once confirmation of death has been established; • All religious and cultural needs of the patient will be clearly identified and recorded in the patients nursing documentation prior to death.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the	• Cardiff & Vale University Local Health Board (LHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales' capital city: Cardiff. 72.1 and 27.9 percent of the LHB area population live within Cardiff and the more rural Vale of Glamorgan respectively • The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet). No comments were received. • A part of good practice, other policies from different organisations were considered. • Internal Stakeholders were engaged in the EHIA and/or policy development (Directors of Nursing from Each Clinical Board and other appropriate nursing leads from across the organisation). • NMC Code (2015) Professional Standards of Practice and behavior for Nurses and Midwives - **www.nmc.org.uk/standards/code/read-the-code-online/** • NMC advice sheet on Accountability • Department of Health (England) **www.dh.gov.uk** • The Scottish Executive **www.scotland.gov.uk**

	UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	• The Welsh Assembly **www.wales.gov.uk** • Department of Health and Social Services and Patient Safety of Northern Ireland **www.dhsspsni.gov.uk** • Health and Personal Social Services in Northern Ireland **www.n-i.nhs.uk** • Community and District Nurses Association **www.cdna-online.org.uk** • Community Practitioners and Health Visitors Association **www.amicus-cphva.org** • Referral of a Death to HM Coroner (2017) - **South Wales Central Guidance** – A R Barclay HM Coroner Oct 2017 • Royal College of Nursing **www.rcn.org.uk** • Royal College of Midwives **www.rcm.org.uk** • UNISON **www.unison.org.uk**
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The policy applies to all UHB staff who carry out the process of 'Confirmation of an Expected Death' within Cardiff and Vale UHB

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • between 18 and 65; and • over 65	This policy is related to confirmation of an expected death in adults only – therefore would not be applicable for anyone under the age of 18yrs	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disability would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner	N/A	N/A
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is	Gender or gender reassignment would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	Marital status would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not	The death of a woman expecting a baby, on a break from work or breast feeding – would not sit under the 'Confirmation of an Expected Death' Policy – but be within the criteria to refer on to HM	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
they are on maternity leave.	Coroner. This would be termed as an Unexpected / Unexplained death.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The death of a person of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner. Health care professionals do need to be aware of cultural beliefs in relation to the after care of a person confirmed dead and their family / carers	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	People with a religion or belief or with no religion or belief would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner. Health care professionals do need to be aware of religious beliefs in relation to the after care / burial of a person confirmed dead	N/A	N/A
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	People who are attracted to other people of the same sex, different sex or both sexes would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	Coroner.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner. However bilingual patient information leaflets are available for the deceased relatives. This is in line with our current Welsh Language Scheme and the future Welsh Language Standards.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	People on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner.	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Living conditions of the dead individual would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner.	N/A	N/A
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure	Not applicable to this policy	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
and/or service			

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities	Confirmation of death is the responsibility of appropriately trained health care professionals working in and out of the hospital setting, across the whole of Cardiff and Vale – immaterial of	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal - A more equal Wales	demographics of the deceased		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier	N/A for this policy	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Confirmation of death is the responsibility of appropriately trained health care professionals working in and out of the hospital setting, across the whole of Cardiff and Vale – immaterial of financial and employment status of the deceased	N/A	N/A
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the	For this policy, there will be no impact.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos	For this policy, there will be no impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	Guidance on the referral of Deaths to HM Coroner – South Wales Central - 2017 British Medical Association (1999) - Guidance for GPs in England and Wales: Confirmation and Certification of Death - BMA. Nursing & Midwifery Council (2012) Confirmation of Death. A-Z advice sheet. NMC, London. Joint Royal Colleges Ambulance Liaison Committee (2003) - Recognition of life Extinct (ROLE) by Ambulance Staff -	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
	The Joint Royal Colleges Ambulance Liaison Committee.		

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	On writing the first UHB wide policy for the 'Confirmation of Expected Death', this will provide a structured document, underpinned by a stringent governance framework for all health care professionals undertaking this role whether in the hospital, community or primary care sector. It promotes quality of care provision to the deceased and bereaved by promoting a consistent approach. Input in to this document has been received from all relevant areas of care across the UHB. Overall, there appears to be minimal impact on the protected characteristics and health inequalities as a result of this policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Overall, there appears to be very minimal impact on the protected characteristics and health inequalities as a result of this policy – and a UHB wide document will underpin a stringent governance framework for all Health Board employee's confirming death	Kay Jeynes DoN	1 month	Action in accordance with UHB Employment Policies and Procedures.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very minimal impact identified, it is unnecessary to undertake a more Detailed assessment.	Kay Jeynes DoN	N/A	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	The policy in its current format has been adjusted / amended in accordance With consultation agreements across the UHB. Policy to be added to the NMB – Directors of Nursing Cardiff and Vale – agenda for approval Once approval received the policy will be reviewed on a three yearly basis as per UHB policy. When this policy is reviewed, this EHIA will form part of the consultation exercise. This EHIA will also be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.	Kay Jeynes DoN Kay Jeynes DoN Kay Jeynes DoN	Completed 2 months 3 years	

REPORT TITLE:	**HEALTH AND CARE STANDARDS**								
MEETING:	Quality Safety and Experience Committee						**MEETING DATE:**	**18.12.18**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	**Head of Patient Safety and Quality Assurance**								

PURPOSE OF REPORT:

Please set out why this report is being provided to the meeting.

SITUATION:
This report provides the committee with an overview of the UHB's approach to assessment of compliance against the Health and Care Standards.

REPORT:

BACKGROUND:
The Health and Care Standards set out the Welsh Government's framework of standards to support NHS organisations in providing effective, timely and quality services across all healthcare settings. The current set of Health and Care Standards came into force on 1 April 2015 and incorporates a revision of the "Doing Well, Doing Better" Standards for Health Services in Wales (2010) and the 'Fundamentals of Care Standards (2003).

Since 2016 there has been a programme of alignment of Health and Care Standards to existing groups and committees within the health board, the aim of this approach was to reduce variation and to support ongoing monitoring and quality improvement. A corporate assessment of each standard that has been aligned to a group or committee is undertaken annually to give assurance about the UHB performance against that standard and to develop a set of actions to address requisite improvements. Where an appropriate group or committee has not been identified the Clinical Boards will undertake a self assessment of their performance against that standard. The identified corporate lead will use the information included in the self assessment to develop an assurance report incorporating the identified board actions.

Corporate Leads will seek Executive sign off of each of the 22 annual corporate assessments prior to presenting the final assessment to the Independent Members. Details of the Corporate, Executive and Independent leads are detailed in Appendix 1.

The process is subject to scrutiny from Internal Audit and was awarded reasonable assurance in 2018.

ASSESSMENT:
The 2018/2019 approach will remain the same as the previous year with a further 4 standards being aligned to groups and committees:

It is anticipated that the agendas for the committees that have been aligned to a Health and Care Standard will reflect the criteria dictated in that Standard. Monitoring of Clinical Board performance against these criteria will be reported into the relevant committees at appropriate intervals. These standards have been chosen because there is already an established group/committee with a well developed infrastructure to support this development.

The overall approach and timescales for 2018/19 assessment:

Timescale		Activity	Lead
Start	End		
07.01.19	25.01.19	Revision of HCS Driver Diagrams	Corporate Leads
28.01.19	27.04.19	Self Assessment of standards 1.1 3.1 3.3 3.5 4.1 4.2 6.3	Clinical Boards Quality and Safety Leads
04.03.19	29.03.19	Internal Audit Assessment	Internal Audit Manager
29.04.19	10.05.19	Corporate Validation of self assessments and completion of Corporate Assessments	Corporate Leads
-	10.05.18	Assessment of compliance against standards 2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 3.2 3.4 5.1 6.1 6.2 7.1	Related Group/committee
13.05.19	17.05.19	Executive member Sign Off	Executive Leads
20.05.19	24.05.19	Independent Member Sign Off	Independent Leads
18.06.18		Paper to QSE	Patient Safety and Quality Assurance Manager

RECOMMENDATION:

The Committee are asked to approve the approach and timeframe being taken to assess progress against each of the Health and Care Standards.

Appendix 1

Standard	Executive Lead	Corporate Lead	Independent Member	Group / Committee
Standard 1.1 Health Promotion, Protection and Improvement	Executive Director of Public Health	Consultant in Public Medicine	Strategy and Engagement Committee Chair	Clinical Board Self Assessment
Standard 2.1 Managing Risk and Promoting Health and Safety	Director of Planning	Deputy Director of Strategy & Planning Head of Health & Safety Assistant Director Patient Safety & Quality Head of Corporate Risk and Governance	Heath and Safety Committee Chair	Health and Safety Committee
Standard 2.2 Preventing Pressure and Tissue Damage	Executive Nurse Director	Deputy Nurse Director	Quality Safety and Experience Committee Chair	Pressure Damage Group
Standard 2.3 Falls Prevention	Executive Director of Therapies and Health Sciences	Assistant Director of Therapies and Health Sciences	Quality Safety and Experience Committee Chair	Falls Delivery Group
Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Executive Nurse Director	Director of Infection Control Assistant Director of Therapies and Health Sciences	Quality Safety and Experience Committee Chair	IP&C Group
Standard 2.5 Nutrition and Hydration	Executive Director of Therapies and Health Sciences	Head of Dietetics	Quality Safety and Experience Committee Chair	Nutrition and Catering Steering Group
Standard 2.6 Medicines Management	Medical Director	Chief Pharmacist	Quality Safety and Experience Committee Chair	Medicines Management Group
Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	Executive Nurse Director	Deputy Nurse Director Head of Safeguarding	Quality Safety and Experience Committee Chair	Safeguarding Steering Group
Standard 2.8 Blood Management	Medical Director	Haematology Clinical Director	Quality Safety and Experience Committee Chair	Blood Transfusion Group
Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	Executive Director of Therapies and Health Sciences	Assistant Director of Therapies and Health Sciences	Quality Safety and Experience Committee Chair	Medical Equipment Group
Standard 3.1 Safe and Clinically Effective Care	Executive Nurse Director	Assistant Director Patient Safety & Quality	Quality Safety and Experience Committee Chair	Clinical Board Self Assessment

		Assistant medical Director		
Standard 3.2 Communicating Effectively	Director of Workforce and OD	Assistant Director of Workforce	UHB Chair	Strategy and Delivery Committee
Standard 3.3 Quality Improvement, Research and Innovation	Medical Director	Assistant Director Patient Safety & Quality Director of R&D	Quality Safety and Experience Committee Chair	Clinical Board Self Assessment
Standard 3.4 Information Governance and Communications Technology	Executive Director of Public Health	Head of Information Governance Head of IT	Independent Member Information Management and Technology	Information Technology and Governance sub Committee
Standard 3.5 Record Keeping	Chief Operating Officer	Health Records Manager Head of Information Governance	Independent Member Information Management and Technology	Clinical Board Self Assessment
Standard 4.1 Dignified Care	Executive Nurse Director	Assistant Director Patient Safety & Quality Deputy Nurse Director	Quality Safety and Experience Committee Chair	Clinical Board Self Assessment
Standard 4.2 Patient Information	Executive Nurse Director	Assistant Director Patient Safety & Quality Assistant Medical Director Equality Adviser Lead Nurse Patient Experience Mental Capacity Act Manager Mental Health Act manager	Quality Safety and Experience Committee Chair	Clinical Board Self Assessment
Standard 5.1 Timely Access	Chief Operating Officer	Operational Planning Director	Resources and Delivery Committee	Strategy and Delivery Committee
Standard 6.1 Planning Care to Promote Independence	Director of Therapies and Health Sciences	Assistant Director of Therapies and Health Sciences	Quality Safety and Experience Committee Chair	Get Me Home Work Group
Standard 6.2 Peoples Rights	Director of workforce	Assistant Director of Workforce Equality Advisor	Chair Equality Diversity and Human Rights sub-Committee	Strategy and Delivery Committee
Standard 6.3 Listening and Learning from Feedback	Executive Nurse Director	Assistant Director Patient Experience	Quality Safety and Experience Committee Chair	Clinical Board Self Assessment

Standard 7.1 Workforce	Director of Workforce	Assistant Director of Workforce	Strategy and Delivery Committee Chair	Strategy and Delivery Committee

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	✓
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

REPORT TITLE:	**Spotlight on Maternity Services – Safety Improvement Plan**								
MEETING:	QSE						**MEETING DATE:**	**10th December 2018**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:									
REPORT AUTHOR (TITLE):	**Head of Midwifery / Lead Directorate Nurse**								

PURPOSE OF REPORT:

The purpose of the report is to inform and provide assurance to the Committee that the Directorate has undertaken a review and self-assessment of Maternity Services at Cardiff and Vale UHB in light of national maternity service reviews i.e. Care Quality Commission (CQC) investigation into Shrewsbury and Telford NHS Trust (2018) , Investigation of Morecombe Bay Report (2015). The Directorate has also included local issues which require attention and have been placed onto the Directorate Risk Register.

REPORT:

BACKGROUND:

The publication of the CQC Investigation into Maternity Care at Shrewsbury and Telford NHS (SaTH) Trust (2018) has prompted the Directorate to undertake a review of local services within Cardiff and Vale UHB and to assess its current position against areas highlighted for improvement within SaTH. The Directorate has also taken this opportunity to review its position against previous national maternity service reviews such as the Investigation into Morecambe Bay (2015) and Welsh Risk Pool Assessment (2014).

The Directorate has used NHS England's 'Spotlight on Maternity' (March 2016) and its domains as the format which has been adapted for this safety improvement plan. These domains are:-

1. Building strong leadership in maternity services
2. Building capability and skills for all maternity staff
3. Sharing progress and lessons learnt
4. Improving data capture and knowledge in maternity services
5. Workforce
6. Organisation & Environment of Care
7. Quality, Patient Safety & Governance Structures
8. Parent & Public Involvement

ASSESSMENT:

The Directorate has undertaken a self-assessment with RAG ratings. (see Appendix 1). Green denotes full compliance with assurance. Self-assessment of areas rated as amber are those where further audit is due or where work is due for completion within the next 12 months. Red ratings denote those issues which require either urgent attention, or have been placed onto the Directorate & Clinical Board Risk Registers.

Our self-assessment of those areas as **RED** are as follows:-

- **Medical staffing**

Increased obstetric cover for delivery suite has been an ongoing challenge as identified by WRP (201).

Gaps within senior rota remain due to variance in the number of trainees available within year via the Deanery. Gaps within this tier means that women within day assessment / obstetric assessment unit /ante and postnatal wards may not always receive a timely review

ACTION: Funding has been secured via the Clinical Board to employ additional consultant obstetricians to ensure 72 hours resident consultant cover per week (over 7 days). Discussions between Clinical Director and the Deanery being held in relation to number of trainees allocated to Cardiff and Vale UHB Obstetric & Gynaecology Directorate

- **Lone worker**

A new model of community midwifery commenced in November 2018 with additional midwifery staff being rotated within the community. Lone worker devices have previously been trialed but lack of coverage resulted in midwives choosing not to use them.

ACTION: There is full adherence to the lone worker policy for on call midwives but urgent attention is required to ensure that all community staff are familiar with and adhere to the Policy and work is currently underway to address this.

- **Antenatal Clinic (ANC) at Llandough Hospital**

There are plans to re-locate ANC in order to accommodate the move from Rookwood hospital. The Directorate is working with Capital Planning and Estates to find suitable alternative accommodation for women within the Vale.

The Directorate urgently needs plans to be confirmed to ensure that clear communication is shared with staff, women and their families. Plans for the move will need to be developed The Directorate and the Clinical Board are working with Capital Planning and Estates to progress this and ensure suitable alternative accommodation remains within the Vale.

- **Transitional Care**

Transitional care does not currently meet British Association of Perinatal Medicine (BAPM) standards and requires 1 wte neonatal sister to become compliant

ACTION: Work is underway with Finance and the Clinical Board to ensure that all transitional care work is captured robustly and ensure that the area is appropriately funded

- **Maternity Lifts**

There are 3 main maternity lifts which often break down.

ACTION: A contingency is in place for emergencies within the Tertiary Tower however the main lifts are in a state of disrepair. Noted within the Directorate and Clinical Board Risk Registers, there are plans in place to replace and refurbish one lift before the end of 2018

The Directorate is currently taking forward the following additional actions:

- The development of a 'Maternity Board' with key stakeholders (Director of Nursing, Patient Safety, Patient Experience, Head of Midwifery, Obstetric Lead, Risk / Governance Midwife) to ensure that there is further assurance of governance processes and scrutiny of investigation reports. The introduction of staff passports to give staff ownership of mandatory training responsibilities.

- % compliance of mandatory training, sickness and maternity leave to be reported through monthly quality and safety meeting rather than number of staff attended in preceding month.

- Ensuring sufficient senior obstetric leadership to provide adequate cover and timely assessment and review of women.

- Adopting and reviewing the attached Safety Improvement Plan as a standing agenda item at Quality and Safety Directorate Meetings in line with NHS England Spotlight on Maternity Services (2016)

RECOMMENDATIONS:

The Quality, Safety and Experience Committee is asked to:

- CONSIDER the priority areas identified
- NOTE the baseline position and the Safety Improvement Plan that is being taken forward

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	✓

2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	✓
3. All take responsibility for improving our health and wellbeing	✓	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	✓	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	✓

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Kind and caring / Caredig a gofalgar | Respectful / Dangos parch | Trust and integrity / Ymddiriedaeth ac uniondeb | Personal responsibility / Cyfrifoldeb personol

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

Obstetrics & Gynaecology Directorate
'Spotlight on Maternity Services'
Safety Improvement Update
December 2018

Issue	Current Position	Review / Report	Required Actions	Timescales	Owned by:-	RAG Rating
1. Building strong leadership in maternity services						
Maternity Strategy	The UHB has a clearly defined strategy 'Caring for People Keeping People Well' and Future of Our Well-Being Strategy. Both incorporate the Vision for Maternity Services in C&V	Shrewsbury & Telford CQC report (2018) p92	The vision for maternity services at C&V is displayed within public areas. Senior Midwifery Management team are realizing the vision into service improvement via projects and UHB 'LIPS' projects Refresh of Maternity Vision to be placed on agenda for mandatory	Met December 2018 Met December 2018 January 2019	HoM Senior Midwifery Management team Consultant Midwives	

			face to face training with midwives			
Safety Huddles & Multi professional team working within the Obstetric Led Delivery Suite	Multi professional team based on the Obstetric Delivery Suite. Multi professional safety briefing and handovers take place at 8am and 8pm Safety huddles in place for high risk women within the obstetric led delivery suite	Shrewsbury & Telford CQC report (2018) p92 Each Baby Counts (2017, 2018)	To standardise and have evidence of formal safety huddles	March 2019	Delivery Suite Obstetric Lead Senior Midwifery Manager Delivery Suite	
Senior Midwives (Band 7) are equipped with time and resource to undertake their roles effectively	2 Labour Ward Co-ordinators provide management and helicopter view at all times within the obstetric delivery unit Operational ward manager (band 7s) undertake the role of midwifery unit co-ordinator during working hours with the function defaulting to LWC	Recommendations 14 & 16 Report of Morecambe Bay Investigation (2015) Each Baby Counts (2017)	Continue to monitor compliance through off duty and rota development.	Review December 2019	Head of Midwifery Senior Midwifery Manager for In Patient Services	

	after 5pm and weekends.					
There is dedicated time and commitment for frontline staff to be innovative and contribute to service improvement projects	Staff allocated to each cohort of Health Board Leading Improvement in Patient Safety Projects. Work is undertaken with RCM and other Partners to support staff to undertake service improvement and leadership initiatives e.g. RCM Clinical Leadership Programme	Shrewsbury & Telford CQC report (2018) p97	To continue to support staff attendance Evidence of completed projects include Healthy Pregnancy, Through Her Eyes, Babies Don't Bounce	6 monthly review of position.	Head of Midwifery Senior Midwifery Management Team Clinical Director for O&G	
There is evidence of staff engagement at all levels when managing change	There is strong partnership working with staff side representatives who work with maternity in supporting change management	Shrewsbury & Telford CQC report (2018) p98	Evidence of recent management of change include new model of community midwifery, emergency pathway for gynaecology patients, MSW dispute Change management discussed at staff forums e.g. open meetings, c4u, newsletters, staff facebook page	Annual Review	Workforce & OD partner Head of Midwifery Senior Midwifery Management Team	

The executive team are visible	Executive team at C&V undertake regular patient safety walkabouts within the Directorate There is a Lead Executive for the Clinical Board Weekly Chief EXEC Connects Monthly meet the executive meetings for all staff	Shrewsbury & Telford CQC report (2018) p51	Reports from Executive team following walkabout Staff are able to report that they have spoken to / met executive team	Monthly	Executive Team Clinical Board Head of Midwifery & Senior Management Team	
There is clear clinical leadership within the obstetric team with clear roles and responsibilities	There has been a recent restructure of roles and responsibilities within the obstetric team to ensure that there are identified individuals to support the quality and safety agenda within maternity Lead roles were redefined during job planning sessions for obstetric consultants in 2018. All consultant	Recommendations 14 & 16 Report of Morecambe Bay Investigation (2015)	Maintain up to date consultant job plans and maintain regular review	Quarterly review	Directorate Manager Clinical Director	

	obstetricians have up to date job plans with clear roles and responsibilities outlined.					
There is a clear structure for escalation of concerns / patient safety issues out of hours	The Head of Midwifery, Senior Midwifery Managers, Clinical Supervisors for Midwives, Risk / Governance Midwife and Women's Experience Midwife provide on call provision. Escalation and on call support is monitored via monthly professional governance forum. Datix incident reporting and escalation/ Serious Incident process Senior manager and Executive on-call	Recommendations 14 & 16 Report of Morecambe Bay Investigation (2015)	Continue to monitor via Directorate and Clinical Board QSE arrangements	Monthly	Head of Midwifery	
2. Building capability and skills for all maternity staff						

Mandatory training compliance	There is a clear mandatory training plan in place Staff are afforded time to undertake mandatory training (face to face and online) Mandatory on line learning for the O&G Directorate is 78% at 3rd December 2018. Evidenced and monitored by Mandatory Training Database	Shrewsbury & Telford CQC report (2018) p92 Welsh Risk Pool Assessment (2014)	Monitor Attendance lists for all face to face training Continue to monitor uptake of mandatory training compliance	Review quarterly	Clinical Director Directorate Manager Head of Midwifery	
CTG training for medical and midwifery staff	There is a clear plan for intrapartum fetal surveillance training within the Directorate	Shrewsbury & Telford CQC report (2018) p92	Implementation of All Wales Fetal Surveillance Standards launched November 2018 Weekly multi professional table top case review sessions (attendance lists) will be increased to twice weekly from January 2019	Review November 2019 April 2019 January 2019 April 2019	Clinical Director Practice Education Facilitator Senior Midwifery Managers	

			Continue to monitor that all staff are completing the online RCOG /RCM Fetal surveillance package every 3 years. All staff must attend 1 whole day study day (either internal or an external ctg masterclass) Evidenced via database of attendance	Review quarterly	Head of Midwifery Obstetric & Delivery Suite Lead Obstetricians	
Staff have completed adult safeguarding training	Safeguarding midwife delivers adult safeguarding training via face to face mandatory training days for midwives 1st April 2018 – 11th December 2018 59% of midwives have received face to face adult safeguarding training	Shrewsbury & Telford CQC report (2018) p92	The Directorate will continue to monitor staff compliance with adult safeguarding training	April 2019 and quarterly review thereafter	Clinical Director Directorate Manager Safeguarding Midwife Head of Midwifery Practice Education Facilitator	
All staff have completed safeguarding training (children)	Safeguarding midwife delivers children safeguarding training via face to face mandatory training days for midwives	Shrewsbury & Telford CQC report (2018) p92	The Directorate will continue to monitor staff compliance with child safeguarding training	April 2019 and quarterly thereafter	Clinical Director Directorate Manager	

	Midwives have access to training undertaken by LED and are assigned according to requirements for the role 1st April 2018 – 11th December 2018 59% of midwives have received face to face adult safeguarding training				Head of Midwifery Practice Education Facilitator Safeguarding Midwife	
Staff have an opportunity to hear womens' stories and feedback / lessons from concerns and can describe a change in practice as a result	Women's stories are shared within the Professional Practice Study Day for Midwives and Support Workers. Stories are shared at Directorate and Clinical Board monthly Quality & Patient Safety Meetings Stories are shared via Clinical Audit Sessions	Shrewsbury & Telford CQC report (2018) p51	'Through Her Eyes' project developed via women's stories via LIPS programme 2nd bereavement room and a memory making room developed in response to women's feedback	Monthly Review and development	Clinical supervisors for midwives Educational supervisor Practice education facilitator Women's experience lead midwife Head of Midwifery	

	Stories are shared and discussed at group supervision sessions for midwives Women's stories shared via Group Supervision with clinical supervisors for midwives				Clinical Director Risk / Governance Midwife	
Midwives are supported to undertake their role effectively and not acting as e.g. 'scrub' practitioners thus removing them from their role and depleting midwifery staffing.	Annual QUAD audits assessing theatre standards in place. Recruitment to full establishment for RN scrub practitioners challenging but ongoing with commitment to fill vacancies Band 7 midwives maintained 'scrub' skills to support the role in the event of an emergency Working with practice education facilitator for surgical clinical board (theatres) to	Shrewsbury & Telford CQC report (2018) p52	Continue annual Quad audits Continue to monitor attendance at training Support identified Scrub Practitioners to ensure successful completion of the Agored Theatre practitioner course.	November 2019 with quarterly review of QUAD action Plan	Head of midwifery Senior midwifery manager for inpatient services	

	rotate maternity staff to update / upskill Role of scrub / theatre / recovery nurse for obstetric theatres being updated as part of theatre modernisation project Plans in place for Scrub Practitioners to undertake theatre practitioner course with Agored Cymru. To commence January 2019 There is a comprehensive Quad Audit Improvement plan in place					
Newly Qualified Midwives (NQMs) are supported throughout their preceptorship year to achieve Band 6 status	There is an All Wales Preceptorship programme in place, evidenced via national competency framework and individual workbook.	Recommendation 2, 3 & 4 Report of the Morecambe Bay Investigation (2015)	Evidence provided via PADR process and progression of NQMs to Band 6 on successful completion A WHATSAPP Band 5 support group has been set up by practice	Annual Review in line with NQM recruitment October 2019	Head of Midwifery Clinical Supervisors for Midwives Practice Educator	

	At Cardiff and Vale there is preceptorship programme for newly qualified midwives and competencies for band 5 and band 6 midwives.		facilitator / mentorship lead Coffee Cake and Catch Ups have been arranged for all NQMs twice in their first year Clinical Supervisors for Midwives meet preceptorship midwives at least 3 times in the first year Prep for Practice Programme developed at C&V published with plans for implementation across Wales.	December 2019 (ongoing support)	Mentorship Facilitator C4U Steering Group	
There is evidence of a culture of multi professional learning	All staff will attend PROMPT multidisciplinary mandatory training sessions for obstetric emergencies from January 2019. Until present all midwives have attended annual mandatory training with days focused on obstetric emergencies, professional topics,	Recommendation 2, 3 & 4 Report of the Morecambe Bay Investigation (2015)	Monitor attendance via PROMPT Wales training faculty Monitor mandatory training compliance Evidence via Passport / PADR / Annual Appraisal Additional training needs discussed with educational supervisor / line manager	January 2019 Monthly compliance update Annual Compliance Report	Clinical Director Head of Midwifery Practice Education Facilitator PROMPT Faculty	

	public health and fetal monitoring Multi professional leadership days held at C&V PROMPT & Mandatory Training are standing agenda items at Directorate Quality and Safety (Evidenced via monthly meeting minutes)	Recommendation 5 Report of the Morecambe Bay Investigation (2015)	Over the past year, 4 multidisciplinary days have been held, 3 were facilitated by the Confidence cube organisation and one in house. As above prompt training will also aid multi professional learning and team working	Quarterly review	Labour Ward Lead Obstetrician Obstetric Lead Consultant Obstetrician Obstetric Anaesthetist RCM Learning Reps	
3. Sharing progress and lessons learnt						
Action plans developed following internal and external review are embedded in practice	There are robust processes in place within the Governance Framework to close the loop with completion of internal and external action plans.	Shrewsbury & Telford CQC report (2018) p51	Continue to monitor action plan progress and completion Monitoring processes continue monthly An annual nursing & midwifery audit plan is being developed	Monthly via Q&S / Professional Governance	Head of Midwifery Clinical Director Risk / Governance Midwife	

	Areas requiring further review / audit are moved to monitoring programme and cross referenced to DATIX incident number Governance newsletters Safety Briefings Clinical Audit Learning is shared at Heads of Midwifery Wales Cases are anonymised and shared with midwifery students for learning				Clinical Supervisors for Midwives	
Where there are concerns or risks raised by staff / shared at governance meeting, staff are able to report that	Line manager directly feeds back to staff and liaises with clinical supervisors for midwives where feedback is required for more than one individual	Shrewsbury & Telford CQC report (2018) p51	Continue to share feedback with staff	Monthly via Q&S / Professional Governance	Head of Midwifery Clinical Director Obstetric Risk Lead	

they are given feedback	Safety briefings Newsletters Direct emails to staff Discussion with line manager and staff Datix escalation systems Serious Incident processes				Risk / Governance Midwife Clinical Supervisors for Midwives Senior Midwifery Managers Band 7 Midwives	
There is evidence of learning from Serious Incidents and Never Events	There are robust local processes in place for the reporting and management of Serious incidents and never Events (see section **Quality, Patient Safety & Governance Structures)** Never events are shared between health boards in Wales via the Heads of Midwifery and	Shrewsbury & Telford CQC report (2018) p52 Recommendation 25, Report of Morecambe Bay Investigation (2015)	Continue to monitor all patient safety incidents via Directorate and Clinical Board QSE arrangements	Monthly	Clinical Director Head of midwifery Risk / Governance Midwife Clinical Supervisors for Midwives	

	through quality and safety meetings. Where there is learning identified for other areas of the services the findings from these investigations are shared through their clinical board quality and safety meetings. Anonymised cases are also shared with 3rd year midwifery students at local AEIs					
4. Improving data capture and knowledge in maternity services						
A}There is a quality and patient safety dashboard in place to identify key themes / trends B} There are mechanisms in place to review the	There are clearly defined Performance Indicators in line with Maternity Strategic Vision RCOG Trigger list / Dashboard Dashboards in place to support service improvement and	Shrewsbury & Telford CQC report (2018)	Continue monthly Dashboard meetings Continue to present the Dashboard as a standing agenda item at Quality and Safety and Professional Governance Directorate Meetings	Monthly review and update	Head of Midwifery Clinical Director Directorate Manager / Service Manager Risk / Governance Midwife	

patient safety dashboard regularly	identify key risks / themes and trends Red Flag Events are captured e.g. delays in timed activity via Datix reporting				Consultant Midwives Senior Midwifery Managers	
There is consistent reporting to national agencies e.g. NMPA / MBRRACE / Each Baby Counts	Lead Reporters identified with key responsibilities for MBRRACE and EBC Reporting. Maternity Informatics Lead works with NWIS to provide NMPA / WG data from E3 Maternity Information System Reporting of national Audits to UHB QSE Committee PMRT (Perinatal Mortality Review Tool) online tool is used for multi professional review and input of data for stillbirth	Shrewsbury & Telford CQC report (2018)	Continue to work with WG and NMPA to support the Directorate in reviewing data for the service prior to publication.	monthly update and review via Stillbirth Review Forum NMPA data reviewed annually MBRRACE data reviewed annually	Head of Midwifery Directorate Manager / Service Manager Clinical Director Consultant Midwives Risk / Governance Midwife Bereavement Midwives Obstetric Lead	

5. Workforce						
Midwifery Staffing	The service achieved Birth-rate (BR) + compliance on 26th October 2018. (April 2016 assessment) BR+ Actuity tool identifies acuity within the service Maternity Leave is high within the Directorate for this group of staff but funding to backfill has been agreed by the Clinical Board. 3.12.18 – fully established to funded BR+ however current pressures with maternity leave had resulted in 10wte midwives being advertised (16wte currently on mat leave)	Shrewsbury & Telford CQC report (2018) p92 Welsh Risk Pool Assessment (2014)	BR+ assessment review to be undertaken January 2019 as mandated by Welsh Government Continue to provide pre qualifying placements for NQMS to support the transition from student to qualified successfully implemented within the service	Monthly review	Head of midwifery Senior Midwifery Managers Clinical Board Directorate Accountant Directorate Manager Workforce & OD Clinical Board partner	

	Recruitment to vacant midwifery posts successful but recruitment process from appointment to start date is protracted Establishment database monitored by Head of Midwifery and Senior Midwifery Managers to ensure consistency in review of flexible working agreements, career breaks and maternity leave. Senior Midwifery team meet monthly with Directorate accountant to review staffing levels and agree vacancies to go to advert. Once for SEW approach for recruiting NQMs led and initiated by C&V helps attrition rates					

	between application and start date					
Medical (Obstetric) staffing (ward and delivery suite)	Consultant residence is currently 08.00-17.00 with on call consultants out of hours Non compliant with RCOG recommendations as 45hrs Delivery Suite Cover persists There are vacancies within the senior rota unable to be filled.	Recommendations 14 & 16, Morecambe Bay Investigation (2015) Welsh Risk Pool Assessment (2014)	Funding achieved via Clinical Board to employ additional consultant obstetricians to ensure 72 hrs resident consultant cover per week (over 7 days) – continue to recruit Continue to work with the Deanery to retain the desired number of trainees available within year via the Deanery	1st February 2019 Quarterly review	Clinical Director Obstetric Lead Clinical Board Directorate Manager	
Local Leaders & connection with senior leaders	Several forums are in place for staff engagement and feedback Quarterly newsletter 'Bump Talk' Quarterly Pt Safety Governance Newsletter Bi-Monthly Open Staff Forums	Shrewsbury & Telford CQC report (2018) p57	Continue to ensure that regular communication is maintained with staff groups	Monthly review	Head of Midwifery Clinical Director Obstetric Lead Senior Midwifery Managers	

	Monthly Coffee Cake and Catch ups for individual staff groups. Staff Facebook page Weekly open door drop in (every Wednesday 7.30-9.30) on delivery suite hosted by Head Of Midwifery Regular walkabouts by senior staff of all areas				Clinical Supervisors for Midwives Directorate Manager	
Staffing on postnatal wards must be appropriate to enable midwives to care for babies on transitional care	11.2 wte Nursery Nurses are in post to support mothers and babies within transitional care. Strong working relationships with Neonatal colleagues supports transitional care The transitional care ward does not meet BAPM criteria	Shrewsbury & Telford CQC report (2018) p57	Continue to monitor the situation in line with BAPM Guidance for Transitional Care Services	Monthly review	Head of Midwifery Senior Midwifery Manager In Patient Services Operational band 7 midwife for transitional care	

	Birthrate + compliance has resulted in safer staffing ratios to be adhered to for this cohort (90:10_ Staff are encouraged to report staffing issues as 'red flags' and contact the senior midwife on duty / on call if unable to provide appropriate levels of care There is an Escalation / Chain of Command Protocol in place to support heightened acuity out of hours					
For staff working within the community, there is evidence of adherence to the Lone Worker Policy	Lone worker devices were trialled within the Directorate but coverage was patchy and ineffective. New model of community midwifery commenced 18th November 2018. Lone worker policy	Shrewsbury & Telford CQC report (2018) p92	Continue to raise awareness of the Lone Worker Policy amongst Community midwives	Audit due December 2018	Senior Midwifery Manager Out Patient Services Band 7 Community Team Leaders	

	refreshed but further work needed to ensure compliance On call midwives are adherent to policy but not all community midwives Evidence of Lone worker responsibilities is being carried out via:- • Team Meeting Minutes • Operational Band 7 Minutes • Midwives diaries • Midwives Workbook • Team Leaders Communication Diaries				Head of Midwifery Risk / Governance Midwife	
Sickness Absence rates	Sickness absence within maternity services for Qualified and Unqualified is 5.5% against the National Target of 4%	Shrewsbury & Telford CQC report (2018) p92	Continue to manage sickness absence robustly in line with UHB policies and processes	Monthly review	Head of Midwifery Workforce & OD partner	

	Sickness absence is monitored via: • triggers within staff records • long term sickness absence policy • Senior Midwifery Management team meetings • Band 7 meetings				Senior Midwifery Managers Band 7 Midwives	
There is a support network in place for vulnerable women	The ELAN team of midwives support vulnerable women. Specialist midwives include bereavement, FGM & Asylum Seekers, perinatal mental health, safeguarding, substance misuse There are clear plans of care in place for vulnerable women within hand held records A Consultant Midwife for public health and vulnerable women leads the strategic	Shrewsbury & Telford CQC report (2018) p92	Continue to monitor outcomes for women	Monthly	Head of Midwifery Senior Midwifery Manager Out Patient Services Consultant Midwife for Public Health and Vulnerable Women ELAN Team	

	agenda for this cohort of women within C&V Group supervision is in place					
Women who are deemed 'high risk' in labour are regularly reviewed by the appropriate level of staff	There are a variety of policies in place for the management of high risk women (see Section 6 below) Lack of senior medical staff leads to delays in women being reviewed in a timely manner Red flag events Datix incident reporting	Shrewsbury & Telford CQC report (2018) p50	Continue to monitor red flag events and incident reporting	Quarterly review	Head of Midwifery Obstetric Lead Ward Managers Senior Midwifery Managers Risk / Governance Midwife Clinical Supervisors for Midwives Women's experience midwife	
Maternity Services are staffed to meet requirements of Obstetrics Anaesthetists' association / Association of Anaesthetists of Great Britain and Ireland (2013)	Obstetric anaesthetists at C&V meet the requirement of OAA (2013) However, to open a 3rd obstetric theatre there would be a requirement for	Shrewsbury & Telford CQC report (2018) p50 RCOG External Review of SaTH (2017)	Continue to monitor anaesthetic provision in line with theatre expansion programme	Review in 6 months June 2019	Consultant Obstetric Anaesthetists Clinical Board	

	further anaesthetic and ODP cover	Cardiff and Vale UHB Local Concern				
Balance a sustainable workforce with skills and experience	Newly qualified midwives or newly appointed midwives are offered a supernumerary period to ensure exposure to different areas Rosters are co-ordinated by Operational Band 7 midwives to ensure there is appropriate skill mix on each shift in each clinical area. Staff are rotated occasionally to ensure 1:2:1 midwifery care is maintained and appropriate level of skill. Medical staff follow RCOG guidance and are supervised with tasks until signed off as competent.	Recommendation 8 & 10 Morecambe Bay Investigation Report (2015) Welsh Risk Pool Assessment (2014)	Continue to monitor engagement with staff Continue to monitor skill mix Continue to monitor red flag events	Quarterly Review	Head of Midwifery Senior Midwifery Managers Clinical Supervisors for Midwives Band 7 Midwives	

	As from November 2018, 2 Band 7 Labour Ward Co-ordinators are on duty at all times, being free to lead and take a helicopter view of the whole obstetric delivery suite					
There are procedures in place to support staff who 'whistleblow'	There is a UHB Whistleblowing policy in place Freedom to Speak up Datix incident reporting UHB Safety Valve process	Recommendation 26, Morecambe Bay Investigation Report (2015)	Continue to encourage staff to raise concerns about care and or behaviour	Review quarterly during 2019 or as and when an issue is raised	Corporate Team	
6. Organisation & Environment of Care						
Management of high risk pregnancies in the correct environment with support of medical staff	All women who meet the criteria for obstetric led care are reviewed by obstetric and medical colleagues throughout their antenatal journey to ensure the woman receives	Shrewsbury & Telford CQC report (2018) p92	All Wales antenatal hand held records to be audited Audit of admission to review times to be	Annual audit due January 2019 Review June 2019	Head of Midwifery	

	appropriate and timely care with review of risk assessment in place For women transferred from AMU to OLU, transfer meetings are held monthly, chaired by Consultant Midwife / Band 7 AMU lead midwife E3 Euroking Maternity Information system in place		undertaken in 2019 by Clinical Supervisors for Midwives		Senior Midwifery Managers Clinical Director Obstetric Lead Antenatal lead obstetrician Clinical supervisors for midwives	
Midwife Led Unit designed and fit for purpose	A Purpose build alongside midwife led unit at UHW The team are reviewing the environment with possibility to install a further 2 pools, thus increasing access to water for labour and birth There are currently challenges with consistent heating of the MLU. Issue placed	Shrewsbury & Telford CQC report (2018) p92	Continue to review risk register	Risk Register Review Due December 2018	Head of Midwifery Consultant Midwives Senior Midwife Out Patient Services	

	on Directorate and Clinical Board Risk Register All Wales Normal Labour Pathway in place with clear guidelines for criteria. Consultant Midwife for Normality based within the AMU.					
Delivery Suite & Obstetric Theatres	15 bed & 2 obstetric theatre There are challenges with environment due to leaking roof during times of heavy rain Obstetric Theatres, Recovery & HDU not meeting QUAD Audit standards Lack of storage space	Cardiff and Vale UHB Local Issue	Continue to carry out Quad Audit Annually, to monitor the improvement plan T2 3rd Obstetric Theatre & 8 inpatient beds due for handover but no uplift in medical or nurse staffing to support an additional environment Working with theatre practice educator facilitator to upskill staff	November 2019 Review May 2019 January 2019	Head of Midwifery Directorate Manager Senior Midwifery Manager In Patient Services	

			Continue to develop Role profiles for qualified staff who scrub / work in theatre are being updated	December 2018	Risk / Governance Manager	
Ante Natal Care UHW	There are joint clinics in place with other specialities for women with complex health co-morbidities e.g. diabetes, medical disorders Women can often wait up to 3 hours to be reviewed due to ultrasound scanning (USS) / capacity issues. Business case being developed for increase in uss provision	Shrewsbury & Telford CQC report (2018) p96 WRP Assessment (2014)	Continue to monitor situation via: • clinic lists • number of cancelled appointments Continue to progress LIPS project to improve flow	January 2019	Band 7 ANC Manager Senior Midwifery Manager Out Patient Services ANC Obstetric Lead	
ANC UHL	There are plans to move ANC at UHL to a different location in order to accommodate a move	Cardiff & Vale UHB Specific	Suitable locations being explored. As of December 2018, working with Planning & Estates to find suitable alternative	Review March 2019	Directorate Manager Senior Midwifery Manager Out	

	from patients from Rookwood hospital				Patient Services	
Day Assessment Unit	There are clear pathways in place for women presenting with reduced fetal movements RCOG and NICE guidelines in place	Shrewsbury & Telford CQC report (2018) p92	Continue to monitor that RCOG and NICE evidence is adhered to. Audit to be undertaken March 2019 Continue to seek solutions so that there is access to timely uss	Review March 2019 Review June 2019	Clinical Supervisors for Midwives	
1st Floor In Patients (ante & postnatal)	There is a growing requirement for transitional care beds. Transitional care arrangements do not meet BAPM standards BAPM Standards require 1 wte Neonatal Sister Band 7 to manage Transitional care unit Working with Finance and Clinical Board to ensure all data is captured appropriately via PMS	Cardiff & Vale UHB Specific	Continue to progess requirements for BAPM Standards for transitional care Reducing Unintended term admissions to NNU audit 2018	Review August 2019	Senior Midwifery Manager In Patient Services Head of Midwifery Directorate Manager Band 7 Ward Manager	

Obstetric Assessment Unit	OAU is managed 24 hrs a day / 7 days a week. Introduction of telephone triage by a midwife in 2018 has been successful and ensured midwives working within OAU are free to care for women without distraction	Cardiff & Vale UHB Specific	Audit of times of admission to review & Telephone triage	March 2019	Band 7 Ward Manager Obstetric Lead Clinical Director Head of Midwifery Senior Midwifery Manager In Patient Services	
Bereavement / Dignity Rooms	SANDS bereavement room is next to a 4 bedded antenatal bay. This may cause distress to bereaved parents. A 2nd bereavement room has been developed following women's feedback. This room is based within the main obstetric delivery suite and will ensure women who are unable to use the SANDS Teardrop room	Cardiff & Vale UHB specific	Continue Medium term plans to explore relocation to more suitable environment	Due to formally open December 2018	Consultant midwife Senior midwife in patient services Head of Midwifery Bereavement Midwife	

	within OAU are cared for sensitively (Delivery Suite Room 3, Memory Making Room, Teardrop Room					
Maternity Lifts	The main maternity lifts are in a state of disrepair. There are plans for a replacement programme with one lift being replaced at the end of 2018	Cardiff & Vale UHB (Local Issue)	Continue to monitor incidents	Review January 2019	Clinical Board Head of Midwifery Clinical Director Directorate Manager	
Management and Storage of Medicines inc O2 cylinders	In 2016, C&V switched to portable lightweight Entonox cylinders for community midwives. Cylinders are stored within the AMU within a locked cupboard as per required regulations	Shrewsbury & Telford CQC report (2018) p92	Continue to monitor compliance with storage requirements	December 2019	Senior Midwifery Manager Out Patient Services Community Team Leaders Band 7 Ward Manager	
Women are booked by 10 completed weeks	75% of women are booked by 10 completed weeks at C&V There is a Performance indicator	Shrewsbury & Telford CQC report (2018) p92	Continue to monitor Performance indicator report from Welsh Government	November 2019	Head of Midwifery Community team Leaders Antenatal Clinic Manager	

	report from Welsh Government				Senior Midwifery Manager Out Patient Services	
All women have a detailed risk assessment at booking which is reviewed Supporting women making difficult choices Supporting women who have had a	There is a risk assessment protocol to aid the decision for option of delivery at which hospital site. There is an antenatal RAG rating system to aid community midwives to book women under the appropriate care whether that be midwifery led care or consultant led care. At Cardiff and Vale all maternity services are based at the University Hospital of Wales but women may choose to birth either at home, on the alongside midwifery led unit or the obstetric unit. Women are risk assessed	Recommendation 6, Morecambe Bay Investigation Report (2015) Shrewsbury & Telford CQC report (2018) p92	Audit due March 2019 Cardiff and Vale offer services on a single site, therefore issues identified within Morecambe Bay and Shrewsbury and Telford are not applicable	March 2019	Clinical supervisors for midwives Consultant Midwives Senior midwifery managers Head of Midwifery Antenatal clinic manager Band 7 team leaders	

traumatic / difficult experience through pregnancy, labour or birth	throughout pregnancy to ensure most appropriate place of birth. Cardiff and Vale also offer a birth choices clinic with our consultant midwife to ensure that there is informed decision making for place of birth. Cardiff and Vale offer a Birth Afterthoughts service for women who have experienced traumatic birth					
Women are supported to have a home birth	Home birth rates at C&V are 2%. Community midwives offer choice and informed information via Birthplace (2013) and women are supported in their decision making Maternity Information system E3 monitors	Shrewsbury & Telford CQC report (2018) p96	Continue to monitor women's choice	December 2019	Head of midwifery Senior midwifery manager out-patient services Consultant midwives Community Team Leaders	

	rates of AMU, OLU and home births Women's experience feedback				Band 7 Ward Manager	
There are processes in place to support vulnerable women	Team of midwives in post to support vulnerable women within C&V Specialist midwives are also in post such as substance misuse, FGM, bereavement midwife, and perinatal mental health.	Shrewsbury & Telford CQC report (2018) p96 Recommendations 14 & 16 Report of Morecambe Bay Investigation (2015)	monitor vacancies and ensure posts are filled	December 2018 Review December 2019	Head of Midwifery Senior Midwifery Manager for Out Patient Services	
There is evidence that equipment is checked and monitored	Equipment checking lists are in all areas	Shrewsbury & Telford CQC report (2018) p49	Audit due April 2019	April 2019	Senior midwifery managers Band 7 team leaders Ward managers Head of midwifery Clinical Supervisors for Midwives	

					Risk / Governance Midwife	
Staff have the equipment they need in order to carry out their role effectively	All requests for essential equipment are actioned. Maintenance contracts are reviewed and renewed accordingly	Shrewsbury & Telford CQC report (2018) p50	Continue to monitor patient safety incident reporting and concerns raised by staff.	Monthly review	Head of midwifery Senior midwifery managers Team leaders Band 7 ward managers Directorate Manager	
One to One Midwifery Care is maintained for all women in labour	One to one midwifery care is maintained at all times. Birthrate + intrapartum tool monitors acuity and prompts escalation policy Senior midwifery manager on call provides support in times of escalation	Shrewsbury & Telford CQC report (2018) p53	Continue to monitor Red flag events via datix reporting	Monthly review	Senior midwifery managers Band 7 team leaders Ward managers Head of midwifery Clinical Supervisors for Midwives Risk / Governance Midwife	

CTG (Cardiotocography) traces are kept in line with UHB and National Guidance	All intrapartum CTGs within C&V are stored electronically via Omniview system Antenatal ctg traces are stored within brown envelopes as per trust guidance	Shrewsbury & Telford CQC report (2018) p53	Audit of women's records Review and audit of omniview system	May 2019	Senior midwifery managers Band 7 team leaders Ward managers Head of midwifery Clinical Supervisors for Midwives Risk / Governance Midwife Obstetric Lead Clinical Director	
Resuscitation equipment is checked and recorded daily in all areas	Equipment checking lists are in all areas and are signed and checked after each use	Shrewsbury & Telford CQC report (2018) p53	Audit due April 2019	Review April 2019	Senior midwifery managers	
There is evidence that care plans for women are updated and are accessible to staff at all times	Care plans are monitored via E3 Maternity Information System which is accessible to all staff	Shrewsbury & Telford CQC report (2018) p94	Monitor compliance via annual record keeping audit	Review May 2019	Senior midwifery managers Band 7 team leaders	

	Community midwives also have access to HV PARIS reporting system E3 Maternity Information System Hand Held Records PARIS				Ward managers Head of midwifery Clinical Supervisors for Midwives Risk / Governance Midwife	
Fetal Medicine Services are not meeting demand for either C&V residents or tertiary referrals	There is insufficient capacity / resilience within the service to ensure women are given timely appointments	Cardiff & Vale UHB specific	Business case has been submitted to WHSCC to consider both short and long term solutions	Review December 2018	Clinical Director Directorate Manager Clinical Board	
7. Quality, Patient Safety & Governance Structures						
Guidelines & Operational Policies	Out of date guidelines are discussed and disseminated for updating via monthly Maternity Professional Forum. There is a named lead obstetrician for guidelines.	Shrewsbury & Telford CQC report (2018) p92	Continue current local documentation control mechanisms	Continue Monthly review	Senior midwifery managers Band 7 team leaders Ward managers	

	Consultant midwife / Clinical Supervisor for Midwives also support development / update of guidelines within maternity Database of guidelines held within the Directorate with RAG ratings and date of expiration As at 3.12.18 there are 133 local maternity guidelines. 29 are currently being updated with a further 11 being incorporated into other guidance / lapsing to avoid duplication				Head of midwifery Clinical Supervisors for Midwives Risk / Governance Midwife Senior midwifery managers Band 7 team leaders Ward managers Head of midwifery Clinical Supervisors for Midwives Risk / Governance Midwife Obstetric Lead Clinical Director	

					Senior midwifery managers Senior midwifery managers Band 7 team leaders Ward managers Head of midwifery Obstetric lead Clinical Director Clinical Supervisors for Midwives Risk / Governance Midwife	
Insufficient ultrasound scan resource to meet the requirements of NICE / RCOG	Increasing number of National Guidance and Recommendations for more ultrasound	Cardiff & Vale UHB Specific	Business Case being prepared for additional resource funding	January 2019	Consultant Obstetrician with ANC special interest	

National recommendations	provision e.g. diabetes, GAP / GROW / Pre Term Labour Service Improvement work ongoing to reduce harm, waste and variation Do we have sufficient resource?				ANC lead midwife Senior Midwifery Manager Out Patient Services Directorate Manager Service Manager	
Timeliness of PTR & RCA investigations	Women's experience midwife in post since 2015. The post-holder has a lead role to investigate concerns and undertake proactive parent and public involvement initiatives and supports MSLC / Women's Voices Duty of candour is considered through all stages of the investigation process/ concerns process and an open and honest	Shrewsbury & Telford CQC report (2018) p92 Recommendations 1, 13, 24 & 31, 34, Morecambe Bay Investigation Report (2015)	Continue with all current processes	Dec 2018 with review Dec 2019	Head of Midwifery Clinical Director Director of Nursing C&W Clinical Board Women's Experience Midwife Patient Safety Team	

	culture has been introduced to ensure that both staff and families receive the appropriate feedback. This feedback includes systemic / organisational failings in care which may have contributed to the overall outcome for the woman and her family Evidence of performance provided by patient experience team Performance monitored via Q&S meetings. The family are allocated a point of contact either the risk manager for O&G or the Womens experience midwife to ensure that they can have updates throughout the investigation process				Patient Experience Team Risk / governance Midwife	

	and ask any further questions if they wish. Evidenced via investigation reports Concerns reporting for 2018 32 formal concerns = 90% responded to in line with PTR regulations. 15 informal all responded to within time = 100% When the decision is made to undertake any investigation in maternity services the family are informed at the beginning of the process and given the opportunity to ask questions and inform the investigation. When the investigation is completed families are given the option					

	of how they would like that report shared either with a meeting or sent to them via post.					
Direct access to the Executive Board	The Head of Midwifery and CD have Directorate access to the Executive Team through formal and informal routes. Clinical Board structures also in place Monthly Clinical Board and Directorate Quality and Safety Meetings in place. Clinical Board report monthly to QSE Committee	Shrewsbury & Telford CQC report (2018) p53	Continue to monitor through agreed processes and forums	Monthly review	Head of Midwifery Clinical Director Clinical Board Executive Team	
Incidents are graded correctly to identify the appropriate level of potential harm	There is robust incident reporting within maternity services, encouraged within an open and honest culture. All incidents are reviewed at weekly DATIX Meeting by midwifery and patient	Shrewsbury & Telford CQC report (2018) p53	Audit of DATIX organisational incidents due	January 2019	Head of Midwifery Clinical Director Risk / Governance Midwife	

	safety team and graded accordingly. From this meeting, incidents requiring further investigation or discussion are placed on the agenda for clinical risk meetings					
Incidents are reviewed and closed in a timely manner	As above	Shrewsbury & Telford CQC report (2018) p57	As above	As above	As above	
Identification and management of risks	The Directorate has a Clinical Governance SOP in place for the identification and management of risks . This includes 'Red Flag' events, RCOG triggers and WG Criteria for Never Event Reporting. Action plans are monitored via monthly professional governance meetings SOP Governance Framework Professional governance meeting minutes	Shrewsbury & Telford CQC report (2018) p92	Continue review of Directorate risk register and update as risks emerge	Monthly review	Head of Midwifery Clinical Supervisors for Midwives Clinical Director Senior midwifery Managers Risk / Governance Midwife	

Awareness of the UHB Vision, Values and Behaviours	The maternal health strategy is displayed in public areas throughout maternity services at UHW Values and Behaviours training forms part of the professional mandatory study day for staff Multi professional leadership days in place which incorporate UHB Values	Shrewsbury & Telford CQC report (2018) p92	Continue to monitor incidents, complaints and concerns raised by staff	Monthly review	Head of Midwifery Clinical Supervisors for Midwives Clinical Director Senior midwifery Managers Risk / Governance Midwife Consultant Midwives Band 7 teams	
Management of women presenting with reduced fetal movements	There is adherence to RCOG/NICE recommendations for management of women with reduced fetal movements Quarterly refresh of safer pregnancy campaign to raise	Shrewsbury & Telford CQC report (2018) p92	Notes audit	February 2019	All staff	

	awareness for staff and women Stickers in place for women's notes highlighting the number of occasions women have presented with reduced fetal movements Women scanned in accordance with national and local guidance					
There is a clear Quality and Patient Safety / Governance Framework within the Directorate	There is a clear governance framework in place for the Directorate 1 wte Governance / Risk midwife in post There is an appointed obstetrician with a special interest in risk within their job plan	Shrewsbury & Telford CQC report (2018) p97	There is a need for a senior midwife to be appointed as Governance lead for the directorate due to the size and context of the role within maternity services	March 2019	Clinical Director Clinical Board Head of Midwifery Clinical Supervisors for Midwives Senior Midwifery Managers	

					Risk / Governance Midwife	
There are processes in place to identify and address medicines management errors	Datix reporting is used to identify medicines management errors New Directorate pharmacist took up post in November 2018 Errors managed via UHB meds management code	Shrewsbury & Telford CQC report (2018) p49	Continue to monitor Datix incidents and to put in place Capability programmes	March 2019 (audit)	Clinical Director Head of Midwifery Clinical Supervisors for Midwives Senior Midwifery Managers Risk / Governance Midwife	
There is robust open and honest culture for incident reporting within the service. There are clear processes in place for incident reporting and investigation	There is an incident trigger list in all areas in line with both RCOG and local triggers. Incidents are reported on E-datix by all staff grades and disciplines, electronic reporting has been in place since June 2015	Shrewsbury & Telford CQC report (2018) p51 Recommendations 11,12 & 23 Morecambe Bay Investigation Report (2015)	Heads of Midwifery Wales are working with Welsh Government to develop standardised criteria for Serious Incident Category and reporting to ensure consistency across Wales	review June 2019	Clinical Board Director of Nursing Senior Midwifery Managers Risk / Governance Midwife	

	All intrapartum stillbirths, maternal deaths and unexpected neonatal deaths are escalated to the patient safety team in view of reporting as serious incidents. Any incident where there is breach and causation identified is also escalated to the patient safety team. The Welsh Government Serious incident guidance is used to decide whether SI reporting is required at a corporate level. Monthly governance mandatory training takes place on the professional day so that all staff are aware of the risk process and understand the process of an investigation.				Obstetric Lead Executive Nurse Director Patient Safety Team	

	A patient story is used to highlight each aspect of the investigation including patient involvement and being open and honest. All incidents that are reported on E-Datix are discussed in a multi professional weekly meeting and open for anyone to attend. At these forums, the decision is made whether further discussion is required either at clinical risk, stillbirth review forum or neonatal mortality meeting. Further investigation may be a root cause analysis, serious incident investigation or never event. For any investigation there is correspondence with our patient safety facilitator for the					

	Children and Women's Clinical Board. Incidents are only closed during the Datix meetings or following further investigation. Incident investigations are conducted by a senior clinical midwife and a consultant obstetrician. Staff involved in an incident are asked to write a statement of their involvement in the patients care and are offered support by their line manager, clinical supervisor for midwives/ educational supervisors and are directed to support available by the health board wellbeing service and their unions. As above families are allocated					

	a point of contact and given the opportunity to contribute to the investigation.					
There is a clear plan in place for supervision following removal of statutory supervision of midwives	Following removal of statutory supervision, the All Wales Model for Clinical Supervision in Wales was implemented in April 2017 with clear Key Performance Indicators (KPIs) There are 2.4wte CSfMs in post with 20% clinical direct time to support staff. KPIs audited November 2018 and met	Shrewsbury & Telford CQC report (2018) p50	Continue to monitor via KPIs	November 2019	Head of Midwifery Clinical Supervisors for Midwives Senior Midwifery Managers Risk / Governance Midwife	
Prescription and Observation charts are stored confidentially and not left unattended at the midwives' desk	Audit programme in place for CSfM via monitoring dashboard Medicines Management audit completed in 2018, due for repeat once new Directorate Pharmacist in post	Shrewsbury & Telford CQC report (2018)	MEOWS audit revealed low compliance within community setting. Repeat audit after necessary education and training completed	January 2019	Directorate Pharmacist Clinical Supervisors for Midwives Head of Midwifery	

Women's weight is recorded on all medication charts	MEOWS audit last undertaken August 2018 Medication chart audit to include women's weight to be repeated when new Pharmacist has commenced in post				Senior Midwifery Managers Band 7 Team Leaders	
Items on the Maternity Dashboard are colour coded and clearly identify improvements needed There is evidence that the Maternity Dashboard is reviewed and discussed at key multi professional meetings as a standing agenda item for	RCOG Dashboard colour coded and risks / improvements clearly identified to inform Q&S and audit programme Public Health Dashboard Dashboard meetings held monthly / bi monthly	Shrewsbury & Telford CQC report (2018) p50	Continue monthly review of Dashboards	Monthly review	Clinical Supervisors for Midwives Head of Midwifery Senior Midwifery Managers Band 7 Team Leaders Maternity Informatics Support Directorate Manager	

					Clinical Director	
Identified risks are recorded on the Directorate Risk Register.	The Directorate has an up to date risk register which in turn informs Clinical Board Risk Register Risk registers are reviewed monthly by HoM, Directorate Manager and Risk / Governance Midwife	Shrewsbury & Telford CQC report (2018) p51	Continue monthly review of Risk Register	Monthly review	Head of Midwifery Senior Midwifery Managers Risk / Governance Manager Directorate Manager Clinical Director	
The UHB has an appointed Maternity safety champion	Independent member Chairs Quality and Safety Committee Cardiff & Vale UHB has a designated Executive Quality and Safety Lead Consultant Obstetrician with a special interest in safety works jointly with risk / governance	Shrewsbury & Telford CQC report (2018) p52	Continue to ensure that there is a nominated Maternity Safety Champion	Annual Review	Corporate Team Head of Midwifery Clinical Director Obstetric Lead Obstetrician Risk / Governance Midwife	

	midwife as safety champions					
Safety Thermometer results should be displayed for staff and public to see Visible information for women within the hospital regarding data, outcomes, activities	'Hot Boards' are visible within all areas of maternity services Performance information shared with MSLC National Performance Indicators published via Stats Wales (Welsh Government) and inform Annual Maternity Performance Board	Shrewsbury & Telford CQC report (2018) p57	Continue to display all information publicly as appropriate	Boards updated by team leaders monthly Performance Board with WG due November 2019	Consultant Midwives Head of Midwifery Clinical Director Directorate Manager Womens' Experience Midwife Team Leaders Band 7 ward managers	
Processes in place for independent (external) perinatal and maternal mortality review	All perinatal and maternal deaths are discussed in multidisciplinary forums. Maternal deaths would be discussed at clinical risk, stillbirths through stillbirth review forum which although multidisciplinary also has a SANDS representative and neonatal deaths through neonatal mortality meeting	Recommendations 39, 40 & 41, Report of the Morecambe Bay Investigation (2015)	Continue with current processes and regular programme of review	Annual Audit / Presentation following publication of national reports. December 2018 for review December 2019	Clinical Director Clinical Board Director of Nursing Clinical Board Clinical Director Head of Midwifery	

	which features an independent neonatologist from another health board. Representatives from SANDS attend multi professional stillbirth review forum External reviewer present for neonatal mortality meetings arranged via the Neonatal Network All maternal deaths are reported and cases reviewed via MBRRACE Multi professional review with the Clinical Board and Patient Safety identifies need for further external review of cases where required				Risk / Governance Midwife	
MBRRACE report (2016) highlighted an perinatal	At Cardiff and Vale a monthly report is extracted from our	Shrewsbury & Telford CQC report (2018) p94	Continue to contribute to MBRRACE national audit and to report	Annual audits	Clinical Director	

mortality rate of 6.89, stillbirth rate of 4.59 and neonatal death rate of 2.25. Overall C&V extended perinatal mortality rates are up to 10% higher within the UHB This must be reviewed and plans for improvement identified	maternity informatics system (Euroking) and this data is then triangulated with the registers, incident reports and the bereavement midwife to ensure that all mortality cases are included. Processes are in place to systematically review all mortality cases within maternity services Safer pregnancy campaign fully implemented and refreshed every 3 months Healthy pregnancy clinic initiated in 2017 GAP / Grow modified programme embedded into clinical practice. Data is triangulated via:- ONS, Registrar's office, Maternity	Recommendation 38, Report of the Morecambe Bay Investigation (2015)	findings to QSE Committee annually.	February 2019	Head of Midwifery Risk / Governance Midwife Clinical Board Consultant Midwives Bereavement Midwife	

	Reporting System (Euroking), DATIX Incident Reporting, MBRRACE Perinatal & Maternal Mortality Reports There is a stillbirth review forum, neonatal mortality meeting as well as a Clinical Risk Forum Between January and end of November 2018 there has been a significant reduction in stillbirth rates within C&V i.e.					
8. Parent & Public Involvement						
Accessible information in different languages	Big Word interpretation services are used for women. The service has recently trialled	Shrewsbury & Telford CQC report (2018) p92	Continue to monitor timely access to appropriate interpretation services	Monthly review Annual Record	Head of Midwifery Band 7 team leaders	

	'skype' interpretation services which has evaluated positively Face to face interpretation services are also available for women Antenatal Screening Wales provide information for women in most languages			Keeping Audit	Senior Midwifery Managers Clinical Director Directorate Manager	
Support systems for women experiencing a loss	C&V has a full time bereavement midwife in post since 2016. The midwife provides practical and pastoral support for women who have experienced a loss. Close working relationship with SANDS and other voluntary organisations Teardrop team of midwives and support workers in place	Shrewsbury & Telford CQC report (2018) p95	Continue to monitor and review all losses via stillbirth review forum Maintain strong relationships with voluntary organisations	Monthly review	Head of midwifery Senior midwifery managers Consultant obstetrician with special interest in bereavement and loss Clinical Director Consultant Midwives	

	throughout the maternity service Development in 2018 of a 2nd bereavement room and room for memory making with support from SANDS Monthly stillbirth review forum in place which reviews all stillbirths (multi professional)				Teardrop team Bereavement Midwife	
There are mechanisms in place for collecting feedback from women and their families	National surveys are collected each month 95-100% of women during 2017-18 told us they were treated with dignity and respect and that they felt confident to care for their baby 2 minutes of your time questionnaires given to women during the postnatal period MSLC meets quarterly with doula, service user and 3rd sector	Shrewsbury & Telford CQC report (2018) p95	Continue to explore all possible patient feedback mechanism, monitor feedback and take action as required	Monthly data collection	Head of midwifery Women's experience lead midwife Consultant midwives Senior Midwifery Managers Clinical Director	

	organisations. MSLC has a service user Chair CAV Voices parent forum via Facebook				Consultant Obstetrician with	

In addition to the above progress report, the following recommendations from the Investigation into Morecambe Bay (2015) were reviewed & considered and found to be specific to Morecambe Bay NHS Foundation Trust and NHS England

Recommendation 7 to audit maternity and paediatric services in relation to risk assessment protocols on place of delivery.

Recommendation 9 to identify an approach to better joint working between hospital sites.

Recommendation 15 to audit their current governance systems.

Recommendation 17 in relation to the physical environment.

Recommendation 18 in relation to the stakeholders (such as CQC) responsibilities to oversee the process and provide support.

Recommendation 19 investigation and the actions for the regulatory bodies.

Recommendation 20 a national maternity review.

Recommendation 21 investigation for NHS England.

Recommendation 22 in relation to training opportunities in smaller units for action by the RCOG, RCPCH and RCM.

Recommendation 27 for professional bodies to reiterate the importance of duty of professional staff to report concerns about clinical services particularly if these relate to patient safety.

Recommendation 28 clear national standards to be drawn up setting out the professional duties and expectations of clinical leads at all levels.

Recommendation 29 clear national standards to be drawn up setting out the responsibilities for clinical quality of other managers.

Recommendation 30 a national protocol to be drawn up setting out the duties of all trusts and their staff in relation to inquests.

Recommendation 32 Local supervising authority system for midwives was ineffectual at detecting manifest problems. The LSA was disaggregated in April 2017 and each country has since implemented a new model of midwifery supervision. In Wales this model is clinical supervisors for midwives and has a supportive rather than investigatory focus. In Cardiff & Vale we have 3 clinical supervisors for midwives (2.4 WTE) and over the last 12 months all 7 KPI's were met in line with the national standards for clinical supervision of midwives in Wales.

Recommendation 33 separating the organisational regulation of quality and finance and performance. At Cardiff and Vale the decision has been made to incorporate all of these areas into the monthly quality and safety meetings at directorate, board and executive levels.

Recommendation 35 in relation to the responsibilities of the CQC and other parts of the NHS that oversea quality.

Recommendation 36 in relation to the impact and processes to achieve foundation trust status.

Recommendation 37 similar to the above (36) suggests a protocol to mitigate risk when there are organisational changes to ensure transfers of responsibility and accountability.

Recommendation 42 registering of suspected service failures with the CQC.

Recommendation 43 in response to the rationale for the investigation

Recommendation 44 in relation to the lack of established frameworks.

REPORT TITLE:	**ANNUAL QUALITY STATEMENT 2018 / 2019**							
MEETING:	Quality Safety and Experience Committee					**MEETING DATE:**	**18.12.18**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**	
LEAD EXECUTIVE:	Executive Nurse Director							
REPORT AUTHOR (TITLE):	**Head of Patient Safety and Quality Assurance**							

PURPOSE OF REPORT:

SITUATION
This paper sets out the proposed plan and timeframe for the development and publication of the 2018 /19 Annual Quality Statement.

REPORT:

BACKGROUND

NHS bodies are required to publish Annual Report and Accounts. An important element of this will be the publication of the Annual Quality Statement (AQS). Welsh Government has developed draft guidance on production of the 2018/19 Annual Quality Statement and it is anticipated that this will be issued in the near future.

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

The AQS should:

- Provide an assessment of performance across all services
- Promote good practice to spread and share more widely
- Confirm any areas that require improvement
- Report on progress year on year
- Account on the quality of the services

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

The AQS for 2018 / 2019 is required to be published by no later than 31ST May 2019

ASSESSMENT

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

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

It is anticipated that this will be the final year of reporting the Annual Quality Statement in this format, and that from 2019/2020 there will be a move towards real time reporting through the UHB internet page. Welsh Government are in the process of developing guidance around the reporting requirements in the new format.

The following timeline is proposed for the 2018/19 AQS:

Date	Task	Lead
January 2018	Engagement with Community Health Council (CHC) to influence early thinking of contents/design the 2017-2018 AQS	Patient Safety and Quality Assurance Manager
24th January 2019	Present to Stakeholder reference Group	Patient Safety and Quality Assurance Manager
February 2019	Development of Chapters	Corporate Leads
February 2019	Introductory Chapter	Chief Executive and Chair
March 2019	Review and introductory chapter by Chief Officer Community Health Council	CEO Community Health Council
March 2019	Collation of chapters	Patient Safety and Quality Assurance Manager
11th March- 15th March	Consistency check between Annual Report and AQS	Patient Safety and Quality Assurance Manager
March 2019	Internal Audit	
18th March - 5th April	Design and formatting	Media Resources
16th April 2019	Draft to QSE	Patient Safety and Quality Assurance Manager
30th May 2019	Presentation to Board	Executive Nurse Director
31st May 2019	Publication of AQS	
25th July 2019	AGM	Executive Nurse Director

RECOMMENDATION:

The Committee are asked to Approve the plan and the timescale for the development of the 2018/19 Annual Quality Statement.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term		Integration		Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

REPORT TITLE:	**High vigilance arrangements required for the use of synthetic vaginal mesh and tape**								
MEETING:	Quality, Safety and Patient Experience Committee					**MEETING DATE:**	18.12.2018		
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**	**x**	
LEAD EXECUTIVE:	Medical Director								
REPORT AUTHOR (TITLE):	Medical Director/AMD Professional Affairs								

PURPOSE OF REPORT:

SITUATION:

On 1.8.2018 the Chief Medical Officer wrote to all Medical Directors (appendix one). New guidance prepared by the Clinical Advisory Group was issued in England on 20 July 2018 to NHS (England) on this subject (vaginal mesh). The same guidance is to be adopted in Wales with immediate effect. This report summarises the progress made within Cardiff and Vale UHB.

REPORT:

BACKGROUND:

The recommended governance and assurance process in Wales is to build on the 2014 NHS Wales Patient Safety Notice PSN002/18 July 2014 : 'The Surgical Management of Urinary Incontinence and Pelvic Organ Prolapse'. This required management to follow NICE guidance (CG171, IPG 267and IPG 283) , to ensure good quality consent processes, clinical competence, and audit and adverse event reporting.

The advice also aligns with the report of the Welsh task and finish group which emphasised the key patient safety principles of using non-surgical approaches as a first step, avoiding potentially risky procedures, careful multi disciplinary team assessments, fully informed consent, registration of all operative procedures, and the audit and monitoring of complications and outcomes.

The new guidance requires Medical Directors to be assured about the clinical competence, process and outcomes for any surgeons undertaking this work, for whom they are Medical Directors or Responsible Officers. Assurance to undertake this work will require an initial 'critical interview' with each surgeon, in parallel with their appraisal, and a review of the clinical pathway, including patient selection, consent, operative logs, operative registers, participation in audit and clinical outcome reviews.
The guidance requires participation in multi disciplinary teams with at least 2 consultant surgeons appropriate to the condition, and each surgeon's participation in these, and the trail of clinical decision making, will have to be evidenced.

It is envisaged that these 'critical interviews' will need to be repeated at least every 6 months, and more often if there are concerns. This high vigilance process is necessary at present until some key questions are clarified about potential patient harm following such procedures.
There are two main professional surgical organisations in this area, BAUS and BSUG.

ASSESSMENT:

The Medical Director replied in a letter to the Chief Medical Officer 31.8.2018. He reported to the CMO the following actions:

1. There was circulation of the CMO letter and requirements to all relevant Directorates and Clinical Boards. All of those Directorates and Clinical Boards were requested to bring the letter to their Quality and Safety meetings to ensure that the requirements are fully recognised in each individual specialty.

2. For assurance about the clinical confidence, process and outcomes of any surgeons undertaking the procedure an Assistant Medical Director (Mr David Scott Coombes)has taken on the lead role and will be ensuring that processes are in place including the 'critical interview' with evidence that the surgeon:
i. has been appropriately trained
ii. has actively maintained their skills
iii. has a record of their practice of the procedure, follow-up, and documented complications including mesh/tape removals
iv. is recording every procedure on the specialty database or any subsequently developed national recording system.
Four surgeons have been identified and satisfactory critical interviews completed.

3. Assurance will be further confirmed by a paper which will go to the Cardiff and Vale UHB Quality, Safety and Patient Experience Committee in the Autumn confirming the arrangements and processes in place.

RECOMMENDATION:

The Committee is asked to **NOTE** the actions put in place by the Medical Director to comply with the Chief Medical Officers guidance.

1.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable – N/A If "yes" please provide copy of the assessment. This will be linked to the report when published.

Kind and caring / Caredig a gofalgar
Respectful / Dangos parch
Trust and integrity / Ymddiriedaeth ac uniondeb
Personal responsibility / Cyfrifoldeb personol

Dr Frank Atherton
Prif Swyddog Meddygol/Cyfarwyddwr Meddygol, GIG Cymru
Chief Medical Officer/Medical Director NHS Wales

Llywodraeth Cymru
Welsh Government

To: Medical Directors
Via email

1st August 2018

Dear colleagues

High vigilance arrangements required for the use of synthetic vaginal mesh and tape

In early July I wrote to you outlining the recommendations of the task and finish group set up by the Cabinet Secretary for Health and Social Services to review the use of synthetic mesh in the management of prolapse and stress urinary incontinence (SUI). I subsequently wrote to you on 10 July drawing your attention to the " pause" recommended by Baroness Cumberlege in the use of vaginally inserted mesh to treat stress urinary incontinence, until six conditions identified by her could be adequately met. Following Baroness Cumberlege's announcement, NHS England established a Clinical Advisory Group to propose guidance for the safe management of those undergoing mesh procedures due to clinical need. The Welsh Government had an observer on this group.

New guidance prepared by the Clinical Advisory Group was issued in England on 20 July 2018 to NHS (England). I am now writing to you to confirm that the same guidance will be adopted in Wales with immediate effect. A copy of the Clinical Advisory Group's advice is attached.

The recommended governance and assurance process in Wales builds on the 2014 NHS Wales Patient Safety Notice PSN002/18 July 2014 : 'The Surgical Management of Urinary Incontinence and Pelvic Organ Prolapse'. This required management to follow NICE guidance (CG171, IPG 267and IPG 283) , to ensure good quality consent processes, clinical competence, and audit and adverse event reporting.

The advice also aligns with the report of the Welsh task and finish group which emphasised the key patient safety principles of using non-surgical approaches as a first step, avoiding potentially risky procedures, careful multi disciplinary team assessments, fully informed consent, registration of all operative procedures, and the audit and monitoring of complications and outcomes.

The new guidance , requires Medical Directors to be assured about the clinical competence, process and outcomes for any surgeons undertaking this work, for whom they are Medical Directors or Responsible Officers. Assurance to undertake this work will require an initial 'critical interview' with each surgeon, in parallel with their appraisal, and a review of the clinical pathway, including patient selection, consent, operative logs, operative registers, participation in audit and clinical outcome reviews.

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Parc Cathays, Caerdydd CF10 3NQ Cathays Park, Cardiff CF10 3NQ
Ebost/Email:PSChiefMedicalOfficer@wales.gsi.gov.uk

The guidance requires participation in multi disciplinary teams with at least 2 consultant surgeons appropriate to the condition, and each surgeon's participation in these, and the trail of clinical decision making, will have to be evidenced.

It is envisaged that these 'critical interviews' will need to be repeated at least every 6 months, and more often if there are concerns. This high vigilance process is necessary at present until some key questions are clarified about potential patient harm following such procedures.

You may be aware that there are two main professional surgical organisations in this area, BAUS and BSUG (see below). There are also specialist groups for continence nurses, physiotherapists, pelvic pain specialists and service user groups, focused at The Pelvic Floor Society (TPFS) http://thepelvicfloorsociety.co.uk/pages.php?t=Patient-Information&s=Patient-Information&id=92

Data collection, audit and benchmarking

The British Association of Urological Surgeons (BAUS) Data and Audit project publishes a range or data and audit sets and combined site outcome indicators https://www.baus.org.uk/professionals/baus_business/data_audit.aspx
An audit done in March 2018 on 3 years of data (2015-2017) is available on the BAUS website. This includes data from surgeons at Cardiff and Wrexham. Cumulative analysis of 2015, 2016 & 2017 Stress Urinary Incontinence (SUI) data
The British Society of Urogynaecology (BSUG) has accreditation standards for units, https://bsug.org.uk/pages/information/accreditation-of-units/102 for which the assessment document can be downloaded **here** and the re-accreditation pro-forma can be downloaded **here.**

Dealing with complications and adverse incidents

Serious incident or no surprise reporting should follow current WG guidance in the event of any harm, significant near miss or organisational failure.

Patients and service users should be given information about using Putting Things Right and the option of yellow card reporting in the event of any complications or problems at any point of the patient pathway.

Medical Directors will need to be assured that logbook and register data are being linked to outcomes and any relevant adverse incident reports for these procedures.
Scoping work is currently underway by the Department of Health on establishing a registry for mesh implants and setting up a national database. There is no date as yet as to when these will be introduced.

Next steps

The Women's Health Implementation Group established by the Cabinet Secretary for Health and Social Services to take forward the recommendations of Welsh review into the use of synthetic mesh and tape meets for the first time on 16 August. They will take the high vigilance requirements into account in planning implementation of the wider recommendations.

I should be grateful if you would ensure that this letter is distributed to appropriate clinicians and other relevant individuals within your health board area.

Please confirm that you have put the necessary arrangements and governance in place to confirm compliance with these high vigilance requirements **by Friday 31 August 2018.**

Yours sincerely

DR FRANK ATHERTON

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

Ysbyty Athrofaol Cymru
University Hospital of Wales
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e.mail : Medical.Director@wales.nhs.uk

31 August 2018

Dr Frank Atherton
Chief Medical Officer
Welsh Government
Cathays Park
Cardiff CF10 3NQ

Dear Frank,

High vigilance arrangements required for the use of synthetic vaginal mesh and tape

As per your letter dated 1 August 2018, please find enclosed the response on behalf of Cardiff and Vale UHB regarding the arrangements and governance that have so far been put in place to ensure compliance with these requirements.

I am writing to confirm the following actions taken within Cardiff and Vale UHB:

1. There has been circulation of your letter and requirements to all relevant Directorates and Clinical Boards. Within the next month all of those Directorates and Clinical Boards will be bringing this paper to their Quality and *Safety meetings to ensure that the requirements are fully recognised in each* individual specialty.

2. For assurance about the clinical confidence, process and outcomes of any surgeons undertaking this work my Assistant Medical Director (Mr David Scott Coombes) has taken on the lead role and will be ensuring that processes are in place including the 'critical interview' for each surgeon in parallel with appraisal and a review of the clinical pathway including patient selection, consent, optive logs, optive registers and participation in audit and clinical outcome reviews. We believe there may be four surgeons involved and he has already conducted three out of four interviews with appropriate documentation.

3. Assurance will be further confirmed by a short paper which will go to the Cardiff and Vale UHB Quality, Safety and Patient Experience Committee in the Autumn confirming the arrangements and processes in place.

As discussed at the All Wales Medical Directors, I am sure you will understand that the timescale was short but I recognise the importance of this piece of work. I do believe we have made good and very satisfactory progress in ensuring the use of synthetic vaginal mesh and tape is robust.

Do not hesitate to contact me if you need any further information or confirmation of arrangements within the UHB.

Yours sincerely,

Electronically checked - GJS 4th September 2018 – No hard copy to follow

Dr Graham Shortland BM, DCH, FRCPCH.
Medical Director

Mr David Scott-Coombes, Assistant Medical Director, Professional Affairs
Dr Heather Payne, Welsh Government

REPORT TITLE:	**INFECTION PREVENTION AND CONTROL, CURRENT POSITION AGAINST TIER 1 INFECTION REDUCTION GOALS FOR HEALTHCARE ASSOCIATED INFECTIONS**								
MEETING:	Quality, Safety and Experience						**MEETING DATE:**	**18.12.18**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	**Senior Nurse Infection Prevention and Control**								
PURPOSE OF REPORT:									

SITUATION:

Cardiff and Vale UHB has continued to make good progress against the 2012-13 baseline numbers of HCAI with an overall reduction of 62.5% in *C'diff* cases, 8.3% reduction in MSSA and a 55% reduction in MRSA bacteraemia in the 2017-18 target period.

Six months into the 2018-19 reduction goal period we continue to see a reduction in target infections compared to April – September 2017, though the Health Board is not currently on tragectory to meet the reduction expectation goals.

C'diff

- The reduction goal for 2018-19 is at least the reduction expectations set for 2017/18 i.e. no more than 26 cases per 100,000

SAUR

- University Health Boards have been given more time to reduce to the rates set for 2017-18. The overall rate for 2018/19 should be no more than 20 cases per 100,000 population

E Coli

- University Health Boards will be given more time to reduce to the *E.coli* bacteraemia rates set for 2017/18. The overall rate for 2018/19 should be no more than 60 cases per 100,000 population.

Klebsiella* sp. and *Pseudomonas aeruginosa

Klebsiella sp. and *Pseudomonas aeruginosa* bacteraemia have been added to the reporting dashboards, and a reduction of 10% in numbers of cases in 2018-19 compared to 2017/ 2018 cases is expected.

REPORT:

BACKGROUND:

Healthcare Associated Infections (HCAI) remain a key patient safety issue and result in a significant burden of disease and financial cost to the NHS in Wales. The burden of HCAI is broader than the indicator organisms of MRSA and *C. difficile*. A Point Prevalence Survey, conducted in June 2017 as part of a European 5 yearly study, showed that within our acute hospitals 6.9% of patients had a HCAI and that urinary tract infections (UTI) caused the greatest burden of HCAI, closely followed by respiratory tract infections.

For 2018-19 Health Boards are required to continue to drive down all preventable HCAIs and specifically within the Tier 1 targets:

ASSESSMENT:

The position for Cardiff and Vale UHB April - September 2018 is as follows:

Implementation of ANTT and PVC insertion packs across the Health Board

- PVC packs are now in use in most areas across the UHB and Blood culture collection packs are currently being rolled out. ANTT training and assessment is being monitored by LED and the ANTT steering group with good progress being made in Nursing staff groups and in Primary Care and Community Clinical Board with District and Practice nurses. The main challenges remaining are to train senior medical staff in ANTT as undergraduates are trained, but post-graduate training for junior doctors in training and Consultants is more challenging. Compared to other Welsh Health Boards, CAVUHB has the second highest number of staff who have completed the online training (4850) and over 1700 of these have been competence assessed.

Learning

- Effective learning from RCA process with resultant interventions to reduce the burden of *Staph. aureus* bacteraemia and *C. difficile* cases.
- Clinical Boards have established review systems, current figures suggest that the learning is translating into reductions however further work is required to achieve the reduction expectation goals. Examples of good practice in General Practice where RCAs for *C. difficile* cases are now embedded.
- Compliance with pre admission and admission screening for MRSA is much improved and some areas are moving to undertake SAUR screens including: Renal/transplant, haematology, elective orthopaedic surgery.
- UTI guidance for District nurse and care home staff has been designed and are almost ready to pilot

e

Antimicrobial stewardship

- CAVUHB participated in World Antibiotic Awareness Week, 12th – 17th November, focusing on Primary Care.
- Implementation of the Antimicrobial Delivery Plan continues to be led by Medical Director

- Dr Shortland continues to use his patient safety reviews monthly to focus on antimicrobial stewardship issues in particular related to areas where there has been outbreaks or periods of increased incidence of infection.
- Implemented the UTI pathway mid July 2018

Policy and Practice

- Carbapenemase Producing Enterobacteriacea (CPE) / Multi-Drug Resistant Policy and accompanying screening protocol have been embedded across the Health Board.
- Decontamination Repeat Audit was undertaken, staff engaged fully with the auditors. The Health Board continues to address the audit findings, very good progress has been made to improve facilities and procedures within the endoscopy units.
- CAVUHB participated in the recent All Wales HSDU audit and are awaiting the final report.
- Water Safety Plan is in place and predominantly negative results of water tested provides assurance that changes implemented following a case of Legionella are reducing the risk of Legionella.

C SECTION Surgical Site Infection

- From 01/01/2018 – 30/06/2018 the rate for CABUHB is 1.58% compared to the All Wales rate of 3.76%

Table 1: CAVUHB 6 MONTH POSITION 2018-19 AGAINST 2018 – 19 HCAI GOALS

Year	C. difficile	SAUR	(MSSA)	(MRSA)	E.coli	K. pneumonia	P. aeruginosa
To Sept 2017	76	89	79	10	182	54	22
To Sept 2018	62	79	73	6	188	47	14
Position compared to same time period previous year	18↓	11↓	20↓	40↓	4.5↑	13↓	36.5↓
Position at the end of the first 6 months of the target period	**+7**	**+31**	N/a	N/a	**+42**	**-2**	**-1**

RECOMMENDATION:

The Committee is asked to accept the report

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	√	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Kind and caring / Caredig a gofalgar | Respectful / Dangos parch | Trust and integrity / Ymddiriedaeth ac uniondeb | Personal responsibility / Cyfrifoldeb personol

REPORT TITLE:	**Health and Care Standards - Standard 2.6 Medicines Management – Interim Report**								
MEETING:	Quality, Safety and Patient Experience Committee					**MEETING DATE:**	18.12.2018		
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
LEAD EXECUTIVE:	Medical Director								
REPORT AUTHOR (TITLE):	Medical Director/Chief Pharmacist								

PURPOSE OF REPORT:

SITUATION:

The overall conclusion is that the Health Board in May 2018 for this standard was "**Getting there"** (see appendix one). The rationale for this response was that, whilst there are some areas of robust and innovative practice in relation to safe and effective medicines management and very good governance processes, this is not yet consistently evidenced either within Clinical Boards or across the Health Board. This report notes progress and actions achieved over the last six months.

REPORT:

BACKGROUND:

The assessment for May 2018 stated the aim of achieving **"Meeting the Standard"** with a number of actions to be completed. Progress with each of the actions is being monitored through the corporate Medicines Management Group.

ASSESSMENT:

An update on progress is as follows:

- **Strengthen medicines-related audits in non-ward areas.**

Work is progressing with audit of medicines storage and administration in non-ward areas e.g. radiology, theatres, endoscopy

- **Medicines storage, security and destruction compliant with UHB Medicines Code (and updated MARRS policy when available)**

UHB Medicines Code relaunched and updated following consultation and feedback. Processes in ward areas compliant as evidenced by self audit. UHB staff closely engaged in updating MARRS policy, awaiting further Welsh Government Advice.

- **Specific support to patients/carers in presence of sensory loss**

More work needs to be completed in this area.

- **Agree UHB non-medical prescriber strategy**

A non medical prescriber forum has been re-established (reporting to the corporate Medicines management group) and a work programme is being agreed. A UHB policy and strategy will be progressed by the group as part of the work-plan.

- **Work to understand and reduce medicines-related admissions**

A formal research project to investigate medicines-related admissions has been developed between the Department of Clinical Pharmacology and the Pharmacy Medicines Information and Safety team. Resource to progress the project is being sought currently. Strategies to address medicines-related admissions are being considered across NHS Wales and the UHB medicines safety officer and consultant pharmacist are both involved with that work.

RECOMMENDATION:

The Committee is asked to **NOTE** the actions and progress made.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable – N/A If “yes” please provide copy of the assessment. This will be linked to the report when published.

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	Standard 2.6 Medicines management (Corporate) Self-assessment completed May 2018 **Overall rating: Getting there**
B **Background**	The overall conclusion is that the Health Board is **Getting there** The rationale for this response is that, whilst there are some areas of robust and innovative practice in relation to safe and effective medicines management and very good governance processes, this is not yet consistently evidenced either within Clinical Boards or across the Health Board. Notable improvements over the past year include the widespread implementation of MTeD (electronic discharge) on all wards, except Mental Health and some specialised day units (where a "discharge on demand" functionality has recently been launched. The links to the community pharmacy Choose Pharmacy platform facilitates discharge communication to primary care and safe transfer of patient care. Also supports post discharge medicines review with patients. All initial target outpatient clinics implemented electronic prescribing (COPPS). Dissemination and actions related to Patient Safety Notices and internal communication of medication safety issues is led by the Medicines Safety Executive (reporting to corporate Medicines Management Group). Effective sharing of lessons from medication-related incidents is supported through this process, including a widely circulated monthly medicines safety briefing. Systems to manage the UHB joint formulary and manage the entry of new medicines are well embedded. The New Treatment Fund has supported timely and robust patient access to new medicines. Medicines-related procedures have been updated to align with the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal published November 2015 (update progressing) and a single UHB Medicines Code was launched in November 2017. A Health Board wide audit of all inpatient areas relating to storage and security has been undertaken supported by Clinical Board nurses and the Nurse Advisor.

	Continued development of Antimicrobial stewardship across primary and secondary care remains a challenge due to lack of resource and clinical engagement. Positive outcomes have been realised in relation to HCAI – the concern is that these may not be sustainable. A case for resource support on a sustainable footing in 2018-19 IMTP failed to cross the UHB prioritisation threshold. A patient helpline to support provision of information and advice on medicines (after hospital discharge or outpatient consultation) is available and messages are fed on to Pharmacy Medicines Management Practice Group to inform improvement strategy.
A **Assessment**	Medication chart (prescribing and administration, including omitted and delayed doses) audits need to be fully implemented and reported with supporting remedial action plans across all sectors (including district nursing and domiciliary care). A plan to complete this audit for 2017/18 is in place. Recent NICE guidance on management of controlled drugs in hospitals (May 2016) has been used to support review of all related processes across primary and secondary care, via the Local Intelligence Network. Training and revalidation of staff (including HCSW) involved in medicines administration (including intravenous therapy) is a key development area and supports the continued implementation of the MARRS policy noted above. Supporting e-learning is now available. A review of the Non Medical Prescribers register held within pharmacy was completed to ensure all information and scope of practice was up to date for each individual non medical prescriber. A UHB forum for Non-Medical Prescribing has been re-established. National Prescribing Indicator performance has improved across all indicators and C&V performs best for number of practices meeting the NPI thresholds. Pain and antimicrobial prescribing shows greatest variation and is a specific focus for the Medicines Management Incentive Scheme 2018-19 (by both NPI improvement and also audit of prescribing and peer review). Key performance metrics for medicines management to be agreed and reported through Clinical Board and corporate Medicines management groups.

	Improved access to the GP-record of a patients medication has been implemented, and facilitates safe admission processes including medicines reconciliation. MTeD supports safe transfer of care at discharge. Yellow care (adverse event) reporting has increased across primary care and by pharmacists in secondary care.
R **Recommendation**	With the aim of achieving “Meeting the Standard”, progress with each of the actions noted above will be monitored through the corporate Medicines Management Group. Specific areas for focus in 2018-19 are: - Strengthen medicines-related audits in non-ward areas - Medicines storage, security and destruction compliant with UHB Medicines Code (and updated MARRS policy when available) - Specific support to patients/carers in presence of sensory loss - Agree UHB non-medical prescriber strategy - Work to understand and reduce medicines-related admissions This assessment will be signed off by the Executive Medical Director and Independent member (Susan Elsmore) and through the corporate Medicines Management Group. May 2018

REPORT TITLE:	**Point Of Care Testing (POCT) ALERT**							
MEETING:	Quality, Safety and Patient Experience Committee					**MEETING DATE:**	18.12.2018	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**	
LEAD EXECUTIVE:	Medical Director							
REPORT AUTHOR (TITLE):	**Annette Thomas- Consultant Clinical Lead for C&V**							

PURPOSE OF REPORT:

SITUATION:

Cardiff and Vale University Health Board has now completed Phase 1 (Secondary Care) roll out of the All Wales Point Of Care Testing Connectivity Solution (WPOCT). This is a National solution which allows all Point of Care Testing (POCT) devices to be connected to the POCT Data Management system and the results viewed in the Laboratory Information system (WLIMS) and the Welsh Clinical Portal (WCP). The POCT Data management middleware is also interfaced to the ADT feed (*Admission, Discharge, Transfer*), thus facilitating positive patient verification on the devices where supported.
Information on who carried out the testing, the time and location and the full patient demographics are now captured in the database. This feature has recently been extended to all POCT devices within the UHB. This is a major initiative to improve the quality and safety of POCT within the UHB.

Audit of the WPOCT database has revealed several issues (mismatches) which is preventing the flow of data into both WLIMS and WCP-see Appendix 1. These include: incorrect use or manual entry of patient demographics, not acknowledging the POCT result when prompted, and the incorrect use or manual entry of user ID. The data mismatches are predominantly due to users of POCT not following correct test procedures when undertaking patient testing. This is compromising patient safety.

Appendix 1- Error mismatched 180917 Final_AT.xlsx

REPORT:

BACKGROUND:

Evidence from a historical clinical incident highlighted poor practice by users when undertaking point of care testing. The incident was a major driver for the implementation of WPOCT. This system has enabled greater detection of errors for all POCT equipment used across all Clinical Boards.

ASSESSMENT:

The predominant error detected by the POCT Dept. was the incorrect entry of patient and user demographics at source.

RECOMMENDATION:

1. No new POCT devices to be rolled out until there has been a marked improvement in compliance. This will be set at 95% compliance (up to 5% mismatch error) and monitored over a three month period for all existing POCT devices in service across each Clinical Board.

2. The POCT Business Case Proforma for acquisition of new devices must be signed-off by both the designated POCT Lead and Quality and Safety Lead in each Clinical Board and must also be agreed by local Clinical Board Quality and Safety Committees, prior to submission to POCT Group for approval.

3. Ongoing Ward-based audits are being undertaken on a monthly basis to monitor compliance. These commenced in Sept-18. Review progress after three months by the Medical Director.

4. Communication plan being agreed, this includes cascade to all Clinical Board Directors at the already at theNovember HSMB meeting.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable – N/A If "yes" please provide copy of the assessment. This will be linked to the report when published.

REPORT TITLE:	**Cancer Peer Review Breast 2018**								
MEETING:	Quality, Safety and Experience						**MEETING DATE:**	December 2018	
STATUS:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Dr Graham Shortland, Medical Director								
REPORT AUTHOR (TITLE):	Annette Beasley, UHB Macmillan Lead Cancer Nurse								

PURPOSE OF REPORT:

SITUATION:
The purpose of this report is to present the committee with an analysis of the findings and actions required following the Cancer Peer Review process. Following peer review of each cancer tumour site, a report is forwarded to the UHB and an action plan agreed by the multidisciplinary team and relevant Clinical Board. The action plan is reported back to the Wales Cancer Network and Welsh Government.

This report outlines the findings of the re-review of the Breast cancer services in Cardiff and Vale University Health Board, the initial review having taken place in 2015.

REPORT:

Please provide your report in no more than 2 sides of A4 using the space provided and the headings below. Essential supporting documentation can be provided as an appendix.

BACKGROUND:
Peer review is a collaborative, quality improvement process which allows for the evaluation of scientific, academic or professional work by others working in the same field and constitutes a form of self-regulation by qualified members of a profession. It is designed to allow peers to share information, learn where their strengths and weaknesses lie and agree plans for improvements to patient care.

Peer review methods are employed to maintain standards of quality, improve performance and provide credibility.

In 2011 Welsh Government recommended that the peer review process for cancer services be led by Health Inspectorate Wales (HIW), working in partnership with the Cancer Networks. Peer review was then launched in Wales in 2012.

In 2017, through Welsh Health Circular WHC/2017037 the NHS Wales Peer Review Framework was published and tasked the NHS Wales Health Collaborative to oversee an all-Wales programme for peer review.

A three yearly re-review process has been developed by the cancer network. Following the peer review meeting, a report is sent to the UHB. An action plan is then developed and implemented to address the concerns raised at each peer review and re-review.

ASSESSMENT: Summary of Peer Re-review Report for Breast

Improvements since last peer preview

1. The Health Board/MDT reported progress to the concerns raised from their peer review of 2015, including:
    a. Improved resources and nursing support for oncology patients;
    b. Ratification of the MDT follow up protocol;
    c. The addition of a breast surgeon and oncologist to the MDT since the last review;
    d. The use of Canisc MDM module during the MDT in a fully functioning MDT room
2. The MDT reported the completion of seventeen (17) clinical audits or service improvements since the last review.

Good Practice/Significant Achievements:

- A proactive MDT striving to improve all aspects of the patient pathway with involvement in studies around shared decision making led by the Breast Cancer Nurses.
- Additional Consultant Surgeon and Consultant Oncologist since last review, which leads to improved cross cover working.
- Metastatic breast forum at Velindre Cancer Centre.
- Development of the eHNA programme.
- Consultant nurse has a role with both diagnostic and follow up clinics, including service for BRCA patients and counselling. Ward nurses also support clinics and examples of up-skilling of Healthcare Assistants (HCAs).
- The Breast centre team worked closely with the Physiotherapy service and the Macmillan AHP Cancer Lead to redesign the limited inpatient physiotherapy service to develop a Physiotherapy led exercise service utilising charity monies. The Health Board are working towards the permanent funding of the Macmillan AHP Cancer Lead role.

There were no immediate risks or serious concerns highlighted.

Concerns noted were:

- **Pathway Performance** - USC performance is at 90% and it takes an average of 29 days to be seen. With a large number of people being referred and patients being managed by the MDT it is a challenge to see, diagnose and treat within the timescales defined by policy.
- **Pathology service** - There is a shortage of pathologists and biomedical scientists within the pathology department. With much of the service reliant on “good will”, the service is fragile. The pressures on pathology and within the processing lab are reportedly affecting FISH turnaround times from the University Hospital of Wales. This can lead to sub-optimal care for patients who would be eligible for neoadjuvant therapy pertuzumab. Assurance should be provided for turnaround times to improve the care of patients within the region.
- **Data quality** - The MDT Charter checklist noted that the MDT did not provide a performance status for recording and that pre-operative staging was not always recorded.
- **Radiology service** - The Health Board and MDT are aware of the challenges to recruit.consultant radiologists. There is a concern regarding the lack of succession planning and the ability to provide adequate radiological support with the current establishment of radiologists in the Health Board.

- **Outpatient service / survivorship** - The review panel noted a reduction in the availability and clarity of supportive therapeutic services available to breast cancer patients.

See attached Action Plan

ASSURANCE AND RECOMMENDATION

Assurance is provided by:

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

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report
- **AGREE** that appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.
- **NOTE** that the NHS Wales Peer Review Framework WHC 17 037 has been received and will be considered by the QSE in November 2018.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	√
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	√
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable If “yes” please provide copy of the assessment. This will be linked to the report when published.

Cardiff and Vale University Health Board

Breast Peer Review (2nd) Action Plan 2018

Concerns

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
1	**Pathway Performance** USC performance is at 90% and it takes an average of 29 days to be seen. With a large number of people being referred and patients being managed by the MDT it is a challenge to see, diagnose and treat within the timescales defined by policy.	Managing short term staffing shortage of radiologists (2 vacant positions) to maintain service delivery. Cancer Lead to meet with Macmillan GP lead to discuss high referral rates and improve links with Primary Care. Operational plan being to review staffing levels and how the team works to try and deal with increasing referrals from C&V UHB area.	High	Clinical Lead for breast Surgery Clinical Board/Directorate Clinical Lead for breast & Macmillan GP Lead Clinical Lead for breast and Surgery Clinical Board.	Immediate High End of Quarter 1 2019	Exploring short term solutions, including outsourcing of mammogram reading, short term locum in November 2018 and using local HB. See Section 4 for longer term plans. Meeting October 2018 Regular meetings with Surgery Clinical Board ongoing.
2	**Pathology Service** There is a shortage of pathologists and biomedical scientists within the pathology department. With much of the service reliant on “good will”, the service is fragile.	Appoint to new posts.	High	Pathology Directorate management team	Nov 2018	The Pathology Directorate has recently advertised for 3 new Consultant Posts. Anticipated interviews November 2018. This situation will need to be

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
	The pressures on pathology and within the processing lab are reportedly affecting FISH turnaround times from the University Hospital of Wales. This can lead to sub-optimal care for patients who would be eligible for neoadjuvant therapy pertuzumab. Assurance should be provided for turnaround times to improve the care of patients within the region.		High	Lead Pathologist & Biomedical Scientist	Immediate	monitored due to a UK shortage of Consultant Histopathologists. Since Peer Review several changes have taken place to improve the time taken to report biopsies, especially for ER/PR and HER2. These changes have already made a significant difference to the cancer pathway.
3	**Data quality** The MDT Charter checklist noted that the MDT did not provide a performance status for recording and that pre-operative staging was not always recorded.	The MDT should ensure the accurate recording of all data items through validation.	High	MDT Lead and co-ordinator from Cancer Services	Oct 2018	From October 2018 the MDT will record performance status at the time of diagnosis and the pre-operative staging for cancer patients.
4	**Radiology service** The Health Board and MDT are aware of the challenges to recruit consultant radiologists. There is a concern regarding the lack of succession planning and the ability to provide adequate radiological support with the current establishment of radiologists in the Health Board.	To provide adequate radiological support	High	Managers within Surgery and Radiology Directorates.	August 2019	- A review of radiology service provision for the Breast Centre is being undertaken. - There has been a series of meetings which have improved working relationships between directorates within the Surgery Board and the CD&T Board - A meeting has been held with Breast Test Wales

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
		Recruit Consultant Radiologists				- We are working to develop a team of consultant radiologists, advanced practitioners in radiography and surgeons who have radiological expertise. - Verbal agreement between the 2 Boards and Breast Test Wales to jointly fund 2 new consultant radiologist posts across 2 sites. -Job descriptions are being prepared for 2 new Consultant Posts to be ready for trainees who obtain CCST in August 2019. - We are planning to collaborate further with Breast Test Wales to train radiographers who will be able to support both services- screening and symptomatic.
5	**Outpatient service / survivorship** The review panel noted a reduction in the availability and clarity of supportive therapeutic services available to breast	Macmillan AHP Cancer Lead to work with the Cardiff and Vale Therapies Directorate and the Therapies team in Velindre to explore the current service provision and establish how this can be improved to meet the	High	Macmillan AHP Cancer Lead	April 2019	A review of the therapies services and pathway for breast cancer patients is to be undertaken.

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
	cancer patients.	needs of breast cancer patients.				

REPORT TITLE:	**Cancer Peer Review Acute Oncology Service 2018**							
MEETING:	Quality Safety and Experience					**MEETING DATE:**	**December 2018**	
STATUS:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**	
LEAD EXECUTIVE:	Dr Graham Shortland, Medical Director							
REPORT AUTHOR (TITLE):	Annette Beasley, UHB Macmillan Lead Cancer Nurse							

PURPOSE OF REPORT:

SITUATION:
The purpose of this report is to present the committee with an analysis of the findings and actions required following the Cancer Peer Review process. Following peer review of each cancer tumour site, a report is forwarded to the UHB and an action plan agreed by the multidisciplinary team and relevant Clinical Board. The action plan is reported back to the Wales Cancer Network and Welsh Government.

This report outlines the findings of the first Peer Review of the Acute Oncology Service in Cardiff and Vale University Health Board.

REPORT:

Please provide your report in no more than 2 sides of A4 using the space provided and the headings below. Essential supporting documentation can be provided as an appendix.

BACKGROUND:
Peer review is a collaborative, quality improvement process which allows for the evaluation of scientific, academic or professional work by others working in the same field and constitutes a form of self-regulation by qualified members of a profession. It is designed to allow peers to share information, learn where their strengths and weaknesses lie and agree plans for improvements to patient care.

Peer review methods are employed to maintain standards of quality, improve performance and provide credibility.

In 2011 Welsh Government recommended that the peer review process for cancer services be led by Health Inspectorate Wales (HIW), working in partnership with the Cancer Networks. Peer review was then launched in Wales in 2012.

In 2017, through Welsh Health Circular WHC/2017037 the NHS Wales Peer Review Framework was published and tasked the NHS Wales Health Collaborative to oversee an all-Wales programme for peer review.

A three yearly re-review process has been developed by the cancer network. Following the peer review meeting, a report is sent to the UHB. An action plan is then developed and implemented to address the concerns raised at each peer review and re-review.

ASSESSMENT: Summary of Peer Re-review Report for Acute Oncology Service.

Good Practice/Significant Achievements:

- Good access to spinal opinion in rapid fashion.
- Good use of CNS sub-specialisation for neutropenic sepsis, MSCC and MUO/CUP, with future vision for new roles.
- Use of intranet site and App.
- The Health Board had good understanding of their data.
- The Health Board make good use of a live flagging system.
- Good relationship with Accident and Emergency department and to wider Health Board services.
- Excellent response from Acute Oncology Services (AOS) seeing 99.7% of patients within 24 hours.

There were no immediate risks or serious concerns highlighted.

Concerns noted were:

- **Neutropenic Sepsis** - further improvement required around the administering of antibiotics within 1 hour. The UHB did not have a policy for the management of neutropenic sepsis.
- **Metastatic Spinal Cord Compression (MSCC)** - Only 43% of patients received a whole spine MRI within 24 hours. 15 patients were subsequently referred for surgical opinion, which is 93% having received a surgical opinion within 6 hours. Patients suspected to have MSCC are required to have a whole spine MRI within 24 hours and a surgical opinion within 6 hours.
- **Staffing** - funded clinical leadership will be required to both sustain and mature the service.
- **Malignancy of Unknown Origin (MUO) / Cancer of Unknown Primary (CUP) MDT** - The Health Board did not have formalised access to an MDT for the management of MUO/CUP patients. The Health Board works with Velindre Cancer Centre to make use of the lunchtime meeting for acute oncology patients. However, systematic or protocol driven policies could aid the clarity for the management of acute oncology patients with regard to whether advice is provided or patient is admitted.
- **Flagging System** - whilst there is a flagging system in use for identifying patients in admission units with a cancer diagnosis, the system is overburdening the Acute Oncology Service and further refinement would be required to improve automated efficiency.
- **Defining the oncology provision** - the service would benefit from oncology input. Systematic or protocol driven policies could aid the clarity for the management acute oncology patients whether advice is provided formally or patients are admitted to Cardiff & Vale or Velindre Cancer Centre. The business case to develop an acute oncology unit should engage with neighbouring stakeholders, including the oncology provider of Velindre NHS Trust.
- **Governance** - out of hours communication is still heavily reliant on fax machines, an unsecure method of communicating information

See attached Action Plan

ASSURANCE AND RECOMMENDATION:

Assurance is provided by:

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

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report
- **AGREE** that appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.
- **NOTE** that the NHS Wales Peer Review Framework WHC 17 037 has been received and will be considered by the QSE in December 2018.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	√
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	√	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Cardiff and Vale University Health Board

Acute Oncology Service Cancer Peer Review Action Plan November 2018

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
1	**Neutropenic Sepsis** The timely response by the AOS team is excellent, however administration of antibiotics within an hour from the patient presenting at an admission unit is 25% with an average (mean) 1 hour 32 minutes. Further improvements around the administering of antibiotics within 1 hour is required. The Health Board does not have a policy for the management of neutropenic sepsis.	Ongoing education and audit annually Implementation of PGD Implement Neutropenic Sepsis Policy	High	AOS Clinical Nurse Specialists	Within 12 months	PGD currently being piloted in UHL MEAU. Discussions with ED in UHW to introduce PGD Policy written and awaiting ratification
2	**Metastatic Spinal Cord Compression (MSCC)** Only 43% of patients received a whole spine MRI within 24 hours. Patients suspected to have MSCC are required to have a whole spine MRI within 24 hours. 15 patients were subsequently referred for surgical opinion, which is 93% having received a surgical opinion within 6 hours. Patients with MSCC diagnosed are then required to have a surgical opinion within 6 hours.	Implementation of MSCC guidelines Ongoing education of staff. Potential development of MSCC Coordinator role. To be discussed with the Wales Cancer Network.	High	AOS Clinical Nurse Specialist / AOS Lead Clinician & Cancer Services AOS Clinical Lead	Ongoing Within 3 years Within 2 months	Discussions at All Wales AOS Network group

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
3	**Staffing** The review panel recognised a strong team, but funded clinical leadership will be required to both sustain and mature the service. The panel noted that permanent funding of the service was not evident and this is seen as a concern.	Medicine Clinical Board to fund staff for current service	High	Clinical Board	Within 6 months	Currently funded at risk by Medicine Clinical Board
4	**Malignancy of Unknown Origin(MUO) / Cancer of Unknown Primary (CUP) MDT** The Health Board did not have formalised access to an MDT for the management of MUO/CUP patients. The Health Board works with Velindre Cancer Centre to make use of the lunchtime meeting for acute oncology patients. However, systematic or protocol driven policies could aid the clarity for the management of acute oncology patients with regard to whether advice is provided or patient is admitted.	Link with Velindre Cancer centre to develop CUP MDT included within new AO consultant job plan.	Moderate	AOS team	Within 1 year	Awaiting Velindre Acute Oncology consultant post to be filled

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
5	**Flagging System** Whilst there is a flagging system in use for identifying patients in admission units with a cancer diagnosis, the system is overburdening the Acute Oncology Service and further refinement would be required to improve automated efficiency.	Review of flagging system to reduce sensitivity	Moderate	AOS co-ordinator	Within 6 months	With IT developers
6	**Defining the oncology provision** The service would benefit from oncology input. Systematic or protocol driven policies could aid the clarity for the management acute oncology patients whether advice is provided formally or patients are admitted to Cardiff & Vale UHB or Velindre Cancer Centre.	Linking with Velindre Cancer Centre to provide specific Oncology support	High	Cancer Services & Velindre Cancer Centre Clinical Director	Within 3 years	Awaiting Velindre AO consultant post to be filled
7	**Governance** Out of hours communication is still heavily reliant on fax machines, an unsecure method of communicating information.	IT systems to supersede use of fax machines	Low	Cancer Services & NWIS	Within NWIS timeline	Development in progress with NWIS

REPORT TITLE:	**CLINICAL AUDIT PLAN UPDATE 2018 / 2019**								
MEETING:	Quality Safety and Experience Committee						**MEETING DATE:**	**18.12.18**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Medical Director								
REPORT AUTHOR (TITLE):	**Head of Patient Safety and Quality Assurance**								

PURPOSE OF REPORT:

SITUATION:

The purpose of this paper is to present an update of the UHB 2018 / 2019 Clinical Audit Plan.

REPORT:

BACKGROUND:

A targeted programme of clinical audit measuring the standards of care delivery against evidence based guidelines is a valuable tool in providing assurance and also in informing quality improvement projects.

The NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) is developed annually by Welsh Government and confirms the list of National Audits and Outcome Reviews which all health boards and trusts are expected to participate in. In addition there are a significant number of national clinical audits administered by national professional bodies eg Royal College of Physicians, that are not included within the NCAORP but that provide valuable assurance around the quality of care provision.

The National Clinical Audits are an integral part of the quality improvement process and are embedded within the Welsh Health and Care Standards. The requirement to participate and learn from the audits is a central component of the Delivery Plans developed for NHS Wales.

A formal assurance process is in place for all audits included within the NCAORP. The results of audits should be used as part of the Clinical Board assurance arrangements, however full assurance can only be obtained if the requisite improvements are implemented and performance is re audited post improvements.

Local clinical audit functions best as part of a planned programme of quality improvement activity. The development of a clinical audit plan should be informed by local quality and safety priorities and should meet the priorities of each Clinical Board. Clinical Boards should have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. When deciding on clinical audit activity consideration should be given to recent:

- Serious Incident / Never Events
- Patient Safety themes
- Patient outcomes
- Release of new or revised best practice guidance.

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ASSESSMENT :

In May 2018 the 2018/2019 clinical audit plan was presented to the committee. The plan comprised Tier 1 and Tier 2 audits planned by directorates.

- **Tier 1** National clinical audit.
- **Tier 2** Local clinical audit undertaken to address the patient safety and quality agenda,
- **Tier 3** Local clinical undertaken for any other reason including revalidation and CPD purposes.

The audits incorporated within the clinical audit plan were identified as being a priority to inform the Directorates and Clinical Boards through the systematic review of their services against explicit criteria. It is therefore implicit that all clinical audit outcomes will be presented at the Directorate Quality Safety and Experience Committees or similar forums where the results can be considered and where the appropriate support can be provided to implement improvements. Where necessary clinical audit results should be escalated to mitigate any risk associated with the findings.

Appendix 1 details the progress made against the 2018/19 clinical audit plan. A detailed report will be provided to the committee in June 2019 indicating the outcomes and improvements implemented.

RECOMMENDATION:
The Committee are asked to note the progress being made against the 2018/19 Clinical Audit Plan

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration		Collaboration	x	Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Appendix 1 - Cardiff and Vale University Health Board - Local Clinical Audit Plan 2018-2019

Clinical Board	Directorate	Tier	Audit Title	Audit Lead	Progress
Corporate	All Inpatient areas	1	National Audit of Inpatient Falls	Karl Davis	Data Collection Starting January 2019
Corporate	All Inpatient Areas excluding Mental healt	1	National Dementia Audit	Swapna fernandez	Data Collection Complete
Corporate	All Inpatient Areas	2	Audit of Falls Risk Assessments	Oliver Williams	Data collection 02/2019
Corporate	UHB wide	2	Audit of risk assessment fro Women of child bearing age prescribed Valproate	Mathew McCarthy	Data Collection 02/2019
Corporate	All Inpatient Areas	2	DNACPR audit	Resus team	Data Collection Complete
Corporate	All Inpatient areas	2	Audit of Mental Capacity Assessment	Julia Barrell	Feb-18
Children and Women	Acute Child health	1	National Neonatal Audit project (NNAP via Badgernet)	Alok Sharma	Ongoing
Children and Women	Acute Child health	1	MBRRACE-UK perinatal mortality reporting (and contribution to Each baby Counts via maternity)	Alok Sharma	Reported

Children and Women	Acute Child health	1	Vermont-Oxford Network- benchmarking	Alok Sharma	Ongoing
Children and Women	Acute Child health	2	All Wales neonatal network: Neonatal Sepsis calculator	Amar Asokkumar	Awaiting Update
Children and Women	Acute Child health	2	All Wales neonatal network: management of RDS	Mallinath Chakraborty	Awaiting Update
Children and Women	Acute Child health	1	Paediatric Intensive Care Audit	Allan Wardaugh	Reported
Children and Women	Acute Child health	1	National Neonatal Audit Programme	Roshan Adappa	Reported
Children and Women	Obstetrics and Acute Child health	1	National Maternity and perinatal Audit	Suzanne Hardacre / Nigel Davies	Reported
Children and Women	Acute Child Health	1	National Paediatric Diabetes Audit	Justin Warner	Reported
CD&T	Laboratory medicine	1	Calculated Globulin	Dr Soha Zouwail	Complete
CD&T	Laboratory medicine	2	Inpatient Troponin Testing	Dr Soha Zouwail	Complete
CD&T	Laboratory medicine	2	Effects of GP transport on patassium - CAV and BCUHB	Dr Soha Zouwail	Ongoing

CD&T	Laboratory medicine	1	Myeloma - All Wales Audit	Dr Soha Zouwail	Ongoing
CD&T	Laboratory medicine	1	HbA1c in presence og Hb variants and other interfering factors	Dr Soha Zouwail	Nov-18
CD&T	Laboratory medicine	1	Fluids	Dr Soha Zouwail	Ongoing
CD&T	Laboratory medicine	1	Troponin	Dr Soha Zouwail	Ongoing
Dental	Dental Hospital	2	An audit of compliance by UDH OMFS department to new MRONJ protocol guidelines (SDCEP) prior to extractions.	Andrew Cronin	Ongoing
Dental	Dental Hospital	2	Re-audit WHO checklist in oral and maxillofacial surgery	kim Lewis	Ongoing
Dental	Dental Hospital	2	An audit on new patient periodontal assessments in UDH	Polyvius Charalambous	Reported
Dental	Dental Hospital	2	The use of cone beam CT in impacted maxillory teeth	Baljeet Nandra	Abandoned
Medicine	Gastroenterology	1	IBD standards	Dr Clare Tibbatts + Dr Dharmaraj Durai	Rolling audit
Medicine	Gastroenterology	1	JAG audits (includes GI bleed, Gastric ulcer FU and Missed GI cancers, ERCP audit, Endoscopy withdrawal times, Decontamination audit, oesophageal stents & dilatation perforation rates)	Dr John Green (Endoscopy lead C&V)	Rolling audits

Medicine	Internal Medicine	2	An assessment of allergy and adverse reaction history and documentation in patients on UHL MAEU	Dr Laurence Gray	Ongoing
Medicine / Surgery	EU / T&O	1	TARN	Melissa Rossiter / Suzanne Thomas	Ongoing
Medicine	Internal Medicine	2	Sepsis audit: adult medicine	Dr Laura Potts	Ongoing
Medicine	Internal Medicine	2	Care pathway and observation chart for adults undergoing treatment with acute NIV	Mr Andrew Bishop	Ongoing
Medicine	Internal Medicine	2	Audit of Drug errors on an in-patient medical ward	Dr Laurence Gray	Ongoing
Medicine	Internal Medicine	1	National Diabetes Audit	Aled Roberts/ Julia Platts	Ongoing
Medicine	Gerentology	1	Sentinal Stroke National Audit	Shakeel Ahmed	Ongoing
Medicine	Gastroenterology	1	Inflammatory Bowel Disease registry		Ongoing
Medicine	Internal Medicne	1	National Asthma and COPD	Ramsey Sabit / Katie Pink	Ongoing
Medicine	Rheumatology	1	Rheumatology and Early Arthritis	Anurag Negi	Ongoing
Medicine	Inetrnal medicne	1	Hip Fracture database	Anthony Johansen	Reported

Mental Health	Adult Mental health	2	Audit of Psychosocial screening practices used with older adults with Chronic physical health Conditions	Ms F Evans	Ongoing
Mental Health	Adult Mental health	1	National Audit of Psychosis	Bala Oruganti	Reported
PCIC	Primary Care	1	National Core Diabetes Audit	Sarah Davies	Reported
PCIC	Department of Sexual health	2	British Association of Sexual Health & HIV UK National Audit into Partner Notification in newly diagnosed people living with HIV	Dr. Darren Cousins	Complete
PCIC	Department of Sexual health	2	Syphilis treatment and outcomes	Dr. Nicola Lomax	Repoted
PCIC	Department of Sexual health	2	Audit of sexual and reproductive healthcare issues in HIV positive women	Dr. Sinead Cook	Reported
PCIC	palliative Care	1	National Audit of Care at the End of Life	Melissa Jefferson	Data Collection Complete
Specialist	Critical Care	1	Case Mix Audit	Dr Martyn Reed	Ongoing
Specialist	Cardiology	1	Natonal Heart Failure Audit	Dr Z Yousef and Dr Sim	Reported
Specialist	Cardiology	1	Cardiac Rhythm Audit	Dr Peter O Callaghan	Ongoing

Specialist	Cardiology	1	National Audit of Cardiac Surgery	Indu Deglurkar	TBC
Specialist	Cardiology	1	National audit of percutaneous coronary Interventions	Dr Tim Kinnaird	Ongoing
Specialist	Cardiology	1	National Congenital heart Disease Audit	Dirk Wilson	Ongoing
Specialist	Cardiology	1	MINAP	Tim Kinnaird	Reported
Specialist	Cardiology	1	National Vascular Registry	Mr Richard	Ongoing
Specialist	Cardiology	1	Cardiac Rehabilitation Audit	Rachel Owen	Ongoing
Specialist		1	Epilepsy 12 Children and Young People National Audit		Ongoing
Specialist	Medical Genetics	2	CEQAS Clinical Genetics Quality Assurance Scheme- Cardiovascular Genetics	Angus Clarke and Francis Sansbury	Data Collection Complete
Specialist	Medical Genetics	2	CEQAS Clinical genetics Quality Assurance Scheme- Cancer Genetics	Angus Clarke and Alex Murray	Data Collection Complete
Specialist	Medical Genetics	2	CEQAS Clinical genetics \quality Assurance Scheme- Dysmorphology	Angus Clarke and Arveen Kamath	Data Collection Complete

Specialist	Medical Genetics	2	CEQAS Clinical genetics Quality Assurance Scheme-Mendelian Disorders	Angus Clarke and Andrew Fry	Data Collection Complete
Specialist	Medical Genetics	2	Use of 6 item or 24 item GCOC (genetic Counselling Outcome Scale) across the all Wales Medical Genetics Service)	Angus Clarke and Fadmin Team	Data Collection Complete
Surgery	Surgery	2	National Lung Cancer Audit	Dr Diane Parry	Ongoing
Surgery	Surgery	1	National oesophago Gastric Cancer Audit	Prof. Wynn Lewis	Reported
Surgery	T&O	1	Fracture Liason Service Database		Ongoing
Surgery	Surgery	1	National Audit of Breast Cancer in Older People	Ms Eleri Davies	Reported
Surgery	ENT	1	All Wales Audiology Audit		Ongoing
Surgery	Urology	1	National Prostate Cancer Audit	Mr Owen Hughes	Ongoing
Surgery	Urology	1	Stress urinary Incontinence I Women	Mr O Tatarov	Audit dependant on Joint clinic for the surgical management of female urinary incontinence
Surgery	Urology	1	Urethroplasty	Mr O tatarov	Update Pending

Surgery	Urology	1	Cystectomy	Mr j Fethaerstone	Update Pending
Surgery	Urology	1	Nephrectomy	Mr R Coultard	Update Pending
Surgery	Urology	2	Release Audit	H Serag	Update Pending
Surgery	Urology	2	Time to TURBT	H Serag	Update Pending
Surgery	Urology	2	Waiting times for Nephroureterectomy for upper tract urothelial tumours	H Abdelmoteleb	Update Pending
Surgery	Urology	2	Long term functional outcomes post robotic assissted Laparoscopic radical prostatectomy	H abdelmoteleb	Update Pending
Surgery	Urology	2	Scrotal Pain Pathway Audit	H Wells	Update Pending
Surgery	Urology	2	Consent for day of surgery admission patients	R Fraser	Update Pending
Surgery	Opthalmology	1	National Opthalmology Audit	Roger McPherson	Reported
Surgery	Anaesthetics	1	NELA	Dr Margaret Coakley	Reported

Surgery	Anaesthetics	1	National Anaesthetic Audit Project NAP 6	Dr Simon Logan	May-19
Surgery	Anaesthetics	2	OBS CYRU	Dr Sarah Bell	Ongoing
Sugery	T&O	1	National Joint registry	Alun John	Ongoing
Sugery	T&O	1	Surgical Site Infection	Mark Foster	Ongoing
Sugery	T&O	1	National Hip Fracture Database	Anthony Johansen	Reported
Sugery	T&O	1	National Knee Ostetomy	Chris Wilson	Ongoing
Sugery	T&O	2	Return To theatre	Angus Robertson	Ongoing

REPORT TITLE:	**PRIMARY CARE GENERAL MEDICAL SERVICES AND DENTAL GOVERNANCE HIW PRACTICE INSPECTION UPDATE REPORT – NOVEMBER 2018**							
MEETING:	**QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE**					**MEETING DATE:**		
STATUS:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**	
LEAD EXECUTIVE:	**EXECUTIVE NURSE DIRECTOR**							
REPORT AUTHOR (TITLE):	**PRIMARY, COMMUNITY AND INTERMEDIATE CARE QUALITY AND SAFETY MANAGER**							

PURPOSE OF REPORT:

SITUATION:

The routine Welsh Government practice and performer inspection programme was commissioned from Healthcare Inspectorate Wales (HIW) from August 2014. The UHB Primary Care Team seeks to provide assurance to the Executive Team that Inspection Reports have been received, reviewed and acted upon.

REPORT:

BACKGROUND:

All General Practices and General Dental Services/Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local Community Health Council. The HIW inspections produce an Action Plan which it then assesses and follows up. The UHB then ensures ongoing compliance with the outcomes of the inspection.

ASSESSMENT:

Any significant issues are reported to the Practice and UHB in the form of an Immediate Assurance letter. An initial report is sent to the Practice along with the HIW action plan. The Practice provides a response for each element of the Action Plan and, once HIW has approved the Practice feedback and actions, the report is released to the UHB and is sent for translation. The UHB Clinical Director for Clinical Governance for PCIC and Primary Care Dental Advisor review the Inspection Report and Action Plan and produce a RAG-rated summary including any additional actions for the UHB. HIW reviews each report; any responses from the Practice which HIW are not happy with are escalated internally to generate a more detailed response from the Practice. The outcome of the action plan is assessed by HIW and satisfaction with steps taken or proposed by the Practice are included in HIW's final report. The process is also overseen by the Assistant Director Patient Safety and Quality.

The Primary Care Team reviews each Practice report and any potential actions for follow-up required. These steps are in addition to any satisfaction HIW has with the outcome and so are managed with sensitivity. The review and summary of reports are attached (**GP Appendix 1, Dental Appendix 2**).

Since May 2018, there have been no General Medical Services reports published. There remains one amber rated Practice (Llanrumney) that the GMS team continues to work with following the merger of 2 Practices. There are no immediate concerns.

The following General Dental Services inspection reports have been completed: Windsor Road Dental

Care – Immediate Assurance letter received(compliance required within 7 days); Bay House Dental Practice – Immediate Assurance letter received (compliance required within 7 days); Castle Court Dental Practice; Smiles Studio Penarth; Integrated Dental Facility, Plas Iona (Butetown).

There are 3 yellow Practices and 12 Amber Practice that the Dental Team are following up. The two Practices with immediate assurance letters have been followed up by the Dental Practice Advisor and Contracts Manager. Assurance has been received for Bay House; Windsor Road Dental Care has received an unannounced visit from the Dental Practice Advisor and is taking steps to carry out the necessary corrective capital improvement work.

Over the past year the Health Board has not always been given prior notice of inspections occurring and have not always received embargoed reports in a timely way. The situation has been raised formally with HIW and we will continue to be monitored.

RECOMMENDATION:

The Quality, Safety and Patient Experience Committee is requested to **NOTE** the ongoing monitoring and performance management systems and outcomes for Primary Care Dentists and GMS contractors.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	✓	Long term		Integration		Collaboration		Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

HIW GENERAL PRACTICE INSPECTION PROGRAMME
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

HIW Inspection Reviews				
Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions/Update*
Butetown	5 December 2017	1. The Practice must have a Notice Board 2. The Practice must ensure that Complaints process and information is up to date. 3. The Practice should continue to update and share Policies on shared IT system 4 the Practice should keep a record of safety checks 5. The practice should ensure that all staff are Trained to appropriate Safeguarding Level 6. The practice should consider introducing more structured staff meetings 7. The practice should review Incident reporting Process 8. The practice should ensure that there is sufficient support to the Practice Manager to assist in Management of the practice	**G**	1. Completed. 2. The complaints leaflet has been updated and information is displayed on the notice board. 4. The Practice continues to improve in the recording and compliance of safety checks and is adhering to HB fridge Temperature Policy. 5. All GP's are level 3 trained. The practice scored themselves as level 2 on the Self-Assessment Toolkit. The Practice has engaged with the Health Board Sustainability Team for support. The Practice was granted a temporary List Closure of 1 month in February 2018.
The Penylan Surgery	24 October 2017	4.1. The practice to ensure that patients are aware of their right to request a chaperone during intimate examinations regardless of the gender of the GP/nurse conducting the consultation. 3.2. The practice to review process in place to follow-up those patients who fail to attend their appointments. 6.3. The practice need to ensure Complaints process is clear and information is available to patients. 2.1. The practice is complete staff DSE assessments.	**G**	4.1. Primary Care Team to review chaperone training register and Practice literature during Practice Annual Appraisal visit. 3.2. New Policy in place 6.3. Primary Care Team to request copy of Complaints Policy and review at Practice Annual Appraisal visit. 2.1. Workstation risk assessments completed.

HIW GENERAL PRACTICE INSPECTION PROGRAMME
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

		2.4. The practice to implement IPC checks in respect of baby changing facilities. 2.7. The practice is to ensure nursing staff complete level 3 safeguarding training.		2.4. Primary Care team to review records at Practice Annual Appraisal visit. 2.7. Primary Care team to review at Practice Annual Appraisal visits due September 2018 .
Woodlands Medical Centre	5th September 2017	4.2 The practice is required to inform HIW of the action taken/to be taken to provide patients with a website link to the My Health Online service and to ensure that the Carer's link contained within the practice website is fully functional. 2.1 The practice is required to provide HIW with details of the action taken in response to the identified absence of an Equality and Diversity Policy and Business Contingency Plan 2.7 The practice is required to inform HIW of the action taken to ensure that staff receive refresher training in relation to CPR.	**G**	4.2. The Primary Care team verified recommendation has been implemented. 2.1. The Primary Care team to review policies during Practice Annual Appraisal visit. 2.7. The Primary Care team to review during Practice Annual Appraisal visit due November 2018 .
Llanrumney Medical Centre	2nd Nov 2017	1.The Practice is required to review and update referral process 2. The practice is required to ensure Staff are appropriately trained in Equality Act Training 3. Regular Fire Drills are required	**A**	Since the Inspection (December 2017) the Practice has merged with Llanedeyrn Medical Centre and is now known as Llan Healthcare. The Practice received a Practice Appraisal visit from the Primary Care Team in June 2018. The Practice confirmed that all GMS contractual and statutory requirements had been met

HIW GENERAL PRACTICE INSPECTION PROGRAMME
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

		4. The practice are required to ensure all Nurses complete Level 3 Safeguarding Training 5 All Safeguarding Policies are to be up to date 6 Incident reporting process to be followed		3. The Practice holds regular fire drills and keeps records of regular alarm testing 4. The Practice has confirmed that Nursing Staff have completed or have dates to complete relevant Safeguarding Training. 6. Llan Healthcare engage in the Health Board Interface Reporting system.
The City Surgery	24th January 2017	1. Strengthen review of patient test results 2. a)Inform HIW of actions taken for flexible registration appointments, b)also treating patients with respect 3. Protocol in place for patients without appointment but in need for medical advice 4. Ensure action taken to obtain patient views and act on them accordingly 5. Ensure Sharps containers are relocated and secure in patient areas 6. Action to provide minimum emergency/resuscitation equipment 7. Content of medical records is comprehensive enough and carry out audit to improve 8. Ensure med notes are summarised, to assist in clear clinical decision making 9. Access to current policies and procedures to meet requirements	**G**	1. Patient results are now checked daily by Senior GP and actioned. The practice Manager audited the new system in May 2017 and has concluded that the new system is effective. 2. a) A more flexible registration process now exists with registration appointments available daily. b) Practice manager confirmed Dignity and Respect Policy is in place and was reviewed at team meeting. 3. A new protocol is in place for registered and non-registered patients who attend the practice outside of normal consulting hours with a need for medical advice. An Emergency/Temporary Appointment Request Form has also been developed.

HIW GENERAL PRACTICE INSPECTION PROGRAMME
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

				4. The Practice Manager has developed a patient Questionnaire. To be reviewed at Practice Development meeting 2017/18 5. Wall brackets for sharps containers are in place in all clinical areas 6. The practice have purchased relevant equipment 7. Information regarding GMC and NMC standards is available to the practice and has been signposted to relevant record keeping courses. GP's to discuss record keeping in their annual appraisal and provide Form 4 to Quality &Safety Director. 8. The practice GP's have refined their summary and care planning process. The practice will share outcome of audit Feb 2018 Practice have scored Level 2 on Clinical Governance Self-assessment tool kit. 9. Practice confirmed full range of policies available at Annual practice development meeting 24th January, 2018.

HIW GENERAL PRACTICE INSPECTION PROGRAMME
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Four Elms Surgery	18th January 2017	1. The practice is required to describe the action taken/ to be taken in order to address the absence of staff (DSE) Health and safety risk assessments. 2. Ensure Sharps containers are relocated and secure in patient areas	G	1. A training DSE training session occurred in March 2017. Training is diarised in staff calendars. Workstation risk assessments have been completed 2. All sharp containers are securely wall mounted.
Cloughmore Medical Centre	31st January 2017	1. Non clinical staff made aware of what's expected when they are required to act as a chaperone. 2. Obtain patient consent to clinical procedures 3. Manage concerns/complaints with accordance to Putting Things Right 4. Describe action taken to address the absence of staff health and safety risk assessments 5. New staff have access to appropriate induction	G	1. Chaperone Policy is in place and has been discussed in Team Meeting. The Practice has booked training for October 2017. The Practice has reported itself as Level 4 on the CGS. 2. The Practice has new consent forms which are being embedded into practice. 3. A new protocol and patient leaflet has been developed. The Practice scored itself as level 2 on Clinical Governance tool kit and this will be verified during Practice development visit. 4. The practice have undertaken risk assessment on all workstations and staff received E learning training in April 2017. 5. New chairs have been order. 6. The practice has developed a new Induction checklist and embedded into practice.

HIW GENERAL PRACTICE INSPECTION PROGRAMME
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Meddygfa Albany Surgery	23rd February 2017	1. Non clinical staff made aware of what's expected if they are required to act as chaperone. 2. Manage concerns/complaints with accordance to Putting Things Right 3. Recording outcome of house call consultations 4. Receive annual appraisals in the near future and on an ongoing basis	G	1. Primary Care Team have checked and a Chaperone Policy is in place. Training is being rolled out to practice staff. 2. Putting things right leaflet and poster in practice. Clinical Governance Tool Kit . Primary Care team to review at Annual Practice Development Visit in October 2017 3. The practice remind all GP's that all clinical records must be written contemporaneously. 4. The practice is reviewing their HR policies and process and will provide detail in their Annual Practice Plan

HIW Immediate Assurance Letters (received since last SBAR update)			
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to October 2018) - TABLE OF INSPECTIONS

Item 13 Appendix 2

	Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
46	Windsor Road Dental Care	29/10/2018 Awaiting full report				An unannounced visit has been made by the Dental Practice Advisor and the Practice is taking steps to carry out the necessary corrective capital improvement work.
45	Bay House Dental Practice	06/08/2018 Full report received from HIW 26/10/2018	This is a well-run and well led practice. Patients describe a high degree of satisfaction and are well-supported by the practice. Clinical records are very thorough and well-kept. Immediate Improvement Plan issued- One set of protective eyewear was damaged and unsuitable for use, and there was not sufficient eyewear for a parent or chaperone. One set needs to be replaced and a spare set acquired. The machine was also not located within a suitably secure environment when not in use. The machine should be kept in a secure location at the practice where possible. There is no service, maintenance and calibration agreement in place. The machine needs to be serviced and calibrated in line with manufacturers' guidelines prior to use. • The practice make available for patients a selection of health promotion information, including leaflets about treatments and preventative advice leaflets		• Response requested by: 24/09/2018	Letter sent to practice 01/11/2018 requesting confirmation/Evidence of completed Improvement Plan The Practice have confirmed the actions taken in respect of the immediate assurance issue in a written response to PCIC in Sept 2018

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to October 2018) - TABLE OF INSPECTIONS

Item 13 Appendix 2

	Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
			• Staff ensure that all computers are locked to ensure no unauthorised access to patient information • The practice to provide a patient information leaflet setting out risks, benefits, describing treatment and side effects of receiving treatment from the surgical laser and records patient consent to treatment. • The practice to ensure its Patient Information Leaflet meets the requirements of Schedule 2 of the Private Dental Regulations 2017 • The practice to update its website to include details of all clinical staff, the relevant contact numbers for obtaining emergency dental treatment, and the practice's current complaints policy • The practice to ensure that all clinical staff have undertaken training in infection control • The practice to store the oxygen and related equipment together. • The practice to ensure that all staff know where the emergency kit, emergency drugs and oxygen are located. • The practice to store the drugs and their respective algorithms in clearly labelled wallets for ease of identification and access • The practice to ensure regular checks are undertaken of all medication and equipment to make sure they are in date. • DBS check and Hepatitis Certification needed for a staff member			

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to October 2018) - TABLE OF INSPECTIONS

Item 13 Appendix 2

	Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
44	Castle Court Dental Practice	31/07/2018	Overall evidence that Castle Court Dental Practice provided a friendly and professional service to their patients. Improvements Required • Patient information leaflet to be made readily available for patients. • To replace surgery chairs with non-fabric versions The practice to ensure that all areas of the clinical areas are dust free • Feminine hygiene bin to be placed in staff toilet • Replace hand towel in staff toilet with paper towels or hand dryer. • Clinical waste bins to be liner with correct clinical waste bags • To fit lock to x-ray room door where emergency kit and emergency drugs are stored to ensure their security • To ensure prescription pads are kept securely • The dentists to arrange regular peer review meetings • Both Statements of Purpose are to be amended to provide further information on the process for dealing with patient complaints.		• Letter sent to practice 01/11/2018 requesting confirmation/Evidence of completed Improvement Plan	• HIW satisfied with Improvement Plan submitted by practice (25/09/2018)
43	Smiles Studio Penarth	02/07/2018	Good leadership and communication. Friendly and professional service with good medical record keeping. Improvements Required		• Letter sent to practice 01/11/2018 requesting	

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to October 2018) - TABLE OF INSPECTIONS

Item 13 Appendix 2

	Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
			• The practice to amend the Practice Information Leaflet to ensure it complies with current guidance. • In accordance with the Private Dentistry Regulations 8 (1)(b) the practice to develop a policy setting out the arrangements for the assessment, diagnosis and treatment of patients • The practice to ensure the following faults are remedied: 1.Areas of the flooring in surgery 1 and in the hygienist's room to be sealed 2. The damaged flooring in the decontamination room to be replaced 3. The chipped work surface in the decontamination room to be addressed 4. The gap between the electrical housing and work surfaces in surgery 2 to be sealed or eliminated 5. The carpet in surgery 1 to be replaced with appropriate flooring 6. The fabric sofa in surgery to be replaced with one that is washable or as a minimum, the practice develop a disinfection protocol 7. The network cable box in the hygienist's room to be securely fixed 8. Sharps bins in the surgeries should be wall mounted • The practice to ensure that all areas of the clinical areas are dust free • The practice to ensure that the corridor in the basement that is one of its fire exit		confirmation/Evidence of completed Improvement Plan	

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to October 2018) - TABLE OF INSPECTIONS

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	Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
			routes, is clear of rubbish and potential hazards. The door should be secured • Practice to remove all portable fans from surgeries. • Practice to undertake an environmental risk assessment • The practice to ensure that all fire exits are signposted • The practice to ensure that the emergency equipment and emergency drugs are stored together and securely • The practice is to put in place a policy for monitoring the quality and suitability of facilities and equipment including maintenance of such equipment. • The practice put in place a programme of clinical audits. • The practice to develop a clinical audit policy. • Dentists to organise peer review group • The practice to make provision for staff to evidence that they had read and understood the policies. • The practice to put in place an emergency contingency procedure • The practice ensure that all temporary staff have the necessary pre-employment checks in place and have completed the required training			
42	Integrated Dental Facility,	11/06/2018	Friendly staff providing high quality care and happy patients. Very conscientious in talking to patients		• Letter sent to practice	• HIW satisfied with Improvement Plan

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	Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
	Plas Iona (Butetown)		about prevention. Instruments cleaned and sterilised in accordance with WHTM01-05. • Display list of private prices • Ensure wide range of robust audits to assess procedures and improve services • Formalise arrangements with health board and property management company to ensure maintenance and inspection certificates are shared.		01/11/2018 requesting confirmation/Evidence of completed Improvement Plan	submitted by practice (27/07/2018)

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
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	Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
41	Church Road Dental Practice	05/02/18 (published 08/05/18)	*Improvements Required* • Review /update website to include information about NHS dental provision • Amend its complaints policy to include relevant and up to date contact information. • Develop process for recording patient concerns • Suitably qualified person to undertake PAT testing • Ensure all clinical staff received appropriate infection control training • Undertake audits in line with WHTM 01-05 • All staff to receive CPR training • Ensure all staff have access /complete relevant safeguarding training. • Record keeping: o Basis Periodontal Examination (BPE) o Medical histories signed by patient and countersigned by the dentist • Appropriate health and safety risk assessments • Records to evidence policies read and understood by all staff *Positive Findings* • Staff interaction with patients was professional, kind and courteous • Dental equipment was well maintained and regularly serviced • Clinical facilities were well equipped and were visibly clean and tidy		• Response requested by: 30/06/18 • Reminder letter sent to practice 02/11/2018	• HIW satisfied with Action Plan submitted by practice (18/04/18)

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40	West Quay Dental Practice	11/12/17 (published 12/03/18)	Overall a positive report *Improvements Required* • Ensure staff have access to and completed the relevant safeguarding training. • Record provision of advice on smoking cessation and alcohol cessation in records • Ensure compliance with recommended guidelines regarding the intervals and justification for radiographs. • Amend medical emergency policy/ procedures so staff are aware of roles in a medical emergency. • Ensure staff have access to and complete relevant training: o POVA for 1 Staff • Obtain confirmation that all clinical staff have necessary Hepatitis B documentation *Positive Findings:* • The practice is committed to providing a positive experience for its patients • There was evidence of good management and leadership from the practice manager, area manager and clinical advisor • The practice had dedicated and appropriate facilities for the decontamination of dental instruments		• Response requested by: 30/06/18 • Reminder letter sent to practice 02/11/2018	• HIW satisfied with Action Plan submitted by practice (12/02/18) • Satisfactory response received from practice – 26th June 2018

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33	{my}dentist (Countisbury Avenue, Llanrumney)	17/07/17 (published: 18/10/17	A reasonable report overall *Improvements Required* • Review storage of hazardous and non-hazardous waste • WHTM 01-05 Issues (decontamination training) • DBS certification for all dentists Review storage and access of patient records • Administrative (centralised training records)		• HIW satisfied with outcome of Action Plan submitted by practice • Response requested by: 31/01/18	• Satisfactory response received from practice - 18th June 2018
32	Restore Dental Group (215 & 354 Whitchurch Road)	28/06/17 (published: 29/09/17)	An overall poor report, with a significant number of areas of improvement identified being described below: • System checking medical emergency equipment and drugs • Health promotion information to be available for patients • Private patient's price list displayed • Patient information provided in language/ format meeting needs of patients • Review NHS complaints procedure to : - Compliance with NHS 'PTR' - Complaints handling processes (Cont'd.) - Recording and audit trails • System for recording views of patients • Five yearly electrical testing certificate • Fire risk assessment review • Review access to stock room and decontamination room • Decontamination training required for relevant staff. • Review resuscitation policy for both premises • Review stock control processes: - Materials - Anaesthetics		• HIW satisfied with outcome of Action Plan submitted by practice • Originally categorised as Red. • Letter sent to practice (29/08/17) by UHB to seek written assurances on issues outlined in Action Plan with a request to follow up the process with a meeting within six months. • Response received 19/09/17 • Re-categorised as Amber	~~Practice visit to be arranged for February 2018.~~ Practice visit rescheduled for Spring. Following resignation of DPA practice visit will be undertaken when the new DPA is in post. Interviews November 2018.

			• Child protection/POVA training needed for relevant staff • Review location of X-ray isolation switches • Review appropriate IR(ME)R training for dental nurses • Formalise QA arrangements • Patient records: - Patient medical histories - FP17s for banded NHS COTs - Justification and reporting of radiographs - Treatment plans and options • Clinical Issues: - Clinically necessary treatment carried out under private arrangements - Frequency of BW radiographs • DBS required for five dentists • Staff appraisals on an annual basis. • Practice management and leadership in this practice need to be reviewed and strengthened			

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29	Calgary Dental Practice (Llantwit Major)	08/05/17 (published: 09/08/17)	A positive report overall *Improvements Required* • OOH number for private patients • Update complaint process to include ""Putting Things Right"". • Surgery floor needs to be appropriately sealed • Update Adult and Child Safeguarding policies • Explore relocation of isolation switch for X-ray unit & radiograph processing audit • QA Audit • Immunisation Records need to be retained • Updated DBS certificates for HIW registered dentists.		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan once Report has been formally published. • New practice owner. Letter to new owner to check that improvement plan is being followed through on. • Correspondence sent to the new practice 02/11/2018 – response requested by 16/11/2018	
27	Gwena Dental Care	02/03/17 (published 05/06/17)	Report found on HIW website – June 2017. **Not notified.** A positive report overall *Improvements Required* • Update complaint policy to reflect correct timescales. • Complaint policy on the website • Methods for regular checks of Emergency Drugs		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan	Awaiting Response

			• IR(Me)R Training for all relevant staff • Patient records quality		• Response requested for ongoing work. Response requested by: 31/01/18 • Reminder letter sent to practice 02/11/2018	
26	Wilton House Dental Practice	28/02/17 (published 31/05/17)	Report found on HIW website – July 2017. **Not notified.** A number of areas of improvement were identified, with the main issues being described below: • Separate NHS and Private complaints procedures needed • Private Price List • WHTM 01-05 Audits • WHTM 01-05 (dirty to clean workflow signs, instruments to be cleaned and sterilised properly, single use items not reused on same patients) • Checks on Emergency Drugs expiration dates • Radiographic Audit (Cont'd.) • Patient Record Improvements • Implement Resuscitation Policy • POVA Training • Child Protection Training		• HIW issued satisfactory assurance • Practice written to by UHB to seek assurances on issues outlined in Action Plan. • Practice under new management (01/12/17)	Meeting to be arranged with the new owners for July 2018 Following resignation of DPA practice visit will be undertaken when the new DPA is in post. Interviews November 2018.

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22	Wilson Road Dental Surgery	18/11/16 (published 20/02/17)	Notified to UHB – 15th May 2017 A positive report overall *Improvements Required* • Clinical/hazardous waste storage needs to be safely stored • Review of cleaners handling clinical waste • Review clinical facilities to ensure safety and condition. Specific attention: worktops and handles/flooring sealed in the surgeries/ repairing or replacing the light unit, suction pipe, upholstery/rusting or damage to the dental chair. • WHTM 01-05 Compliance (separation of clean/dirty areas, dental impressions and disinfection, autoclave data logger not being used correctly) • Confirmation letter to HSE (Cont'd.) • IR(ME)R training certificates obtained and kept on file • Patient records administration • Radiography: • Review of policies		• HIW issued satisfactory assurance • Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	Meeting scheduled with the practice 12/06/18 Following resignation of DPA practice visit will be undertaken when the new DPA is in post. Interviews November 2018.
21	Cardiff Smile Centre	15/11/16 (published 16/02/17)	Report found on HIW website - 08/17 **Not notified** A positive report overall *Improvements Required* • Review location of clinical waste bin. • Website to comply with GDC standards for advertising. • Patient records: - Comprehensive patient information to be recorded - Specific Attention: - Addresses - Cessation advice		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	No Updates • Satisfactory response received from practice – 23rd May 2018

			- Consent - OCS • Justification and reporting of radiographs needs to be recorded • Review of all policies and procedures needed to ensure the correct organisations and/or appropriate guidance is listed. • Policies and procedures need to be consistent with version and review dates mentioned within documents • Review of staff training needed.			
20	Ellen Davies Dental Practice	27/10/16 (published 30/01/17)	A positive report overall *Improvements Required* • Informing patients and visitors of the CCTV in operation • Ensure full compliance with WHTM 01-05 (Cont'd.) • Resuscitation equipment needs to be checked • First Aider: certificates obtained held/first aid box needs to be checked regularly • IR(ME)R for dental nurses • Patient records: - Medical histories countersigned - Medical histories are updated - Soft tissue examinations • Justification for x-rays • Review of all staff training needs required and courses • Policies and procedures need to be consistent with version and review dates		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	No Updates Practice under new ownership – Letter to be sent 9th November 2018
19	Nicola Taaffe @ West Grove	26/09/16 (published 29/12/16)	A weak report overall *Improvements Required* • Practice's complaints procedures need updating • Compliance with WHTM 01-05 in respect of:		• Originally categorised as Red	Practice Meeting to be arranged Following resignation of DPA practice visit will be undertaken

			- Autoclave tests - Procedures on Ultrasonic Bath - Maintaining records • Ensure floors are appropriately sealed between the cabinets and walls • Implement system regular checks on the emergency equipment • Review storage of emergency drugs and equipment in one location for easy access • Review safeguarding procedures: • Ensure staff complete training • Patient records issues: - Medical histories - Use of templates - Treatment planning - Consent - Radiographic reports (Cont'd) • Review of all policies, procedures and demonstrate implementation • Training certificates for all clinical staff • Confirmation of the Hepatitis B immunisation for all staff		• HIW satisfied with outcome of Action Plan submitted by practice • Practice written to by UHB to seek assurances on issues outlined in Action Plan. • Assurances received from practice. • Re-categorised as Yellow	when the new DPA is in post. Interviews November 2018.

HIW Immediate Assurance Letters (received since last update)

Members should note that Immediate Assurance letters for Primary Care are *issued* to the Practice for response and *copied* to the UHB for Information and to feed into the broad Performance Management of the practice.

	Practice Name	*Inspection Date*	*IA Letter Date*	*Summary*	*UHB Actions*
1	Bay House Dental Practice	06/08/2018	08/08/2018	Immediate Improvement Plan issued - One set of protective eyewear was damaged and unsuitable for use, and there	• Letter sent to practice 10/09/2018 • Response requested by: 24/09/2018 • Response to UHB Letter received 20/09/2018 **Actions taken in response to Report**: The soft tissue laser is now kept in a safe locked storage.

				was not sufficient eyewear for a parent or chaperone. One set needs to be replaced and a spare set acquired. The machine was also not located within a suitably secure environment when not in use. The machine should be kept in a secure location at the practice where possible. There is no service, maintenance and calibration agreement in place. The machine needs to be serviced and calibrated in line with manufacturers' guidelines prior to use.	The practice has purchased additional safety eye ware required. Service engineers have serviced and calibrated the laser.
HIW Concerns Raised (received since last update)					
	Practice Name	*Contact from HIW*	*Follow Up*	*Summary of Concerns*	*Summary of UHB Actions*
1	Windsor Road Dental Care	Inspection date 29/10/18 Non-compliance notice received		The service is non-compliant with Regulation 22(2)(a) & (b) regarding the Fitness of the premises This is because HIW could not be assured that the practice was providing a clean, safe and secure	• Planned unannounced visit 07/11/18 to inspect the surgery (MA/JW) • Request sent to NHS DS 01/11/18 for record card check on the performer where record card issues were identified.

		from HIW 31/10/18		environment, or that the premises were kept in a good state of repair externally and internally. □ The practice was not up to a suitable standard of cleanliness, and there was significant dust and debris found in both surgeries including dust on the x-ray equipment, dirt along the tops of the splashbacks, dirt within drawers and in cupboards, and significant dust and dirt in corners and below the worktops □ Paperwork had been stored on the floor within the surgery, and there was no evidence that this area had been cleaned. There was also evidence that items such as a radio and the PC unit were also kept on the floor, prohibiting effective cleaning □ There were no seals between the walls and the floor in either surgery, and in the rear surgery the flooring was damaged □ There was evidence that previous damp within the walls had left the walls in the rear surgery uneven, which was causing the wallpaper to peel in various places. This could pose an infection control risk □ The decontamination room was full of clutter, had open areas under the worktops with items such as the compressor below, and was not conducive to an environment for sterilising equipment. These will prohibit effective cleaning and as a result could pose an infection control risk to patients and staff.	

				The service is non compliant with Regulation 20(1)(a) regarding Records This is because we could not be assured on the day that the dentist was keeping comprehensive, succinct and contemporaneous records for the consultations and treatments of patients. During an examination of patient records it was found there were significant shortcomings in the patient records kept for one of the dentists at the practice. Some of the missing sections included, but are not exclusive to: o Previous dental history o Social history, oral and diet advice, and smoking cessation advice o Symptoms o Signed medical histories for both initial checks and updated at each appointment o Full base and updated charting o Baseline BPE o Examinations including extra oral, intra oral and cancer screening; o Treatment plans, options discussions o Informed consent o Referrals information o Radiographs justification, frequency and clinical findings; and o Antibiotic prescribing. For both Private and NHS treatments, patient records should include contemporaneous and	

				accurate notes of all assessment, treatment planning and treatment provided to patients. A lack of comprehensive, accurate and contemporaneous records can have serious patient safety implications for any ongoing or future care and treatment decisions. Care, treatment and decision making must be supported by structured, accurate and accessible clinical records, to ensure that people receive effective and safe care.	

KEY

Issues	Status
Minor issue e .g : Price list not displayed - Translation services not present - Patient Feedback	**GREEN**
Issue requiring remediation, but not likely to pose patient safety issue. E. g - QA arrangements - Policies updating and signing - Complaints Processes	**YELLOW**
Serious Issue requiring remediation due to **potential** patient safety concern. e.g: - Safeguarding procedures - IR(Me)R Issues - Record Keeping Issues - Staff Training Records - Access to staff areas - HTM 01-05 issue : Minor	**AMBER**
Serious Issue requiring immediate remediation due to present patient safety issue:, e. g : - Decontamination processes - Cross Infection control - Emergency Drugs/Equipment - HTM 01-05 : Major	**RED**

REPORT TITLE:	**SENSORY LOSS PROGRESS REPORT 2017-18**									
MEETING:	Quality, Safety And Experience Committee Committee						**MEETING DATE:**	**18 December 2018**		
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**		
LEAD EXECUTIVE:	Chief Operating Officer									
REPORT AUTHOR (TITLE):	Equality Manager									

PURPOSE OF REPORT:

Please set out why this report is being provided to the meeting.

SITUATION:

The purpose of this report is to update the Committee on the progress being made in meeting the accessible the communication and information needs of people with a sensory loss as laid down by the All Wales Standards for Accessible Communication and Information for People with Sensory Loss.
https://gov.wales/topics/health/publications/health/guidance/standards/?lang=en

REPORT:

Please provide your report in no more than 2 sides of A4 using the space provided and the headings below. Essential supporting documentation can be provided as an appendix.

BACKGROUND:
The All Wales Standards for Accessible Communication and Information for People with Sensory Loss, referred to in this paper as "the standards", is to ensure that the communication and information needs of people with a sensory loss are met when accessing healthcare services

In addition, there is a legal duty under the Equality Act 2010 to ensure that reasonable adjustments are made to deliver equality of access to healthcare services for disabled people. This duty is anticipatory and requires public bodies to be proactive in making adjustments to ensure all access and communication needs are met. The UN Convention on the Rights of Persons with Disabilities also provides an international standard for disabled people's human rights. Effective and appropriate communication is fundamental to ensuring services are delivered in ways that promote dignity and respect.

Evidence also demonstrates that ineffective communication is a patient safety issue and can result in poorer health outcomes. The Health of Deaf People – a Report by the Deaf Health

Charity Sign Health (2014) is the largest and most extensive study ever undertaken into the health of D/deaf people. This study found that overall D/deaf people have poorer health, poorer diagnosis and poorer treatment/management than hearing people. These three problems the study suggests are largely caused by poor access to services, poor communication, and poor access to information. The study goes on to suggest that issues with poor access and communication may in fact mean that the Health Service is at risk of harming D/deaf patients rather than helping them.

A report by Action on Hearing Loss Cymru on access to GPs for people with hearing loss highlighted some of the issues that remain. For example, 54% of 380 survey respondents said that they had left the GP surgery unclear about their diagnosis or how to take their medication. The report demonstrated difficulties around making appointments in particular:
29% of survey respondents had to ask someone to call the GP surgery for them and 36% had to visit the surgery to make appointments because they could not use the phone and online access or other forms of communication were not available.

The RNIB reports 'Sight Loss 2013' and 'Living with Sight Loss 2013' note that people with sight loss are 24 times more likely to report bad or very bad general health than those without any impairment. 55 percent of people who have sight loss reported as being dissatisfied with their health. Nearly a third of respondents with sight loss reported some or a lot of difficulty accessing the health service in the last 12 months, compared with 15 per cent of respondents with no impairment.

The Wales Audit Office report 'Speak my language: Overcoming language and communication barriers in public services 2018' identifies that many people experience communication barriers in accessing public services for reasons other than language. This includes people who are hard of hearing, people with sight loss, people with dual sensory loss (a combination of sight and hearing loss) and people with learning disabilities, learning difficulties or autism. While not specifically included in the scope of this report, initiatives such as simplify language will benefit this much broader group of service users.

ASSESSMENT:

There are a number of ongoing workstreams seeking to improve communication with patients with sensory loss. The key schemes are described below:

Accessible Health Service
https://centreofsignsightsound.org.uk/centre-of-sign-sight-sound/accessible-health-service

With the aim of improving quality of health through equality of access to health services, the Accessible Health Service will act as the link/interface between D/deaf/severe hearing loss patients and the Health Board and its staff. The Accessible Health Service Team at the Centre of Sign, Sight and Sound (COS) can act as the enabling link between staff and patients to:

- Translate written (English/Welsh) communication e.g. regarding appointments/requests to make contact from the Health Board to D/deaf British Sign Language (BSL)
- Make/change or cancel health appointments
- Ensure where required that appropriate communication support has been booked for an appointment

- Support the Health Board to develop and implement accessible health communication cards for sensory loss patients to use in health settings
- Provide Health Board staff with a central point of information, advice and guidance supporting their engagement and work with D/deaf/hearing loss patients
- Gather, collate and report to the Health Board feedback of patient and staff experience
- Support sensory loss patient and health staff engagement and participation in Health Board consultation and service development and improvement processes, through an informative evaluation of the project

The Accessible Health Service would be accessible to patient and Health Board staff as follows: Monday to Friday 9am to 5pm service provision, accessible to the D/deaf/severe hearing loss communities via email, text message, glide and the Skype platform DAISY (see below). Contact from and to Health Board staff would be via predominantly telephone call medium but where appropriate also email

- A dedicated service mobile number (for text and glide messaging), email address and DAISY channel
- Liaison with Wales Interpretation and Translation Service to ensure interpreter of preference has been booked
- Production of Digital Access Information Video (trilingual BSL/English/Welsh) to promote service to D/deaf/severe hearing loss communities
- Production of service promotional literature for Health Board staff
- Regular social media activity to promote the service throughout the period it is commissioned

The COS service started in October 2018 and is being led by the Patient Experience Team.

DAISY Online Interpreting
Aimed at providing quicker and more cost efficient access to communication support for D/deaf/hearing loss people to engage with public sector services, COS has developed an innovative remote access British Sign Language (BSL) / English communication support and interpreting service, the first of its kind in Wales.

Using Skype for Business, DAISY 'Face to Place' facilitates quick and cost efficient access to vital communication support via qualified/registered BSL/English interpreters for D/deaf people and lipspeakers and/or note takers for people with hearing loss.

DAISY can be accessed via iPad, tablet, smartphone, laptop or personal computer and importantly via the Health Board's own internal current IT system. DAISY will enable D/deaf/hearing loss patients to access services independently and facilitate Health Board's staff direct engagement, discussion and work with them.

The intention is to pilot this element within a primary care setting, and a GP practice with a high number of deaf users has been identified for this pilot phase. Additional funding for this project is being sought through the Bevan Exemplars programme.

Patient Communication Portal
The Patient Communication Portal is currently in use for ENT out-patient appointments and the intention is to roll this out across all acute services by the end of 2018.

Patients receive a text message with a link to the Patient Communication Portal. The Portal is a website which enables patients to view their appointment information online as well as being able to confirm, change or cancel their appointment. Patients are able to view their appointment letters with zoom functionality and the website uses 'Browsealoud' technology where the website text can be converted into sound.

If the patient does not access the Communication Portal to view their appointment, a letter is sent. These letters are outsourced and the providers offer letter preferences such as a Braille and large font size. However, there is currently no flagging mechanism within PMS which could be used to advise the provider of the patient's letter preference. It is essential that developments are progressed within all IT systems to record communication preferences and flagging as a priority.

Text reminders
These messages remind patients of their appointments via a text message and gives them the option to reply to confirm, cancel or book by text. Patients are able to increase the font on their mobile phone or the message can be converted to voice at their home.

Text (SMS) message appointment reminders have now been rolled out across all acute services.

Recording Communication Preference
PMS has the ability to record the patients' communication preference only in the front demographic screen and the only options available to select are English/Welsh/BSL.

All patients who have accessed BSL interpreter services have been identified and their communication preferences have now been updated to BSL within this demographic screen.

Recording the communication preference does not flag the record and on the booking screens this information is not visible. As stated above it is essential that developments are progressed within all IT systems to record communication preferences and flagging as a priority.

Dedicated email for patients who are deaf
Planning is currently ongoing for a generic appointments e-mail aimed in the first instance for patients with hearing loss but if successful this would be expanded for all patients.

We have had some extremely valuable support from the Deaf Community and now have a process which will navigate concerns over information governance and provide flexibility for patients to receive information about their appointment.

The intention is to respond in two working days by e-mail with details confirming the appointment date and time and the interpreter name (should one be requested).

We plan to have a dedicated webpage for Deaf patients which will explain the process (we intend to have instructions signed as well as written as plainly as possible). We also plan to include the webpage address on as many appointment letters as possible.

The e-mail address is: Deaf.CAV@wales.nhs.uk

Patient pagers

Patient pagers have been introduced in the out-patients department in UHW. These pagers vibrate, flash and make a sound when activated which signals to patients that they have been called for their appointment. Long term funding for patient pagers has now been confirmed from the Health Charity.

Language line in sight video interpretation trial

In October the UHB embarked on a short 2 week free trial to extend the use of the Language Line Insight video interpretation system outside of UHW. This system has already been tested in 5 areas at UHW and has proved popular with staff and patients. At the end of the first and second trial phases, all departments opted to keep their machines and to fully embrace the service in place of face to face interpreters.

The four new areas, based mainly on current usage of language services are:

- GUM Clinic at CRI (start delayed due to non-delivery of iPad)
- Physiotherapy at the Star Centre, Splott
- CAVOC at UHL
- Day Surgery UHL changed to Trauma Clinic, UHW

The UHB accepted an offer of a free 6 week trial of an on-demand video interpretation system provided by one of our telephone interpretation service providers (Language Line). One-touch access to trained professional video interpreters on a iPad facilitates full understanding through spoken and visual communication to reduce the risk of misunderstanding by capturing body language and facial expressions to read visual cues. The chosen areas were:

- Dental Hospital
- Gynaecology Outpatients / Colposcopy, UHW
- Outpatients, UHW

This trial was extended at the end of August to cover a further two areas:

- Antenatal Clinic / Midwifery Led Unit, UHW
- Physiotherapy, UHW

In the end the trial lasted from 24th July to 21st September 2018 – a little over 8 weeks for departments in phase 1 and just over 3 weeks for the two departments added into phase 2.

Video interpretation is now the routine form of interpretation used in the USA and Language Line hopes to develop the service in the UK. We currently use Language Line for telephone interpretation in emergency situations, short consultations and most GP consultations. Following our expression of interest, our Language Line representative attended the site several times to meet staff and demonstrate the system. As part of the trial we were given 2000 free minutes of use plus dedicated equipment sets x5 (i pad and trolley).

Advice was taken from the UHB Technical Development Manager who stated that skype commercial/business systems were as secure as possible. Advice was also taken from Information Governance regarding the transmission of Patient information Details.

Internet access was a serious concern for the trial. Areas wishing to take part in the trial were thoroughly tested beforehand. Gynae Outpatients and main Outpatients both had “black spots” where they understood the equipment could not be used. Dental could not sustain an internet signal on the CAV Wi-Fi and ran their trial through the Cardiff University Wi-Fi to overcome the

problems. Going forward there may be issues with the level of IT support available for apple products and the CAV Wi-Fi which is managed externally.

The interpretation app can be downloaded and used on any computer (with camera and microphone), tablet, i pad or mobile i phone and so could be used by staff in the community. Up to 10 devices with the same cost code can be linked to one "interpreter on wheels" – this has already been done in Maternity and will be done in Physiotherapy in Splott giving staff the option of using 2 machines simultaneously.
Language Line interpreters wear a uniform and have a standard background scene wherever they are in the world. They are highly qualified or their ability has been demonstrated (some languages have no qualifications) and are recruited following thorough selection assessments (only 8% of telephone interpreters pass this test) to ensure the highest quality of language proficiency. They are also fully vetted and insured through Language Line.

Each trial area was asked to carefully consider cancelling WITS face to face interpreter bookings during the trial period, bearing in mind the time period for free cancellations (24 hours for foreign language and fortnight for BSL), so as not to have our current WITS interpreters in the room at the same time as the trial. Staff were also asked to ensure the kit was securely stored when not in use and was charged overnight. WITS supported us throughout the trial. WITS was aware that we may ask for interpreters at short notice and that several bookings may need to be cancelled.

The machine is available when an interpreter has not been booked (often the patient's appointment is wasted as it has to be rearranged which could have safety implications) and can be used just to support people visiting the hospital who do not speak English – as demonstrated in outpatients where staff helped a man to find his son who had been involved in an accident.

The "interpreter on wheels" has already been taken into operating theatres to assist in a caesarean delivery. An unexpected benefit was noticed in waiting rooms where staff reported a quieter, calmer environment and without the additional people present there was sufficient seating.

The video system also has a notepad function. Staff can ask the interpreter to write an instruction in English and the chosen language to reiterate important messages to the patient.

All interpreters are fully insured through Language Line – something that has not been available previously.

Feedback / Evaluation / Testimonials
Full feedback was requested from every user during the trial period
75% of respondents gave the highest feedback possible for the functionality of the app and the overall audio quality and 70% gave the highest feedback for the overall video quality.

When asked if anything went wrong, a number of people specified: Signal dropped out several times (Wi-Fi), unable to connect to the internet, connection took a while, timed out, interpreter was unavailable at the time needed, difficult to use in noisy environment and at one appointment the patient would not communicate with the male interpreter. When asked what worked well, the vast majority of respondents said everything.

- This facility is a good addition to the department and benefits all of us – patients and staff. **Jane Roberts, HCSW, Outpatients UHW**

- Twenty first century interpretation available at the touch of a button. **Laura Groves, Clinic Sister, Gynaecology, UHW**
- Easy to use and instant. Loved by doctors, nurses and patients. **Gill Jones and Sarah Bendon, Midwives, Antenatal Clinic**

The complete feedback is available from the Equality Manger, if required.

Items to consider in future

- Need ability to choose the sex of the interpreter (request already sent to Language Line as a future development).
- in particular available on video (request already sent to Language Line).
- Greater in house IT support will be required for apple systems and CAV Wi-Fi when problems arise.
- Whether signals can be boosted in blackspot areas (IT already looking at Suite 3 in UHW Outpatients).
- Whether this should be rolled out to GP practices. The UHB currently pays for telephone interpretation used by GPs at 67p/minute. The video system would double those costs but significantly improve the quality of service.
- Billing in Outpatients (previously WITS appointment areas were specified at time of booking so each specialty bore their own costs). With Insight, costs are all allocated to a machine – say outpatients – but outpatients do not have a budget for interpretation. The Deputy Director of Finance is aware of this and the concerns raised by Outpatients.
- Who will lead the project forward?

There have been some other noteworthy improvements since the last progress report to the Committee.

- In November 2018, the fourth sensory loss awareness month campaign 'It Makes Sense', was promoted throughout the UHB. The campaign aims to support staff to communicate effectively with people with sensory loss.
- Guidance Regarding Assistance Dogs and Other Animals Attending Clinical Areas have been approved at the Nursing Midwifery Board after the issue was raised by the Sensory Loss Standards Working Group and Champions.
- Sensory loss issues have now been incorporated into the checklist for building and engineering services standards around signage, hearing loops, use of colour and contrast etc.
- An accessible patient story video, for use in training, has now been completed.
- There is a new well-received BSL resource for reception staff called **'BSL Tutorials for NHS Staff'** which is based on a pilot study of two of our GP practices and is available on the internet
- Sensory Loss awareness sessions were successfully provided to Cardiff and Vale GP'S as part of their CPET sessions.
- Work based on the recommendations of the CHC about working with Velindre and reviewing staff awareness has been completed. Work based on establishing a mechanism for all key staff to be aware of patients' who have sight / hearing loss similar to the hand over process currently undertaken by clinical staff is being explored
- In December basic British Sign Language training sessions will take place within the UHB as we look to train 500 front line staff over the next year. Demand has exceeded expectations. Next year we will pursue sight loss awareness training for staff.

- The Chair of the Health Board led a second successful public meeting for the Deaf and hard of hearing communities in September. One of the key actions is the development of a focus group made up of staff and patients.

Summary
There has been demonstrable and meaningful progress in developing the sensory loss agenda since the last up date, particularly in listening to and acting upon the views expressed at the public meeting by our service users. Challenges still remain, for example, around low take up of the sensory loss module in terms of training and barriers around communication.

Next Steps
The Equality Manager is working with other Equality Managers in Welsh Government and other health boards/trusts to explore the proposal to make Sensory Loss part of the mandatory content of equality refresher training.

A steering group has been set up in Audiology to address concerns around want and needs and to explore the difficulties and barriers some deaf and hard of hearing patients are still facing in terms of communication with health care professions. On behalf of the steering group this research proposal has been drawn up to further explore these issues and will initially focus on the experiences of Audiology patients in an outpatients setting.

The Committee will be kept up to date with the study and any outcomes in the next progress report.

RECOMMENDATION:
The Committee is asked to **NOTE**:

- The progress made towards meeting the communication needs of patients with sensory loss
- The need to prioritize the development within all IT systems of the ability to record and flag communication preferences

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

Kind and caring / Caredig a gofalgar · Respectful / Dangos parch · Trust and integrity / Ymddiriedaeth ac uniondeb · Personal responsibility / Cyfrifoldeb personol

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

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

MINUTES OF THE MEETING HELD ON 11TH JULY 2018

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Sarah Jones	Quality Lead, Pharmacy
Kathleen Morris	Clinical Audit Coordinator
Bolette Jones	Head of Media Resources
Carly Podger	Assistant Head of Finance
Maria Jones	Senior Nurse, Outpatients
Robert Bracchi	Consultant, AWTTC
Alun Morgan	Assistant Director of Therapies and Health Sciences
Suzie Cheesman	Patient Safety Facilitator
Holly Williams	Quality and Safety Facilitator for Specialist Services
Claire Constantinou	Dietetics

Apologies:

Matthew Temby	Clinical Board Director of Operations
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Ceri-Ann Hughes	Head of Workforce and OD
Lisa Griffiths	Quality Manager, Laboratory Medicine

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 18/201 Welcome and Introductions

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

CDTQSE 18/202 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 18/203 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 13th June 2018 were **APPROVED.**

CDTQSE 18/204 Matters Arising/Action log

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

CDTQSE 18/160 Attendance from Laboratory Medicine

Lisa Griffiths to ask the Laboratory Heads of Service if they feel her attendance appropriately covers the different departments within Laboratory Medicine.

Action: Lisa Griffiths

CDTQSE 18/160 Attendance from Therapies Directorate

Judyth Jenkins to ask the Therapies directorate to consider the appropriate level of representation required for the breadth of Therapies.

Action: Judyth Jenkins

CDTQSE 18/023 Safeguarding Case

Alun Morgan to present the safeguarding case as a patient story to a future meeting when confirmation is received that the case is closed. The case is currently open and a meeting is being scheduled with the police.

Action: Alun Morgan

CDTQSE 18/056 All Wales RCA Template

Advice has been received from the Patient Safety Team that Cardiff University are expected to follow the All Wales RCA template but there is little the UHB can do to enforce this. Mike Bourne requested that Suzie Cheesman send him the template and he will ask Chris Marshall in PET to ensure that it is completed for RCAs going forward.

Action: Suzie Cheesman/Mike Bourne

CDTQSE 18/101 IPC Meeting

It was agreed in the IP&C Group that a meeting would be held between Radiology and Urology departments on the bacteraemia incident to close this off. Rebecca Vaughan-Roberts has now determined who should be in attendance and will arrange for the meeting to be set up.

Action: Rebecca Vaughan-Roberts

CDTQSE 18/146 Clinical Audit Information

Matt Temby and Alun Morgan to send out communication to directorates to remind them of the process for informing the Clinical Board of clinical audit information.

Action: Matt Temby/Alun Morgan

CDTQSE 18/159 Role Profile for Health and Wellbeing Champion

Ceri-Ann Hughes is trying to obtain a copy of the role profile.

Action: Ceri-Ann Hughes

CDTQSE 18/164 Directorate Presentations to the Sub-Committee

At the last meeting it was agreed that all directorates will present a QSE report and Patient Story to this Group on an annual basis. Sue Bailey has produced a schedule for attendance and a reporting template for directorates to complete when it is their turn to attend and she will circulate these to the Group. It was noted that good attendance will be required from directorates when it is their turn to present including attendance from the Clinical Director/Laboratory Director, Directorate Manager/Head of Service and QSE Lead.

Action: Sue Bailey

CDTQSE 18/168 Speech and Language Therapy Staffing Issues

It was noted that a meeting has been arranged to discuss the staffing issues at St Davids and Barry Hospital.

CDTQSE 18/168 Business Continuity Workshop

The workshop has been arranged for 23rd August. Bolette Jones has volunteered to take on the role as Clinical Board Business Continuity Lead. Mike Bourne stated that he would like the Clinical Board to host 2 major incident/crises test exercises per year.

CDTQSE 18/191 Fax Machines

Sion O'Keefe has been advised that fax machines may be permissible but services would need to justify their use. A proforma will be sent out to all services in order to ascertain if faxes are still being used, where and the justification/need.

Dietetics would prefer to use an email solution to communicate with GP practices going forward. Mike Bourne suggested that the team write to Lisa Dunsford, the Director of Operations for PCIC Clinical Board to request the implementation of an email solution and ask how they would like this to be operationalised.

Action: Claire Constantinou

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 18/205 Patient Story

Daniel Crossland was welcomed to the meeting to present outcome measures from Occupational Therapy in Mental Health. He noted that licences were purchased to measure clinical outcomes. This reduced the need to provide manual statistical data and allow the team to collect the outcomes that matter. It was emphasised to staff that they were responsible for the data and not the outcomes.

He advised that 3 years' worth of data has been collated which equates to 3,816 referrals. Implementation of outcome measures has led to large scale improvements in Adult CMHT. The team have been able to use data effectively to highlight the areas that were underperforming and drive improvements.

Focus was placed on the following key areas:

- Improvement of DNA and CNA rates. The data identified that CNA rates are now showing a downward trajectory and DNA rates have almost halved.

- New to follow up ratios. The aim was to see fewer follow up appointments and over the last 9 months the ratio is 9 follow ups to 1 new assessment, which is efficient for Community Mental Health.

- Reduce time in non-value adding activities.

- Reduce variation.

- Reduce duplication. The majority of referrals over the 3 years were accepted and the team have been able to identify duplicates. The data identified that post assessment, the vast majority of patients are accepted for treatment and the team are seeing the patients that need to be seen. Post treatment outcomes indicate that in the majority of cases, all goals were met.

- Better use of technology. Information is being captured on:
  - Demographics, age, gender and diagnosis.
  - Teams and individuals
  - Referral, assessment and treatment times
  - Treatment outcomes
  - Reasons for poor outcomes

Daniel Crossland presented a case study which involved a patient with a diagnosis of delusional disorder and complex PTSD. The patient was granted asylum following a traumatic experience in its country of origin. At interview, the patient spent most of the day in bed, had no routine no self-care and eats food prepared by friends. He was unemployed (previously a skilled worker in country of origin) and viewed his role as less as a friend and more as a dependent. The patient previously enjoyed social activities, walking and visiting the gym. He was not pursuing interests and was unable to predict his long and short term goals.

Collaborative intervention was put in place and the patient was able to identify his strengths i.e. belief in his skills and ability to change, that he had a good support network and opportunities in a social environment. Goals were set that within 4 weeks a daily routine of self-care would be established with domestic tasks performed without support. By an agreed date his physical fitness would be

improved by visiting a gym and community walking group and also by an agreed date he would explore local voluntary work opportunities. Along with friends engaging him in a social environment due to the interventions he was able to be discharged. His score at time of discharge compared to interview stage showed a significant difference.

The key learning since the implementation of outcome measures has been:

- To define professional roles
- Commit to a decision about outcome measures
- Measure what is important, not just what can be measured
- Accept that outcomes will not always be positive and ensure staff and managers understand this.
- Design data collection systems to gather what information is needed.

CDTQSE 18/206 Feedback from UHB QSE Committee 17th April 2018

The minutes of the meeting are not yet available. It was noted that this Clinical Board attended the UHB Committee on 17th April to present its annual report.

CDTQSE 18/207 Health and Care Standards

Suzie Cheesman agreed to ask Alexandra Scott if there has been any feedback on the corporate response to the health and care standards.

Action: Suzie Cheesman

CDTQSE 18/208 Risk Register

It was reported that the new UHB format template is being finalised.

CDTQSE 18/209 Exception Reports

There have been a number of issues with the LIMS system particularly around unplanned downtime and therefore concerns have been raised with go live in the Cellular Pathology and Blood Transfusion modules.

A blocks and slides audit being undertaken within Cellular Pathology has identified a historical case where tissue was used for a scheduled purpose where there was no consent. An investigating as to why this occurred is being undertaken.

A failure of the air conditioning unit in the Stem Cell Processing Unit was reported. Although the unit is now fixed, there is a requirement to look at business continuity options.

A Serious Incident attributable to Pharmacy has been reported involving a patient who was admitted to MEAU by their GP. It emerged that the patient had been taking a weekly dose of Methotrexate as a daily dose since 21st June. The correct dosage was clearly labelled on the medication and the instructions were clear. An investigation is being undertaken to explore why the patient did not understand the instructions. The patient had received the medication following an outpatient appointment.

Antisocial behaviour outside of the Field Way building was reported to the Clinical Board Health and Safety Group. Sue Bailey has escalated the issues to the Head of Security who will add the building to their walk rounds.

A veteran has made an enquiry to the UHB on his priority rights to diagnostics. A WHC describes the process and this will be circulated to the Group for information following the meeting.

Action: Helen Jenkins

Temperature control difficulties have been reported with the MRI scanner in the Children's Hospital.

Pressure on staffing levels in Haematology have been escalated to the Clinical Board and mitigating actions are being worked through.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 18/210 Initiatives to promote Health and Wellbeing

The National Long Term Plan was **RECEIVED** and **NOTED**. The document was used earlier this week to help inform a Clinical Board Workshop focusing on transformation.

It was noted that the patient story presented at today's meeting is a good example of the strategy and direction of travel outlined in the document

CDTQSE 18/211 Falls Prevention

No new updates to report.

SAFE CARE

CDT QSE 18/212 Concerns and Compliments Report

In June 2018, the Clinical Board received 5 formal concerns. This compares to 5 concerns received in the same period as last year. 3 of the concerns received were related to Radiology and 2 were related to Outpatients/Patient Administration.

The Clinical Board is reporting 10 breaches since 1st April 2018. There were no breaches in response times for concerns received in June; however there are 2 responses to concerns received in March and May that are still outstanding.

Since 1st April 2018 there has been 1 AM concern received. There were no AM concerns received in June.

12 compliments were received in June 2018. This compares to 12 compliments received in June 2017.

Since 1st April 2018 the Clinical Board is reporting 25 compliments and 19 concerns.

The key theme for formal concerns is communication between staff and patients.

- 40% of the concerns in this category relate to difficulties in cancelling or changing appointments.
- 30% relate to staff attitude
- 30% relate to other communication issues.

CDTQSE 18/213 Ombudsman Reports

Nothing to report.

CDTQSE 18/214 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 18/215 Patient Safety Incidents

SI Report

The Clinical Board is reporting 1 SI, Incident No In69239 which relates to blocks and slides that should have been returned to a family in a timely manner. The family have been contacted and an investigation is underway.

CDTQSE 18/216 New SI's

As discussed earlier, a new incident has been reported that is attributable to Pharmacy.

CDTQSE 18/217 RCA/Improvement Plans

Nothing to report.

CDTQSE 18/218 WG Closure Forms – Sign Off

There are no WG closure forms to be reviewed for sign off.

CDTQSE 18/219 Regulation 28 Reports

There are no Regulation 28 reports.

CDTQSE 18/220 Patient Safety Alerts

MHRA Drug Alert

Glass particles were detected within a batch of Bleo-Medac and instructions were issued to UHBs on the additional measures that need to be adopted.

ISN 2018/003 Inpatient Medication Administration Record

It has been identified that some wards are using an old version of the medication chart and departments are instructed to ensure that the correct version is in use.

Patient Safety Alert from Hywel Dda – Electronic High/Low Chairs

Hywel Dda Health Board sent in a patient safety alert around reclining chairs warning of the risk of patient falls if the electronic controller is accidently activated by an individual leaning or sitting on the button of the handset.

CDTQSE 18/221 Addressing Compliance Issues with Historical Alerts

PSN043 Letter from Welsh Government

In May 2018 Patient Safety Notice 043 concerning the introduction of tracheostomy guidelines was circulated. Since publication there have been concerns raised that the guidance is inappropriate for treating and managing children with a tracheostomy. The letter from Welsh Government states that all relevant teams should be aware that the guidelines are to be followed in the adult setting only.

CDTQSE 18/222 Medical Device Risks

MDA 2018/019 – JM103 and JM105 Jaundice Meters Risk of Interpretation of Measurement in Hyperbilirubinemia Cases

Not applicable to this Clinical Board.

CDTQSE 18/223 IP&C/Decontamination Issues

Sue Bailey attended the UHB IP&C Group that was held earlier this week and provided feedback.

Clinical Board are required to produce an IPC delivery plan for the coming year.

A discussion was held around how best to communicate messages around IPC to staff and patients.

Gavin Forbes is replacing Eleri Davies in terms of her role for IPC outbreaks at UHW and Rishi Dhillon has taken on the role for UHL. It was noted that they are invited to attend the Clinical Board IP&C Group.

During hot weather managers are asked to:
- Encourage hydration of staff and patients.
- Staff and patients are encouraged to be vigilant with personal hygiene and skin care.
- Departments to ensure fans are clean and not blowing out dust.

ANTT training was discussed. This Clinical Board has a strategy and will continue with this.

Sue Bailey raised the issue around changes to the usage of rooms from non-clinical to clinical activities and the need for cleaning standards to reflect the new usage of the room.

CDTQSE 18/224 Key Patient Safety Risks

Safeguarding

There was no update to report.

CDTQSE 18/225 Health and Safety Issues

The Clinical Board is reporting 72% compliance against fire training. This needs to be improved. Managers to ensure their staff are up to date with their training. Extra mandatory training sessions are being provided during September and October.

It was also noted that there are COSHH assessments requiring review within the Clinical Board.

CDTQSE 18/226 Regulatory Compliance and Accreditation

The new Clinical Board Regulatory Compliance and Accreditation Group has been implemented and is developing.

This month a service story was presented by Clinical Board Senior Managers and the Cellular Pathology Service Manager on their experiences of working within the HTA Gold Command structure.

CDTQSE 18/227 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 18/228 Clinical Audit

The Clinical Audit Department is in the process of proof reading the Annual Clinical Audit Report.

It was suggested that it would be useful if a presentation could be provided to the Clinical Board from the Clinical Audit team and Kathleen Morris will feed this back.

Action: Kathleen Morris

CDTQSE 18/229 Research and Development

The Clinical Board R&D Group has not met since the last QSE meeting.

It was noted that the UHB Annual Research and Development Report has been circulated to Clinical Boards.

CDTQSE 18/230 Service Improvement Initiatives

A Clinical Board Transformation Workshop was held on Monday. 3 interesting ideas were put forward linked to the strategy highlighted in the National Long Term Plan document.

Staff in the Clinical Board will be asked to come up with ideas for improvements that can be made within services and a prize will be awarded for the best idea. Details of how to apply will be issued shortly.

CDTQSE 18/231 NICE Guidance

Nothing to report.

CDTQSE 18/232 Information Governance

Details and tips around the new GDPR guidelines have been made available for managers and staff from the Information Governance Team.

CDTQSE 18/233 Data Quality

There are plans in IT to conduct work which will determine the flags and alerts required on systems in order to enable staff to better identify patient requirements e.g. sensory loss and allergies.

DIGNIFIED CARE

CDTQSE 18/234 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 18/235 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing further to report.

CDTQSE 18/236 Equality and Diversity

Alun Morgan attended the UHB Welsh Language Workshop. Clinical Boards will be measured on how they comply against the Welsh Language Standards. At the workshop there was a general will to comply with the standards but more understanding is needed on the financial implications that this will involve.

It was noted that transgender services are being hosted on an All Wales basis.

The Eisteddfod is coming to Cardiff in August and it was noted that a number of staff from within this Clinical Board have volunteered to be involved.

TIMELY CARE

CDTQSE 18/237 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 18/238 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Increased demand and some difficult service constraints, particularly relating to recruitment delays to specialist roles, has seen waiting times increase from the end of the last financial year. There are several comprehensive short, medium and long-term plans to address the issues. The waiting time position for June is still to be verified but is in the order of:

Radiology - 560 patients waiting 8 weeks and over.
Therapies - 70 patients waiting 14 weeks and over.

INDIVIDUAL CARE

CDTQSE 18/239 National User Experience Framework

The report for June in not yet available.

STAFF AND RESOURCES

CDTQSE 18/240 Staff Awards and Recognition

Directorates were encouraged to put forward nominations for the Clinical Board Staff Recognition Scheme. The category for July is Values into Action Award.

CDTQSE 18/241 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting 85% compliance with mandatory training.

The fire safety module is of concern which is below target at 72%. All staff are instructed to ensure they are compliant.

The Clinical Board is reporting 56% compliance against PADRs. This is disappointing given the time and investment that has been put into improving the quality of PADRs. The Head of Workforce is interested in hearing managers' views and suggestions on how to improve compliance.

As of 25th June 2018, Ceri-Ann Hughes has been appointed as the Head of Workforce for the Surgery Clinical Board in addition to this Clinical Board. The HR operational team in the Workforce and OD structure is now currently being redesigned.

The Clinical Board sickness rate is 3.06%, which is below the sickness target of 3.68%. There has been a month on month decrease in both short term and long term sickness absence. Long term sickness is currently at 2% and short term sickness is currently at 1.06%.

In terms of the reasons for absence:

12 long term sickness cases are attributed to anxiety/stress/depression/other psychiatric illnesses.
4 long term sickness cases attributed to MSK issues.
3 long term sickness cases attributed to benign and malignant tumours, cancers.

All of the above are being proactively managed along with the relevant signposting to support services including Occupational Health, Employee Wellbeing Service and Physio MSK service.

It was requested that managers complete the staff survey and also encourage their staff to complete the survey.

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

The following minutes were **RECEIVED:**

Draft Clinical Board Regulatory Compliance Group Minutes 28.6.18
Draft Health and Safety Group Minutes 3.7.18

ANY OTHER BUSINESS

It was noted that the Public Health Team have been undertaking work around sustainable travel and active travel plans. It was suggested that Tom Porter is invited to a future meeting to present the travel plans.

Action: Helen Jenkins

DATE AND TIME OF NEXT MEETING

8th August 2018 at 2pm in Classroom 1, UGF, UHW

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING
19th July 2018
Seminar Room, Hafan y Coed, Llandough Hospital

Present: Owen Baglow, Clinical Lead for Quality, Safety & Governance (Chair)
Will Adams, Crisis & Liaison Services
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Philip Ball, Senior Nurse Manager CMHTs
Aline Beveridge, Deputy Ward Manager Alder Ward
Natalie Coombs, Deputy Senior Nurse Manager CMHTs
Lisa Crump, ANP Adult In-patient
Catherine Evans, Patient Safety Facilitator
Steve Ford, Lead CPN Pentwyn CMHT
Rachel Gibbons, Staff Nurse Cedar Ward
Martin Harper, Integrated Manager Links CMHT
Stephanie James, Interim Senior Nurse Manager, MHSOP In-Patient
Robert Kidd, Consultant Psychologist
Lisa Lane, Senior Nurse Manager, MHSOP Community
Mike Lewis, SIMA Co-Ordinator
Jane Morena, Links OTT
Noel Martinez-Walsh, Integrated Manager Pentwyn CMHT
Peter Murray, Integrated Manager Gabalfa CMHT
Alex Nute, Mental Health Lecturer, Cardiff University
Darren Shore, Team Lead North CRHTT
Mark Warren, Senior Nurse Manager Criminal Justice & Forensic
Holly Williams, Quality & Safety Facilitator, Specialist Services
Justin Williams, Team Lead South CRHTT
Lowri Wyn, Ward Manager Cedar Ward

Apologies: Jayne Tottle, Director of Nursing Mental Health
Jayne Bell, Lead Nurse Adult Mental Health
Adeline Cutinha, Consultant Psychiatrist, Gabalfa CMHT
Mark Doherty, Lead Nurse MHSOP/Neuro
Alison Edmunds, Concerns Co-ordinator
Ruth Evans, Lead CPN Links CMHT
Katie Fergus, Clinical Director Adult MH
Mike Ivenso, Clinical Director MHSOP
Jayne Jennings, Ward Manager Willow Ward
Annie Procter, Director Mental Health
Natalie Prosser, Professional Practice Development Nurse
Jayne Strong, ANP Rehab & Recovery
Andrea Sullivan, Concerns Co-ordinator
Ian Wile, Director of Operations MH
Jo Wilson, Directorate Manager MHSOP

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

Chair welcomed all to the meeting and introductions were made. Owen Baglow explained that this meeting was to enable open discussions and views and to highlight good practice and lessons learned.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

No Actions.

PART 3 : CLOSURES

3.1 KE

KE was 61 year old gentleman not previously known to Mental Health Services until he attempted to take his own life by hanging. He went to his garden shed in the early hours of the morning where he had prepared a noose; his partner followed him and attempted to stop him. KE assaulted his partner when she tried to stop him. She called on a neighbour for help, and when he was 'cut-down' he required CPR and emergency services were called. Police later charged KE with the assault on his partner although she did not want to press charges.

KE was admitted to Hafan y Coed, Llandough Hospital for assessment on Cedar Ward then moved to Oak Ward (a treatment ward) and a few days later was transferred to Willow Ward (another treatment ward). KE was discharged home under the care and supervision of the North Cardiff Crisis Resolution and Home Treatment Team. South Wales Police were unhappy that he was home given the pending court case for common assault so KE was admitted to the Crisis House.

KE was due in Magistrates Court for trial for the assault on his partner. KE left the Crisis House on the morning of the court case stating he wished to walk home to get ready for Court, but he failed to arrive home.

KE was very sadly found hanging a few days later.

Issues Identified:

- No previous convictions. KE assaulted his partner when she tried to stop him from committing suicide but did the Police think there was a domestic violence issue? KE's partner said that he had never hit her.

Action: Mental Health to discuss with Police re domestic violence.

- It is not clear from the notes whether he was directly questioned about his feelings regarding his suicide attempt or his anxiety about the court appearance. It is also not clear if he attended his pre-sentencing appointment, or if he was asked how this made him feel on return to the ward.

The nurse on the treatment ward, who saw him on the day before his discharge, clearly spent time trying to get to know him and offered useful suggestions such as OT and physiotherapy, which had not been offered previously.

- KE walked home to get ready for Court

Noted that the Crisis House is for informal admissions, there is no locked door. Also, KE was assessed before he left and staff were re-assured by KE that he would be alright.

Recommendations and Actions:

- Senior Nurse for Crisis Services to reinforce to crisis teams the importance of recording a new assessment on discharge, along with intervention plans. As in this case, the Crisis Team's assessment form was predominantly a duplicate of the one completed in A&E and there was no evidence of what had changed since the day of attempt.

Action: It was noted that a different case had also highlighted the use of copying and pasting resulting in inaccurate information being forwarded to documents. Staff have been told not to copy and paste and the PARIS team were looking at stopping the copy and paste facility for Form 4 and the outcome box on Form 1A

- The policy for staying at the Crisis House is 7 days but may stay longer if necessary. In this case, KE had been told initially that he would have to leave after 7 days which may have caused him anxiety.

Action: Although the Crisis House staff were following the Crisis House Policy. This issue was perceived to be the way that it was said, not what was said. Senior Nurse for Crisis Services to remind Crisis House staff of the unintended consequences of casual comments.

- All inpatient staff to be reminded of the importance of gathering the views of families.

Action: Senior Nurse Manager reminded staff.

- Lead Psychologist for Treatment wards to consider how to support ward staff with the formulation of risk.

Action: Lead Psychologist for Treatment wards to undertake refresher training on the Inpatient Suicide Manual to encourage staff to ask direct questions

Alex Nute, Mental Health Lecturer Cardiff University confirmed that the students' programme does cover suicide

It was noted that a team of ADP nurses have completed a project on male suicide which includes asking difficult questions and are taking this forward.

The Coroner reported that KE had suffered with a condition called Superior Semi-circular Canal Dehiscence Syndrome which involved the thinning, or absence, of a portion of the temporal bone overlying the superior semi-circular canal of the inner ear. The condition made KE hypersensitive to sound.

TO CLOSE.

3.2 JB

JB had an argument with his partner and subsequently hung himself with a bed sheet in the stairwell of the home he shared with his partner and children. His partner was able to release him and called on neighbours to assist. A Social Worker, who works for Cardiff and Vale UHB and who lived in the same street, went to assist and undertook resuscitation at the scene whilst awaiting emergency services. Sadly, this was unsuccessful.

JB had been under the care of the Community Mental Health Team (CMHT) since 2015, following a referral with depression and Attention Deficit Hyperactivity Disorder (ADHD). Interventions had been limited as JB declined medication and was reluctant to engage with the CMHT.

JB had a diagnosis of ADHD and suffered from anxiety and personality traits as a result of a difficult upbringing where he suffered losses and bereavement resulting in attachment difficulties. JB would often express wanting to end his life in times of crisis but on reflection would always express that he wanted to live for his children and family, that they were strong protective factors.

The Coroner concluded that cause of death was 1a) hanging. Conclusion: died from the effects of hanging in circumstances in which his intention was unclear.

It was felt by persons who knew him that he would not have intended to take his own life.

Issues Identified:

JB refused to take his ADHD medication as he felt the medication changed his personality therefore he was offered psychological interventions for his attachment fears and it was hoped that a medication would be found that would not change his character but control the ADHD.

JB was a good parent and partner but his attachment difficulties made him anxious about being a parent and his partner leaving him.

The ADHD prevented JB using talking therapies

JB had impulsive, self harming behaviour.

Recommendations:

A reason for JB's disengagement from the CMHT could possibly be the fact that when he finished work the CMHT would be shut. Suggestions were to extend the working hours of CMHT's or introduce shift work, i.e. 11.00am -7.00pm a couple of times a week and Saturday mornings so that patients could attend before or after work and at weekends.

Action: The current community mental health services review will be addressing capacity issues.

Good Practice

Links CMHT went above and beyond the call of duty. Although there was no longer a clear role for CPN involvement, the CPN continued to develop a good therapeutic relationship with both JB and his partner and it was felt appropriate for JB to remain on the CPN caseload despite minimal involvement.

TO CLOSE.

3.3 SA

SA hung himself from his bathroom door using a bed sheet whilst an inpatient in Hafan y Coed, University Hospital, Llandough. Very sadly, SA suffered a hypoxic brain injury.

SA had been known to Mental Health Services since 2012. There were common themes through each assessment which included experiencing suicidal ideation or thoughts to harm himself and thoughts of wanting to harm other people. Substance misuse was a factor in his mental health difficulties; each assessment concluded there was no evidence that SA was suffering from a serious mental illness. There was acknowledgement that thoughts and experiences of low mood were rooted in continued substance misuse. Appropriate advice was provided to SA in how he could address substance mis-use. A copy of the assessment was sent to the GP with advice that SA start on antidepressant medication. SA was signposted to the Community Addictions Unit for advice regarding his cannabis use, but he declined this service.

During the assessments that took place in 2016 the assessors commented that SA displayed aspects of anger, irritability and intimidation. SA was advised to access support services such as ACT-ion for Living (a community package that helps people deal with stress in their lives) and also to enrol in an anger management group, but he was reluctant to engage in these types of therapy. Following discussion, SA was closed to secondary services and referred back to primary services due to there being no evidence of serious mental illness and a lack of willingness to engage in the offered support services. SA was advised to seek support from services such as MIND.

At the end of 2016, Mental Health Services received a referral from Kingston Crisis Services and SA was admitted to Hafan y Coed, Llandough Hospital as an informal patient for a period of assessment as SA had taken an overdose. SA was placed on 15 minute observations.

Issues Identified:

- Interface with Kingston Crisis Response Home Treatment Team and Cardiff & Vale was poor, in that referral information was not forth coming prior to the assessment for admission taking place. The referral information from Kingston Crisis Response Home Treatment Team shows that the recent overdose was viewed as more important than a recent attempted hanging with shower curtains.

- *Use of the Reassurance Observation System (ROS) in bedrooms*

  The Reassurance Observation System (ROS) is an observation tool specifically designed to unobtrusively observe inpatients in their bedroom areas. It comprises of an infrared camera and microphone system connected to a LCD observation panel which is situated just outside each bedroom; this is the only location where the images can be viewed and there is no facility to access it elsewhere. This panel can be accessed by the observing staff member to check on the patient's safety and well being. The system does not record video/images or sound, only allowing real-time observation.

  It is the opinion of the review team that ROS was not a factor in the incident.

- *Why was the assessment by the Crisis Team undertaken by nursing staff rather than a Consultant Psychiatrist?*

  The Operational Policy for the Crisis Service states that the Crisis Resolution Home Treatment Team (CRHTT) will participate in all assessments when admission to inpatient care is a possibility. This assessment will be multi-disciplinary wherever possible and will identify needs and levels of risk. The staff who conduct the assessment will be determined by the availability and workload of the Crisis Team at that particular time.

  The fact that the assessment of SA on was carried out by two Crisis Team nurses is seen as standard and routine practice. SA was also clerked in by the ward doctor. During the interactions with the Crisis Team and the ward doctor, if the advice of a senior doctor was deemed necessary, then it would have been sought. In this particular case it was the belief of the assessing team that this was not necessary.

- *Why didn't staff act on the information provided by SA's mother?*

  Contention of the family that a phone call was made by SA's mother to ward staff to warn them of SA's distress and the fact that he had texted her to state that he was suicidal. The member of staff who took the phone call recalls the telephone conversation in a different way. She acknowledges that SA's mother contacted the ward just prior to the incident and she states that general concerns about his physical health were expressed by his mother. The nurse stated that SA's mother said that she was concerned about SA's welfare and as his diet was poor she asked if the ward staff could encourage him to eat properly rather than issues of immediate wellbeing. The nurse states that these concerns were not of the nature that warranted immediate action and if she thought that they were or that SA was in danger, then she would have acted straight away; she did made a note to speak to SA as soon as her workload allowed.

  Discussion questioned whether this was cultural issue. Some people are unable to talk about mental health issues.

Lessons Learned:

Levels of Observations

SA was placed on observations at intervals of every fifteen minutes.

Rob Kidd stated that 15 minute observations cannot guarantee patient safety despite Hafan y Coed being a modern environment with limited ligature points but stressed that we will always try to keep people safe.

There was much discussion regarding levels of observation. The rationale of observations in this case was for overdose risk also close observations may have heightened aggression.

Further discussion would be required regarding level of observations and it was recommended that this should be carried out at the Adult Quality & Safety meeting with a possible Task & Finish group being developed.

Resuscitation Process

With regard to equipment factors, the review team noted the issue of non-rebreathe and pocket masks which were at the time on the resuscitation trolleys at Hafan Y Coed. With regard to the task factors, and the very low number of such incidents which staff have to response to, the review team considered that a task familiarity factor was a contributory factor in the resuscitation. The review team found that training in Basic Life Support was adequate. There was an issue with the provision of rescue breaths and the use of the non-rebreathe mask during the resuscitation process. The implications of this are not known

Following the incident, the resuscitation team recommended the removal of Non-Rebreathe masks from oxygen cylinders and pocket masks be placed on top of the crash trolley with spares in the drawer of the trolley. This recommendation had been completed across the Clinical Board, and all qualified staff were trained to ILS standard.

Present day – there are 3 masks in the drawer of the trolley and a poster saying which mask to is to be used is cited by the trolley

Ligature Risk Assessment

Rachel Sykes, Health & Safety Advisor, prepared a Ligature Risk Assessment Protocol for Hafan y Coed and the doors have been removed from bathrooms in the wards.

Good Practice

There was a lengthy nursing 1:1 which was recorded in detail on the PARIS electronic notes system. This was a 90 minute investment of nursing time with the explicit aim of reducing the risks on the first night of admission. In addition to discussion of recent over dose, attempts to hang himself and a variety of other means were explicitly acknowledged.

TO CLOSE.

4.0 DATE OF NEXT MEETING

13th September 2018 at 9.30am in the Seminar Room, Hafan y Coed.

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE held at 1.30 pm, 11th September, 2018 in PCIC Meeting Room 1, CRI

Present

Kay Jeynes (KJ) (Vice Chair)	Director of Nursing PCIC
Anna Kuczynska (AK)	Acting Clinical Board Director
Anna Mogie (AM)	Lead Nurse, North and West Cardiff
Ceinwen Frost (CF)	Lead Nurse Vale Locality
Helen O'Sullivan (HO'S)	Quality and Safety Manager
Ian Stuart (IS)	Primary Care Support Manager
Karen May (KM)	Head of Medicines Management
Lisa Dunsford (LD)	Director of Operations
Matt Williams (MW)	GP OOH Paediatric Practitioner
Nicky Hughes (NH)	Lead Nurse S&E Locality
Nicola Marvelley (NM)	Assistant Head Of Workforce (representing Nicola Evans)
Stuart Egan (SE)	Trade Union Representative
Theresa Blackwell (TB)	Planning and Performance
Rachel Armitage (RA) (Minutes)	PCIC Quality and Safety Officer

By invitation

Karen Davis	Senior Clinical Nurse Specialist, Continence Service

Apologies

Ailsa Pritchard (AP)	Operational manager for GP OOH
Chris Darling (CDg)	Assistant Head of Operations
Danielle Hewings (DH)	Operational Manager, GP Out of Hours
Denise Shanahan (DS)	Nurse Consultant
Gareth Hayes (GH) (**Chair**)	Clinical Director Clinical Governance
Helen Donovan (HD)	Senior Nurse
Helen Earland (HE)	Senior Nurse PC
Lynne Topham (LT)	Locality Manager, North and West Cardiff
Maria Dyban (MD)	Community Director
Matthew McCarthy (MM)	Patient Safety Facilitator
Nicola Evans (NE)	Head of Workforce and OD
Sarah Griffiths (SG)	Head of Primary Care

Preliminaries	**Action**

09/18/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Vice Chair.	
09/18/002	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
09/18/003	**DECLARATIONS OF INTEREST** KJ asked for any declarations of interest – none noted.	
09/18/004	**MINUTES OF THE PREVIOUS MEETING HELD ON 8TH MAY, 2018** The minutes of the previous meeting were recorded as an accurate record. **Matters Arising** There were no matters arising.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
09/18/005	**PCIC CLINICAL BOARD QUALITY AND SAFETY GROUP ACTION LOG** The Clinical Board (CB) Quality and Safety Group action log was reviewed. Members noted the content. The following points were discussed: **Update on service model and staffing for CHAP**: action remains in progress. The revised action plan will be submitted to the Senior Management Team (SMT). A group has been established to consider the needs of vulnerable people, with the first meeting scheduled for September 2018. **01/18/008 Risk Register S&E 06.01.17 HMP Mental Health Provision:** LD and Ian Wile, Director of Operations, Mental Health Clinical Board, are scheduled to meet the Governor of HMP Cardiff to discuss mental health provision in the Prison. This work will continue to be managed as part of ongoing business. Action to be removed from the Action Log. **03/18/007 Risk Register – call recording at CRI:** Awaiting finance approval to order telephones. **03/18/007 Out of Hours Service Delivery:** Action plan under weekly review by LD and Loretta Reilly. Report to be brought back to November QSE meeting. **05/18/007 Quality and Safety Dashboard – Interface Incidents:** KJ confirmed that agreement had been	

	reached outside the QSE meeting that HO'S will provide quarterly updates to the LMC. Action to be removed from Action Log. **05/18/007 Quality and Safety Dashboard – GP Sustainability:** LD is leading work on determining the best mechanism for capturing meaningful data; this will be discussed at the GMS panel on 25th September. Action to be removed from Action Log. **05/18/008 Risk Register – GP OOH IT issues:** Currently on hold; a quote has been received to meet some of the necessary specifications. This is resting with LD awaiting authorisation by the UHB Board. **07/18/007 Quality Dashboard – MSSA:** KJ confirmed that the Root Cause Analysis template is undergoing revision by Eleri Davies, Head of HCAI & AMR Programme PHW, in conjunction with the HCAI Task and Finish Group. Action to be removed from Action Log. **07/18/010 National Clinical Audit and Outcome Review Programme:** MD is arranging for the feedback from the national programme to be submitted to the appropriate forum. **07/18/019 Tracheostomy guidelines:** work is under way. Locality Lead Nurses (LLNs) to provide updates to the November meeting.	**LLNs**
09/18/006	**PATIENT STORY** This item was deferred to the next meeting of the QSE.	
09/18/007	**QUALITY DASHBOARD** KJ summarised the dashboard. The following points were highlighted. **Current SIs:** dialogue is ongoing regarding the reporting of serious incidents and pressure ulcers. Formal recognition was given to the work done by LLN and Matt McCarthy relating to pressure ulcers and serious incidents. **Concerns/complaints**: these reflect primarily complex issues which make compliance difficult. It was highlighted that primary care and dental concerns have always exceeded the process deadlines due to the complex relationship and required engagement required with Primary Care. In addition, there have been a number of complex packages of care where the complainant has involved their AM or Councillor, noting that nevertheless no UHB decisions have been reversed. Thanks were	

	given to the Locality team for timely responses to concerns. LD highlighted that item 3 "% of formal complaints" should read "% of formal concerns"	**RA**
	Vacancy Rates: active recruitment remains ongoing, linked with the nursing productivity group and the UHB recruitment and retention strategy as well as the All Wales streamlining process for newly qualified nurses. AK highlighted the need to ensure a wide mix of experience in teams to enable adequate supervision for people in the early stages of their careers. KJ confirmed that work is under way with the corporate team to ensure that there are robust plans in place which include educating nurses from novice to expert level. It was recommended that the sickness information on the Dashboard should be separated into short- and long-term categories.	**RA**
	Interface Incidents: congratulations were extended to the Quality and Safety team for improving performance on this indicator, with thanks also for the Patient Safety team support.	
	Information Governance: one IG incident for August will be reported.	
	Medication errors: this number was noted as unusually high for PCIC but it was confirmed that there were no particular themes.	
	***C. diff*/ MSSA/*E. coli*:** It was noted that the MSSA template is under revision by IPC colleagues. It was highlighted that there had been a 24% reduction in E.coli between April and August 2018; thanks were extended to the Pharmacy team for their work on this. In addition, PCIC has been recognised as the best performer across the UHB in terms of implementation of ANTT; formal thanks were extended to teams and practice educators for their work on this matter.	
	District Nurse (DN) average escalation levels: Escalation guidance for staff remains under review.	
	OOH: the overall improvement in GP OOH performance was noted.	
	GP sustainability: work is ongoing on how to articulate Practice fragility and associated risk. It was noted that the GP sustainability team is working closely with one Practice which has made a sustainability application. There was discussion on the issues relating to boundary changes for those Practices which share a boundary with neighbouring Health Boards. AK and LD discussed the need for intelligence from Localities and Clusters when decisions are made about Practice boundaries.	

09/18/008	**RISK REGISTER (RR)** **QS&E 000214 OOH** Current position to continue. Performance has been particularly good during the challenging weekend of 7th – 10th September. **QS&E 000113 Independent Sector** Continues to be tolerated. **QS&E 020714 CHAP** Updated action plan has been received for discussion at SMT. More detail and revision of the model would be required. **QS&E 160714 Patient Flow** District Nursing capacity remains a challenge, noting that the Business Case for a Night Visiting service had been declined. LD confirmed that any underspend would be considered for redirection towards Business Cases that had not been approved. LD highlighted also the need to capture the work of the CRTs on improving patient flow. **PCIC 110914 Complex Packages of Care** AM reported that a specialist care agency has given notice on all its packages in Wales, which includes 7 high level complex needs packages for the UHB. An interim plan has been put in place for all the packages to enable replacement care arrangements to be recommissioned. Note was made of the impact of the limited number of suitable staff available and the need to manage the market strategically. KJ confirmed that she had discussed the matter with Mel Wilkey, Head of Outcomes Based Commissioning. LD agreed to help ensure that PCIC is represented on all commissioning groups, noting the serious impact of current market fragility on PCIC strategic plans. **PCIC 160614 Primary Care Estates Development and PCIC 0814 Local Development Plan** LD confirmed that the Primary Care team was in the process of reviewing these risks, including taking some actions to improve security on some sites and arranging meetings with Local Authorities on some specific risk areas. It was noted that the Homelessness Team would be a priority for the IMTP. LD would review and update the risk. **PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainabilty**	**LD**

	Clinical Directors' sessions have been put in place and the GP Fellowship Scheme is almost complete. LD to review and update the risk. **PCIC 10.03.16 Pressure Ulcer (PU) Prevalence** KJ will update in accordance with the Dashboard discussion above. **PCIC18.05.16 Domiciliary Care Provision** KJ will update in accordance with the patient flow and complex packages of care discussions above. **S&E 05.12.16 HMP Cardiff – Prescribing, Staff Stress, Environment** Staffing levels remain challenging; active recruitment is under way. **S&E 06.01.17 HMP Mental Health Provision** To be updated in accordance with discussions above. **S&E 10.07.18 HMP Spice Incidents** Continuing high incidence of code reds and blues; the team was formally congratulated on its resuscitation practice and success. NH reported that a new synthetic drug will soon arrive on the market which will present a high risk to staff. **N&E 10.01.17 Cardiff CRT Medication Administration Procedure** No further progress. **CHC 11.08.17 CHC Commissioning group** KJ highlighted that there is no structured formal commissioning support. LD and KJ will review this matter outside the meeting. **PC141117 GP OOH IT issues** Discussed above. LD to review and update the risk.	**LD** **LD/KJ** **LD**
09/18/009	**NATIONAL RESILIENCE STANDARDS** The QSE Group **noted** these documents which were submitted for information. KJ confirmed that business continuity planning was under way and would be supported by a table top exercise event on 11th October.	
09/18/010	**DATIX** <u>Interface Incidents Draft Internal Audit Brief</u> This document was submitted for information. <u>Interface themes and lessons learnt</u> RA provided a verbal briefing outlining the process for recording interface incidents and subsequently updating the LMC	

	and GPs on learning achieved. A summary was provided of the improvement work that has been undertaken with the Emergency Unit and is currently under way with the Obstetrics and Gynaecology and the Laboratory Medicine teams. Further areas for improvement work will be identified. Additionally, work is under way to map Datix reporting triggers for GPs to assist with the planned roll out of Datix to GPs currently scheduled for Autumn this year. The QSE Group **noted** the report.	
09/18/011	**PHARMACY UPDATES** <u>Pharmacy Quality and Safety Indicators from Annual Returns</u> KM highlighted that pharmacies complete a clinical governance toolkit every year, with 100% compliance. These toolkits are complemented by pharmacy monitoring visits completed by the prescribing technicians aiming to acquire more detailed information regarding application of the standards and observing practice. The intention is to complete these visits every 3 years. It was also noted that during 2017-18 new governance components were included in the community pharmacy contract so that all pharmacists and technicians completed the Improving Quality Together IQT e-learning package on the WCPPE website and all pharmacists, technicians and staff providing NHS services completed a Community Pharmacy Safety Attitudes Survey relating to the pharmacy premises in which they work. <u>Feedback on Pandemic Flu Testing</u> It was highlighted that the testing had identified that in the event of pandemic flu community pharmacies will be used as anti-viral distribution centres, supported by an online assessment and provision of a voucher. Learning from the event focused on the mechanism for developing a plan rather than spot action. It was agreed that the pandemic flu plan should be refreshed. <u>Brexit and medicines supply chain - Preparations for leaving the European Union</u> KJ confirmed that a letter has been issued to Health Board Chief Executives from the Deputy Chief Executive of NHS Wales setting out plans to ensure continuity of supply of medicines. Pharmaceutical Companies are being asked to hold an extra six weeks' worth of stock, while hospitals, GPs and pharmacy contractors are being asked to order as usual and not to stockpile or extend the duration of prescription treatment periods. <u>Short Acting Beta-Agonists (SABA) Community Pharmacy Audit</u> Provided for information, noting the high numbers	**KM/KJ/ CDg**

	and that the information has been fed back to pharmacies for review and action. The following points were discussed: • The reduction in the number of pharmacies providing blister packs, noting the requirement to ensure that blister packs are the appropriate approach for the patient and that pharmacies do not receive funding for the provision of blister packs apart from when it is a requirement of the Equalities Act. • The importance of prescribers maintaining effective dialogue with pharmacies and the discharge liaison team to ensure appropriate provision of medications, noting that work is under way on the development of an All Wales policy. The QSE Group **noted** the report.	
09/18/012	**OPTOMETRY** <u>General Ophthalmic Services – NHS Sight Test Fee, NHS Optical Voucher Values, Payments for Continuing Education and Training and Pre-Registration Supervisors Grant</u> This item was **noted** for information. <u>Quality and Safety in Optometry</u> RA highlighted that Optometrists work to the 1948 Terms of Service for General Provision of Services so they are abiding by regulation rather than working to a contract. Consequently, PTR cannot be invoked and there is no requirement to measure quality beyond post-payment verification. Additional services are provided through Welsh Eyecare Services and Eye Health Examination Wales (EHEW) and the Low Vision Service Wales. For these there should be audits undertaken every 2 years by the Optometric Advisers in PHW under the direction of the clinical leads for EHEW. Local improvement work has been done using referral patterns as an indicator which has improved quality of referrals to secondary care from 25% to 99% meeting the required standard. The General Optical Council deals with all Fitness to Practice issues; Performer Reference Panels are conceptually possible but have so far been exceedingly rare. <u>Update on The General Data Protection Regulations and Notifications relating to the Performers List, Ophthalmic List and Supplementary List for Optometrists</u> This item was **noted** for information. The QSE Group **noted** the update.	
09/18/013	**PRIMARY CARE GOVERNANCE**	

	The draft governance structure and Primary Care QS&E group Terms of Reference were **noted** and **accepted**.	
09/18/014	**CONCERNS THEMES PERFORMANCE SUMMARY** KJ shared the PCIC summary noting that concerns had been discussed above under item 7, PCIC Quality Dashboard, and that individual Business Units are aware of their own themes. It was confirmed that Gareth Hayes and Maria Dyban should be copied into all Primary Care concerns. NH highlighted that the Department of Sexual Health was experiencing one vexatious complainant who was being managed under the appropriate policy. There is a need to improve performance in relation to all PCIC response times, there had been a significant drop in responses, all staff were asked to note the position with a view of improving the position.	
09/18/015	**WELSH LANGUAGE STANDARDS** TB highlighted that Welsh Government expects enforcement of some of the Welsh Language Standards by March 2019. It was noted that there are prohibitive costs associated with some of the work and that Primary Care contractors are not obliged to comply with the regulations. The UHB is in the process of compiling a response which may include commitments for the Clinical Board and will promote the use of Welsh as much as possible. LD reported that the Welsh Language Commissioner would be likely to take a pragmatic approach. The QSE Group **noted** the report.	
09/18/016	**OMBUDSMAN'S REPORTS** • Implementation of Ombudsman's recommendations – HMP Cardiff • Outcome of 3 complaints made to the Public Services Ombudsman for Wales in relation to phase 2 retrospective CHC reviews. • Outcome of the Ombudsman's investigation into a GP OOH complaint – implementation of NICE guidance: CG95 KJ confirmed that all recommendations contained within the Ombudsman's reports had been accepted and actioned. The QSE Group **noted** the update.	

09/18/017	**INFORMATION GOVERNANCE** <u>Continence Service – Paper Light Trial</u> Karen Davis, Continence Team Leader, summarised the work done by the team to meet the challenge of document retention within the service, highlighting that the team now feels safer because the project has made IG more robust; also that a lot of time had been saved to enable increased work with patients, both of which had improved morale. KJ congratulated the team and recommended that KD should write a SBAR report to share with other teams to enable challenge against the existing culture of paper use. LD noted the need to apply similar principles elsewhere, and AM highlighted that pilot work had been undertaken on the scanning of District Nurse home records to enable their inclusion in patients' electronic records and reduce governance risk. It was agreed that this report should be submitted to the next PCIC Information Governance Group meeting. <u>Information Governance Group minutes</u> The QSE Committee **noted** the Information Governance Group minutes.	**RA**
09/18/018	**BUSINESS UNITS QS&E MINUTES** KJ confirmed that she had reviewed and responded to individual business units on matters recorded in their minutes.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
09/18/019	**RESEARCH AND DEVELOPMENT** • <u>Pharmacists and Nurses as Prescribers across a cross-section of primary care providers: what is effective supervision?</u> • <u>Medicines management support for recently discharged patients in the Cardiff West Cluster: a co-ordinated, needs-assessed, approach (Bevan Commission)</u> • <u>Peezy Pilot study</u> • <u>NATROX wound healing study</u> KJ summarised the current position on the above studies, noting that the Bevan Commission research had not yet been approved but will be amended according to feedback received then resubmitted. The QSE Committee **noted** the update.	
SAFE CARE		**Action**
09/18/020	**POOR DISCHARGE FOLLOW-UP PROCESS**	

	CF summarised the process which had been devised in the Vale in response to poor discharges from the hospital to the community. It was recommended that this should be fed back into the relevant clinical board QSE Committee. The QSE Committee **noted** the report.	**KJ**
09/18/021	**PRESSURE ULCERS – RCA/SI REPORTING** The QSE Committee **noted** the SI closure and RCA forms.	
09/18/022	**PARK VIEW HEALTH CENTRE** AM summarised the report, noting the impact on patients and staff and that the interim arrangements continued to have a significant impact on staff and the efficiency of the service. It was highlighted that the Estates Team had undertaken no dialogue with the Locality Team. The following points were discussed: • Locality Managers were attending Programme Board meetings where consideration was being given to moving away from hub solutions to interim arrangements • The need for the programme board, while reviewing the Estates risk, to seek solutions to local issues • School Nurses would be moving to Global Link which in turn would also close, noting that in developing long term solutions to inadequate accommodation more than one move may be required. The QSE Group **noted** the report.	
09/18/023	**POINT OF CARE TESTING** KJ confirmed that links have been made with Localities where necessary. KJ liaising with POCT leads in relation to Primary Care use of Glucometers.	
09/18/024	**MICROBIOLOGY WORKING TO SOP** The QSE Group **noted** the update, which had been provided for information. LMC are in dialogue with the UHB regarding the planned changes	

09/18/025	**ANNUAL AUDIT REPORT - ANTICOAGULATION MONITORING BY THE ACUTE RESPONSE TEAM (ART) 2017** This item was deferred to the next meeting of the QSE Group.	
09/18/026	**MEDICAL EQUIPMENT ISSUES** <u>Richard Wolf TEM Tube Set, single-use item, sterile</u> The QSE Committee **noted** the update, which had been provided for information.	
09/18/027	**PCIC EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE AND BUSINESS CONTINUITY: ACTION NOTES OF THE MEETING HELD ON 15TH AUGUST, 2018** The QSE Committee **noted** the action notes.	
09/18/028	**PCIC DISTRICT NURSE ROTAS DRAFT INTERNAL AUDIT BRIEF** The QSE Committee **noted** the update, which had been provided for information.	
EFFECTIVE CARE		**Action**
09/18/029	**INFECTION CONTROL** <u>Audit of HIV partner notification</u> and <u>National HCAI & AMR Collaborative October 2017 – April 2018: Preliminary Quality Improvement (QI) Projects Overview</u> The QSE Committee **noted** the updates, which had been provided for information.	
09/18/030	**PATIENT EXPERIENCE** <u>OOH Survey responses</u> and <u>North and West Locality summary (email)</u> The QSE Committee **noted** the updates, which had been provided for information.	
09/18/031	**OUT OF HOURS SERVICE DELIVERY ACTION PLAN**	

	LD highlighted that the action plan consolidated actions recommended by previous reviews of the service, while the risk analysis captures the work that is under way.	
09/18/032	**FLU VACCINATIONS AND PLANNING FLU CLINICS** KJ highlighted the issues associated with vaccines intended for people over the age of 75 and the need to plan accordingly, noting the risks associated with availability of vaccines and the different vaccines to be provided to different groups. LD confirmed that the LMC has offered to discuss this issue with the Clinical Board in order to help minimise risks or identify solutions.	
DIGNIFIED CARE		**Actions**
09/18/033	**SENSORY IMPAIRMENT AUDIT** This item was deferred to the next meeting of the QSE Group.	
TIMELY CARE		**Action**
09/18/034	**SAFEGUARDING** 34.1 Paediatric Safeguarding Pathway – pressure damage 34.2 Independent Mental Capacity Advocate Procedure (Mental Capacity Act 2005) 34.3 Safeguarding Steering Group Minutes 19th July, 2018 These documents were presented for information; The QSE Committee **noted** the contents.	
INDIVIDUAL CARE		**Action**
STAFF AND RESOURCES		**Action**
09/18/035	**WORKFORCE UPDATE – RECRUITMENT UPDATE** The QSE Committee **noted** the updates which had been discussed under item 7, PCIC Quality Dashboard.	
SUB-GROUP REPORTS		**Action**
09/18/036	36.1 GP OOH Business Unit No additional issues to report. 36.2 Vale Locality No additional issues to report. 36.3 Cardiff South and East Locality NH highlighted that one District Nurse team in Roath had reached crisis point owing to the sickness of key members of staff. This had required the pooling of three teams' work and a temporary transfer of a member of	

	staff from another team to enable management; this remains under 48-72 hour review. Formal thanks were extended to the North and West team for enabling the temporary transfer of a member of staff. 36.4 Cardiff North and West Locality No additional issues to report. 36.5 Pharmacy and Medicines Management No additional issues to report. 36.6 Palliative care No additional issues to report. 36.7 Primary Care No additional issues to report. 36.8 Clinical Governance Group No additional issues to report.	
PART 2:	**Items to be recorded as Received and Noted for Information by the Committee**	**Action**
09/18/037.	Infected Blood Enquiry	
09/18/038.	VAWDASV strategy & action plan documents on UHB intranet: http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,130425351,253_130425324&_dad=portal&_schema=PORTAL *Please see link – documents circulated at previous meeting*	
09/18/039	**CMO UPDATES** CEM CPhA 2018 009 Drug Alert Class 4 (for information): Kyowa Kirin, Bleo-Kyowa Powder for solution for injection (Bleomycin sulfate) PI 16508/0046 CEM CPhA 2018 010 Drug Alert Class 2 (action within 48 hours): Children's Glycerine and Blackcurrant Cough Syrups Manufactured by Bell, Sons & Co. PI03105/0066 CEM CPhA 2018 011 and CEM CPhA 2018 011 Revision 1 Drug Alert Class 1 (Immediate Action): Dexcel Pharma Limited, Valsartan 40 mg, 80 mg and 160 m capsules; Actavis Group Ptc Ehf, Valsartan 40 mg, 80 mg, 160 mg and 320 mg tablets, Valsartan/Hydrochlorothiazide 160/12.5 mg tablets CEM CPhA 2018 012 Drug Alert Class 2 (action within 48 hours): Novo Nordisk, Fiasp Flextouch 100 units/MI solution for injection pre-filled pen CEM CPhA 2018 013 Drug Alert Class 3 (action within 5 days): FDC International, Sodium cromoglicate	

		2% W/V eye drops 13.5 ml; Murine hay fever relief 2% W/V eye drops 10 ml
	CEM CMO 2018 04a	The Cyrus Project – Unsolicited Packages
	CEM CMO 2018 013a	Drug Alert – Esmya (Ulipristal acetate) for symptoms of uterine fibroids: restriction to use and requirement to check liver function before, during and after treatment
	MHRA MEDICAL DEVICE AND MEDICINES ALERTS	
	MDA 2018 020	Smiths Medical CADD Non-flow-stop medication cassette reservoirs – recall of specific lots due to risk of under delivery of medication
	MDA 2018 021	Alaris Smartsite add-on bag access device – removal and destruction of specific batches due to risk of disconnection or leakage
	MDA 2018 023	Combur[10] Test UX and Chemstrip 10 A test strips – risk of falsely low results when measuring test strips on the Urisys 11 00 urine analyser
	MDA 2018 027	Breast implants, all types, makes and models – continue to report suspected cases of breast implant associated-anaplastic large cell lymphoma (BIA-LALCL)
	Notification of supply issue for Alvesco Inhaler (ciclesonide)	
	WELSH HEALTH CIRCULARS	
	WHC 2018 009	Dental Services: Service Standards for Conscious Sedation in a dental care setting/ Gwasanaethau Deintyddol: Safonau Gwasanaethau ar gyfer Tawelu Ymwybodol mewn lleoliad gofal deintyddol
	WHC 2018 019	Getting the Balance Right in Wales – Supporting quality and safety for dental registrants as part of an assurance process
	WHC 2018 032	List of Welsh Health Circulars - 1 January 2018 – 31 July 2018
	WHC 2018 034	BCG Vaccine Supply and Ordering in Wales
	WELSH GOVERNMENT ADVISORY	
	None received since last meeting.	
	NICE GUIDANCE	
	NG92	Stop smoking interventions and services
	NG95	Lyme disease

	NG96 Care and support of people growing older with learning disabilities NG97 Dementia: assessment, management and support for people living with dementia and their carer NG98 Hearing loss in adults: assessment and management Existing NICE guidelines updated from April to June 2018: CG137 Epilepsies: diagnosis and management last updated April 2018 – uptake of this guidance CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings last updated April 2018 CG185 Bipolar disorder: assessment and management last updated April 2018 – uptake of this guidance CG90 Depression in adults: recognition and management last updated April 2018 **PATIENT SAFETY NOTICES** PSN045 Resources to support safer modification of food and fluid **INTERNAL SAFETY NOTICE AND GUIDANCE** *None received since last meeting.* **UPDATES FROM OTHER GROUPS** NHS Wales Safeguarding Network Minutes – *not yet available* Minutes from the UHB Nutrition and Catering Steering Group June 2018 Public Health Update March 2018 Public Health Wales Infections Surveillance Report
DATE OF NEXT MEETING	
Tuesday, 13th November, 2018, 1.30 pm – 3.30 pm, PCIC meeting room, 1 CRI	

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

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 20th July 2018
Venue: Critical Care Resource Room

In Attendance:
Hywel Roberts (HR), Consultant Intensivist, Medical QSPE Lead Clinical Board (Chair)
Holly Williams (HW), QSE Facilitator
Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Mathew Price (MP), Service Manager, Neurosciences
Colin Gibson (CG), Rehab Engineering. ALAS
Martyn Read (MR), Consultant, Critical Care
Fiona Kear (FK), Assistant Service Manager, Haematology, Immunology & Medical Genetics
Jennifer Proctor (JP), Lead Nurse, Haematology, Immunology and Medical Genetics
Sian Williams (SW), Senior Nurse, Cardiothoracics
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Sarah Lloyd (SL), Directorate Manager, Neurosciences
Sarah Matthews (SM), Senior Nurse, N&T
Vince Saunders (VS), Infection, Prevention and Control
Claire Main (CM), Lead Nurse, N&T

Present:
Emma Jones (EJ), Neuro Vascular Nurse Specialist, Neurosciences
Gemma Williams (GW), PA to the Specialist Services Clinical Board (Note taker)

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome and Introductions HR introduced Holly Williams, QSE Facilitator for the Board to the group. The group introduced themselves one by one.	
1.2	Apologies Mary Harness, Dale-Charlotte Moore, Catherine Wood, Keith Wilson, Steve Gage, Maria Roberts, Carys Fox, Navroz Masani and Gemma Ellis.	
1.3	To review the minutes of the previous meeting 28th June 2018 The minutes were agreed as an accurate record, subject to Martyn Read needing to be taken off of the apologies list. Matters Arising: • Item 1.3 Directorate Risk Registers - All Directorates confirmed they had sent their Registers to CF.	

	• Item 1.4 Patient Story Paul Twose – GW has circulated the patient story to the group. RB/TH to discuss in the Neuro QSE meeting. The project will be discussed in core team in relation to taking it forward. • Item 2.1 Closure Forms – In64902 3 cases of VRE identified in Cardiothoracics. Another case in Cardiac ITU. BO will check if the patient was on the ward during the outbreak. • Item 2.3 Surveillance of patients awaiting Cardiac Surgery – GW is awaiting the presentation from Richard Wheeler and will circulate once received. • Item 4.1 Medication Charts - Directorates confirmed that they have removed all out of date versions. SC noted that she had spoken to the print room and it is an external company through oracle that are still printing the old charts. Procurement are going back to the company to address the issue. It was noted that you have to enter exact wording into Oracle in order to find the correct chart. SC will feed back. • Clinical Board H&S representatives – GJ to send the H&S group dates to GW to circulate. • Haematology Risk – the Directorate has been asked to produce a plan to reduce the risk to patients while awaiting the new facilities to be built. Conversations have taken place with Geoff Walsh and consideration is being given to identifying a space in the Day Unit. There will be a plan going forward. Haematology to update at the next meeting.	**RB/TH** **CF** **BO** **GW** **SC** **GJ** **Haem**
1.4	<u>Patient Story – Neurosciences</u> Emma Jones presented to the group. It was noted that Neurosciences lost the interventional service between May and October last year (2017), which had a significant impact in a number of areas. Since then changes have been made, such as more structure to MDT and referral process. Outcomes uploaded to clinical portal. A positive patient story was presented that spanned the previous service and the current service. Patient presented with a subarachnoid haemorrhage due to ruptured small middle cerebral artery aneurism. GW will circulate the presentation to the group. New service is up and running. Only one interventional radiologist which is a concern. If on leave referring emergency patients out.	**GW**
PART 2: SAFE CARE		
2.1	<u>Open Serious Incidents (SIs)</u> SC updated the group. There are currently 18 open SIs - 10 of which are reaching closure date. Last month 3 closures. New SI in relation to a man on B5 Nephrology (complex renal patient). The patient had a massive bleed and there were issues around the management of low haemoglobin. The patient had a cardiac arrest and sadly died. Maria Roberts, Patient Safety, to speak to Gemma Ellis to take it to the resuscitation committee. <u>Open Inquests</u>	**MRR**

	One Inquest is going ahead today (initials SW) involving EMERTS. Another Inquest on Monday. SC needs to speak to Claire Main, Lead Nurse, N&T as family not attending therefore the inquest is likely not to be held. <u>Closure Forms</u> No closure forms to present. <u>Public Health Wales Briefing</u> 13 July 18: CBRN reminder and Public Health England Briefing Notes for Emergency Departments – documents for information.	**SC**
2.2	<u>Patient Safety Alerts</u> For information: ISN: 2018/003 Medication charts – discussed at the last meeting but too late to include in last month's papers.	
2.3	<u>Healthcare Associated Infections</u> <u>Clinical Board HCAI Review to end of June 2018</u> • No C.Difficile cases in July. • No MRSA since April. • 1 case of MSSA on B5. • No e-coli. HR noted that he had attended the last Clinical Board HCAI meeting which was 2 weeks ago. It was a positive meeting. Hand washing, Bare Below the Elbow (BBE) and commode cleaning were the main issues discussed. There will be sterner measures taken if compliance doesn't improve with regards to BBE. Discussed ways to improve hand washing. VS will be shadowing ward rounds and there will be coaching as well. VS noted that IP&C are looking to produce a newsletter to present the HCAI data in a different more meaningful format. Figures will be broken down by ward. Updates provided for the link nurses. The information included will be based around infection control and what works well in other areas in order to share practice. Information needs to be cascaded down to the wards.	
2.4	<u>Consent – BMT/Haematology doctors</u> Keith Wilson, Haematology Consultant, requested that this item is discussed (Agenda Item from the 11th July Haematology QSE meeting). Unfortunately Keith was not available to attend. The issue pertains to the practice of other teams (who perform invasive procedures on Haematology/BMT patients) insisting that consent for these procedures be obtained from the patient by the Haematology/BMT doctors. This happens most frequently with respect to the insertion of Hickman lines in Radiology and upper or lower GI endoscopy. The most recent example pertained to the endoscopy service refusing to perform a sigmoidoscopy procedure unless the ward doctor had obtained consent. Concern raised as the Junior doctors are not experienced or knowledgable enough to obtain informed consent. HR referred to the 2 documents that he	

	circulated ahead of the meeting; GMC consent guidance (responsibility for consent point 26) and the UHB consent policy (8.2.6). HR noted that final responsibility for consent does lie with the person carrying out the procedure. There is however a process for delegation of consent. EJ noted that their Junior Doctors have also raised concern regarding this issue. They therefore carried out an audit and linked in with the standards the radiologists use. The risks were shared with numerical value and a leaflet was developed for patients. When the patient comes for their induction an email is then sent to them including the leaflet, which details a clear list of complications etc. HR to speak to Keith Wilson in relation to Haematology specific problems and link in with Navroz Masani, Clinical Board Director and Carys Fox, Director of Nursing for the Clinical Board.	**HR**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee Nothing to feedback.	
3.2	Exception reports and escalation of key QSE issues from Directorate QSE Groups Critical Care Secretarial Support MR raised concern that the Critical Care QSE meeting has had no secretarial support for the last 5 months. MR to email HR who will then contact Matt Wise, Clinical Director, Critical Care regarding support for these meetings. Posture Mobility Centre CG raised concern that there has been no hot water at the posture mobility centre for the last 2 weeks. CG to link in with Geoff Walsh. Thoracic Surgery Public Consultation CP referred to the Thoracic Surgery Public Consultation which is taking place between the 3rd July and the 27th August. WHSSC came to Health Board last Friday and the consultation for all staff was well attended. A good debate took place. Concern raised from clinicians with regards to the service moving to a single centre in Swansea. If anyone has any comments really need to encourage all staff to submit them. Link below: Welsh Health Specialised Services Committee (WHSSC) | Public Consultation on the Future Provision of Adult Thoracic Surgery Services in South Wales	**MR/HR** **CG** **All Dirs**
3.3	PMS Accuracy HW referred to an email that she had received from Steve Gage in Pharmacy which gives an example of a lady who rang the hospital to say that her GP had not received a follow up letter and needed this to get her medication reissued. The GP address on the DAL was different to the GP address provided by the enquirer. Discussion took place around PMS and ensuring the details are accurate. Along with the risk factors associated with incorrect patient details. It was agreed that patient demographics should be checked on admission and that	

	the next step was actually updating it on the system which may not always be happening. Checking patient details needs to be reinforced in clinical areas. Details should also be checked on discharge. Nurse talking to the receptionist to change the address on the system is the final step. Need to check GPs address as routine practice. Welsh clinical portal could also be used to check that the letter has been sent to the correct GP address. However it was noted that not all GPs currently can access it but that it is being rolled out.	**Dirs**
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u> <u>Overdue Datix Reports</u> HW noted that there were currently 261 overdue datix reports; 29 awaiting review with no harm, in progress 82, catastrophic 0 waiting review. It should be possible to bring these to a close. Concern raised that the reports are not being sent to the correct people. The list of names from the drop down list is not necessarily accurate. Not all those listed deal with the reports. It was agreed that each Directorate needs an agreed person to circulate the incidents so that none are missed. People need to know how to use the system properly. Names can be hidden from the drop down list for those that need to be. It was suggested that staff listed as an option to send the report to, log in to check when they can if there is anything in their to-do list however there is a 90 day log out period. <u>C.Difficile Testing</u> VS informed the group that testing for C.Difficile is changing from next week. PCR tests will be used which is a more accurate test than GDH.	**Dirs**
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information	
PART 6: DATE OF NEXT MEETING		
6.1	Thursday 9th August 2018 8am in the Critical Care resource room, UHW. HR apologies on leave.	

Medicine Clinical Board Minutes
Quality, Safety & Experience Committee
Date and time: 22nd June 2018 09:00-11:30
Venue: Council Room

Preliminaries			Action
A1	Welcome & Introductions	Present: T Cardew, L Graham, I Dovaston, E Mitchell, D King, D Jones, A Scott, R Aylward, K Prosser, O Williams, S Cheesman, M McCarthy, W Parsons	
A2	Apologies for absence	R Evans, S Follows, S O'Brien, S Brookes, D Pitchforth, G Spinola, C Evans, S Cornes-Payne, M Pasha, Dr J Turner, G Murray, J Murphy, B Davies, R Owen-Pursell	
A4	To receive the Minutes of the previous meeting Matters Arising	Minutes reviewed and agreed. CAMHS booklet shared which is operational within the Paediatric Emergency Department. To discuss with M Rossiter regarding further availability to share Major Trauma update which will affect the Clinical Board and UHB	KP
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY			
1.1	Patient Story	Emergency/Acute Medicine: WP shared a patient story regarding a 21 year old male that presented to the Emergency Department via WAST with what appeared to be 'intoxication'. The patient was conveyed via WAST and handed over that whilst at a cash machine they suddenly became vague and unable to speak. It was identified that whilst the patient and his friends had been drinking alcohol, this was thought not to be excessive. Whilst being conveyed to the Emergency Department the paramedic crews handed over to the triage nurse that the patient was unable to speak and would smile at the crews which was perceived as 'the patient being intoxicated'. On initial assessment the patient was treated as intoxicated and given intravenous fluids but continued to show no improvement. Recognising this the clinicians suspected that there may be an underlying medical cause and a CT head scan was requested which confirmed a Stroke. WP advised that a concern had been received from the patients mother around the nursing and medical approach to patients who are deemed 'intoxicated'. WP shared with the group that nursing and medical teams approach to patients who are intoxicated are treated differently in the fact that they have to be seen as being more assertive and that this concern has resulted in the department reflecting on how this may be perceived and to not take any patient with suspected 'intoxication' as a given. Following the patients diagnosis treatment was commenced and the patient fully recovered from	

		their presenting symptoms, RA stated that this must have been very distressing for the patient and advised that this would be a good opportunity to invite the patient to share their experience in the form of a 'patient story'.	WP
1.2	Feedback from UHB QSE Committee	http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee-	
1.3	Directorate QSE minutes – exception reporting	Directorate QSE papers shared – no exception reporting noted: Dermatology Gastroenterology Clinical Gerontology Internal Medicine Rheumatology	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT			
2.1	NATSSIP's – the way forward	MM provided an overview of the UHB requirements to be compliant with NaTSIPP's. To date each Directorate has completed a gap analysis based on their current processes and procedures measured against NaTTSIPP's requirements. MM shared an example of a LoCSSIP's (local procedure) for Endoscopy as an exemplar noting the focus should be on the processes of procedures and be a MDT approach. For the Clinical Board Gastroneterology are progressing well with their LoCSSIP's for endoscopy and paracentesis. Emergency Medicine NaTTSIP's lead aware of procedures required that would fit with NaTTSIP's, discussions ongoing around placing a WHO checklist within the ED documentation. WP to discuss with MR (NaTTSIP lead EU) regarding progress. Respiratory Nurses have completed a LoCSSIP's for pleural taps/effusions. EM raised that there may be a potential to complete a LoCSSIP's for the procedure room on B7 which is clinician led. KP advised that work with Rheumatology and Dermatology had just started.	WP
SAFE CARE			
3.1	LIP's Falls Simulation Training feedback	OW UHB Falls Strategy Lead presented some initial feedback of a LIP'S project for falls management which involved A4. The project will be formally presented in September 2018. As part of the new simulation suite pre and post falls procedures three different scenarios are undertaken. These are recorded so staff have the ability to discuss and reflect on the actions taken as a means of learning and improvement. Suggestion that this will form part of a UHB training package as a means of improving pre and post falls procedures. OW advised liaising with Melanie Cotter around providing wider training packages as a rolling package. The Practice Development Nurses have been asked to advance on this on behalf of the Clinical Board. OW feedback that initial findings identified that improvements were required with the utilisation of the Hover jack. KP re-	ID/GM

		iterated that this is a reoccurring theme from the lessons learnt whilst undertaking Injurious Assessment investigations. KP also shared that at the UHB Falls Delivery Group meeting concerns were raised regarding the issue of only having one Hover jack per site and the delays that this causes when required for a potential injurious injury.	
3.2	New SIs	KP advised that 6 Serious Incidents were reported in May, all of which were healthcare acquired pressure damage. For June to date there has been 12 reported Serious Incidents: 7 healthcare acquired pressure damage, 3 Injurious Injuries, one Colonoscopy surveillance delay and one medication error Paediatric EU.	
	Clinical Gerontology:	In67619 Injurious Injury: Un-witnessed fall resulting in a fracture to the right neck of femur. Identified that the patient fell whilst mobilizing to the bathroom unsupervised and without using the nurse call bell. Identified as a falls risk and all assessments completed in line with best practice. Sensor mat was in place but the patient had unplugged the alarm tag. Post falls procedures performed in line with UHB best practice and NICE 2015 guidance. At the time of the fall the acuity of the patients requiring support secondary to an IP&C outbreak and another patient requiring emergency treatment prior to the patient falling may have increased the potential risk of falling and subsequent harm. In67662 Injurious injury: An un-witnessed fall from the end of the bed and where the bed rails end, which resulted in an extension to a pre-existing Sub Dural haematoma. Identified as a falls risk with all assessments completed in line with best practice. An un-witnessed fall for a patient with an extensive history of falls. Post falls procedures completed in line with NICE 2015 guidance and UHB best practice. The decision to treat the patient conservatively following inpatient fall and injury completed in-conjunction with medical and neurosurgical teams with the agreement of the patients family noting this to be in the patients best interests. In67705 Healthcare acquired Grade 3 unavoidable pressure damage: All Wales Pressure Damage Tool identified that they patient was admitted to the UHB with pre-existing Grade 2 pressure damage to the sacrum known to Primary Care colleagues which evolved into Grade 3. Several risk factors which increased the risk of further deterioration including admission for a potential CVA and sepsis secondary to gangrenous toes and heel with a background history of poor circulation, diabetes and peripheral vascular disease. All risk assessments were completed on admission in line with best practice. Identified learning that whilst the patient had an individual care plan this did not reflect the changes to the patients skin integrity secondary to incorrect grading.	
	Internal Medicine:	In63326 Injurious injury: Unwitnessed fall from the end of the bed and where the bed rails end, resulting in an extension to a pre-existing sub dural haematoma following a fall at home. The	

		injurious assessment found that this was an un-witnessed fall for a patient who had a pre-existing head injury. A change in the patients level of alertness may have increased the potential falls risk. Evidence of good practice for the completion of neurological observations, and re-evaluation of post falls procedures. There was no documentary evidence to support that the patient was provided with consistent messages about when to ask for help when attempting to get out of the bed. In65036 Healthcare acquired Grade 3 unavoidable pressure damage. All Wales Pressure Damage Tool identified that the patient was admitted to the UHB with known Grade 2 pressure damage to the sacrum that evolved into Grade 3 measuring 0.8cm x 1.1cm. Background history noted as poor mobility secondary to COPD and cardiac failure and admission for an acute infective episode of COPD requiring acute NIV and anti-biotic therapy. Learning identified that the patients was not assessed for pressure ulcer risk within 6 hours in line with best practice. The patients weight was noted to be an approximate weight as they were too unwell to be weighed on admission. In addition, whilst there was extensive documentation noted on the patients body map, there was no specific patient centred care plan for wound care/pressure relief. In64777 Healthcare acquired Grade 3 unavoidable pressure damage. All Wales Pressure Damage Tool identified that the patient had pre-existing Grade 2 pressure damage to the natal cleft on admission which evolved into Grade 3 measuring 1.5cm x 1cm. A review of PARIS notes that patient known to District Nursing for pressure damage in two areas to the natal cleft but no grading is documented. The patient had several risk factors increasing the risk of further deterioration including an acute kidney injury, AF, poor mobility and dietary and fluid intake. Learning identified that whilst risk assessments were completed an updated in line with best practice there was no individual patient care plan for the patients pressure areas. In66800 Healthcare acquired Grade 3 avoidable pressure damage. All Wales Pressure Damage Tool identified that the patient had a pre-existing moisture lesion to the buttock which evolved into avoidable Grade 3 pressure Damage. The patient had several risk factors which would increase the potential risk of further deterioration, including diabetes, below knee amputation, incontinence and a previous history of pressure damage. Risk assessments were completed and re-evaluated in line with UHB best practice noting the patient to be reluctant to be repositioned from side to side. This pressure damage has been reported as avoidable as the patient was held on an ambulance for 5 hours secondary to the pressures experienced within the department and lack of inpatient beds. All patients with pre-existing or identified as high risk of pressure damage are escalated for timely access to an inpatient bed, or an appropriate bed is brought down to the department where available. All ambulance delays are escalated via the Medicine Clinical Board Hub with a plan to off load as soon as possible.	
	Gastroenterology/Hepatolo	In62221: Patient experiencing new symptoms of constipation and rectal bleeding referred by GP for urgent Colonoscopy.	

	gy/Endoscopy:	Referral was vetted by Consultant and listed for an urgent Colonoscopy on 01/09/2017. The patient met the NICE suspected cancer criteria for a 2 week wait referral. A colonoscopy was performed as part of the UHB insourcing work on 27/01/2018 where a malignant rectal tumour was found. The patient has undergone surgery and is continuing to have follow up. The RCA investigation noted the following in terms of learning and actions: The Quality and Governance Lead for Gastroenterology has formally written to all Consultants within the department and fellow primary care colleague to advise them of the criteria for referring against NICE guidance. Some colleagues have also presented at GP educational sessions. A new dedicated 'suspected cancer and lower GI cancer' referral is being used in WPRS (electronic referral system for Primary Care) so General Practitioners have to clearly define priority. The Directorate are also undertaking some pathways for Health Pathway implementation. The UHB continues to work towards JAG accreditation. The UHB continues to balance risk across all categories of endoscopy (urgent, routine and surveillance) and continues with implementation of its endoscopy plan to reduce waiting times. Significant inroads have been made in reducing symptomatic waiting times – with the number of patients waiting greater than 8 weeks at end of March 2018 reducing by 58% in comparison to the previous year end. However, whilst the number of patients waiting greater than 8 weeks past their agreed target date for surveillance endoscopy has reduced in recent months, there has been a deterioration in overall volumes since year end. This is, however, in the context of an increase in demand for both surveillance and symptomatic patients. The UHB has refreshed its demand and capacity plan for 2018 – 19 and in addition to core capacity – continues with additional capacity through internal and external providers to reduce overall waits. In addition, clinical validation of patients waiting for surveillance endoscopy is underway. There is Executive oversight of the service and regular monitoring of the improvement plan is in place In62114: Patient with a several month history of dysphagia and fullness referred for an urgent endoscopy by their GP 18/08/2017. The referral was vetted by a Consultant and was listed for an urgent OGD. A GP expedite letter was received and prioritised as USC due to deteriorating symptoms of dysphagia. An OGD was performed on 27/01/2018 which identified a malignant looking tumour at the Gastro-oesophageal junction. The patient has undergone pre-operative chemotherapy and is now awaiting surgery. The RCA investigation reported noted the following in terms of learning and actions: The Quality and Governance Lead for Gastroenterology has formally written to all Consultants within the department and fellow primary care colleague to advise them of the criteria for referring against NICE guidance. Some colleagues have also presented at GP educational sessions. A new dedicated 'suspected upper and lower GI cancer' referral is being used in WPRS (electronic referral system for Primary Care) so General Practitioners have to clearly define priority. The Directorate are also undertaking some pathways for Health Pathway implementation. The UHB is working towards JAG accreditation. The UHB continues to balance risk across all categories of endoscopy (urgent, routine and surveillance) and	

		continues with implementation of its endoscopy plan to reduce waiting times. Significant inroads have been made in reducing symptomatic waiting times – with the number of patients waiting greater than 8 weeks at end of March 2018 reducing by 58% in comparison to the previous year end. However, whilst the number of patients waiting greater than 8 weeks past their agreed target date for surveillance endoscopy has reduced in recent months, there has been a deterioration in overall volumes since year end. This is, however, in the context of an increase in demand for both surveillance and symptomatic patients. The UHB has refreshed its demand and capacity plan for 2018 – 19 and in addition to core capacity – continues with additional capacity through internal and external providers to reduce overall waits. In addition, clinical validation of patients waiting for surveillance endoscopy is underway. There is Executive oversight of the service and regular monitoring of the improvement plan is in place. In63274: A patient underwent a colonoscopy on 25.02.2010 for polyp surveillance, results of which were normal. A further surveillance colonoscopy was requested for 5 years time; the patient was added to the patient management system (PMS) endoscopy waiting list (13) on 01.03.2010. Meaning a follow up surveillance colonoscopy was due on 25.02.2015. An urgent suspected cancer (USC) referral was received from his GP on 10.05.2016 due to a 3 month history of change in bowel habit and weight loss. A USC colonoscopy was requested and received by endoscopy on 16.05.2016. An appointment date was agreed with the patient on 18.05.2016. He attended for his procedure on 25.05.2016, and a rectal cancer was diagnosed. Following staging the gentleman has subsequently undergone chemo-radiotherapy and surgery. The RCA investigation noted the following in terms of actions and learning: Specific staff have been protected to only dedicate their time to support clearing the backlog of surveillance and planned recall patients awaiting clerical validation. The review and monitoring of performance reports for all staff. Monitoring of sickness and absence in line with UHB policies. The existing rota has been redesigned to improve function and performance with clearly defined performance measures and expectations. The review of roles and responsibilities within the Directorate support team. The Clinical Board have requested from the Directorate a detailed trajectory for quarter 2 to include reduction profile in activity. An accurate reporting template to measure demand versus capacity is being developed, including a demand profile exercise to ascertain capacity gaps which will inform how much further support is required from insourcing. Review the way in which surveillance cases are allocated to insourcing versus outsourcing lists to maximise those allocated to insourcing. The UHB continues to balance risk across all categories of endoscopy (urgent, routine and surveillance) and continues with implementation of its endoscopy plan to reduce waiting times. Significant inroads have been made in reducing symptomatic waiting times – with the number of patients waiting greater than 8 weeks at end of March 2018 reducing by 58% in comparison to the previous year end. However, whilst the number of patients waiting greater than 8 weeks past their agreed target date for surveillance endoscopy has reduced in recent months, there has been a deterioration in overall volumes since year end. This is, however, in the context of an increase	

		in demand for both surveillance and symptomatic patients. The UHB has refreshed its demand and capacity plan for 2018 – 19 and in addition to core capacity – continues with additional capacity through internal and external providers to reduce overall waits. In addition, clinical validation of patients waiting for surveillance endoscopy is underway. There is Executive oversight of the service and regular monitoring of the improvement plan is in place. In65423 Healthcare acquired Grade 3 unavoidable pressure damage. All Wales Pressure Damage Tool identified that the patient had several risk factors which increased the risk of pressure damage evolving, including admission for sepsis. The investigation found that following the completion of risk assessments a primo mattress with a repose would have been recommended. However, at the time Aerospacer mattresses were being used as part of the mattress selection process. All of these mattresses have now been withdrawn following advice from the UHB Tissue Viability Task and Finish Group following concerns raised regarding the use of these. In66021 Healthcare acquired Grade 3 unavoidable pressure damage. All Wales Pressure Damage Tool identified that the patient had pre-existing Grade 1 pressure damage to the coccyx which evolved into unavoidable Grade 3 pressure damage. On admission the patient was admitted with confirmed flu, was noted to be extremely thin and frail and developed diarrhoea which resulted in a deterioration in the patients skin integrity. All risk assessments were completed and updated in line with UHB best practice, however the investigation did note that the patients wound care plan was not updated when the patients pre-existing grade 1 area started to deteriorate to grade 2. In relation to Pressure Damage Serious Incident: Clinical Board update The Clinical Board recognises that ongoing education and development is required to ensure that the correct grading and accurate and timely documentation is maintained around pressure damage treatment and prevention. Form part of the UHB Tissue Viability Task and Finish Group – new patient passports/leaflets/Datix recording stickers introduced. In addition educational booklets have been completed by the Practice Development Nurses. Standardised educational posters are being developed to ensure consistent education/advise is provided across the Clinical Board	
3.2	Patient Safety Alert's, WHC's and MDA's	Patient Safety Alerts, WHC's and MDA all shared for dissemination across Directorates. PSN 043 – Supporting the introduction of the Tracheostomy Guidelines for Wales - KP raised with EM that this would be relevant to B7 and to ensure that this was shared with the ward PSN – 037 Safety of Girls and Women who are being treated with Valporate WHC-2018 020 – HCAI AMR Targets 2018 – 2019	EM

		MDA/2018/017 Cook Vacuum Pump for IVF – risk of electric shock or burn to operator	
EFFECTIVE CARE			
4.1	Director of Nursing Quality & Safety reports	RA shared the Clinical Boards recent Quality Dashboard reporting positive feedback. Continued improvement with the concerns response rate. RA raised concerns regarding the number of Datix in progress between 30-60 days and >60 days and this required some effort by all incident managers and Dif 2 users to reduce the number by ensuring that all actions/recommendations are completed. KP to provide a breakdown of each Directorate and circulate for action. RA noted the increase in the number of E Coli cases reported against the reduction expectation goal. DK advised that the target is noted as being ambitious, this year's targets are yet to be circulated.	KP
4.2	Audit/NICE compliance	AS shared information to the group on NICE guidance. Some of these guidelines are sent for information where no response or action is required or where there is action required. This requires each area to clarify if the guidance is not being implemented or actions taken to provide evidence of implementation. The UHB is required to provide assurance and responses to WG around NICE compliance. AS to continue to attend Clinical Board QSE meetings as a means of re-enforcing the importance of NICE guidance. To consider whether compliance with NICE guidance should be added to the Risk Register. RA commented on that further engagement is needed and noted that it is difficult to engage clinicians at Clinical Board QSE meetings, but Directorate meetings are always well attended. RA to discuss with RE. AS shared that clinical audits results are not received back to the audit team in a timely manner. Directorates have been contacted regarding what clinical audits are being completed within the Clinical Board. AS advised that there are 3 tiers of clinical audits, Tier 1 National Audits, Tier 2 Audits around QSE themes and Tier 3 Audits undertaken for individual staffs CPD/revalidation or clinicians interest. Tier 3 audits should be given the lowest priority. AS advised that additional corporate audits for executive performance include pressure damage and falls which were welcomed from the nursing staff present.	RA
4.3	Infection Prevention and Control up date MDRO procedure	DK presented the Clinical Boards recent IP&C figures: 12 days since last MRSA – this was noted to be on East 2 and the first case since last October. The RCA has been escalated for completion to understand the source and any learning 11 days since last MSSA 17 days since last C Difficile 8 days since last E Coli 7 days post Klebsiella 0 Pseudamonas reported	

		Recent IP&C audits undertaken have highlighted areas of concern and common themes including commodes, environment and hand hygiene. Improvements were noted for bare below the elbow. Actions plans are already been undertaken with timeframes noted for improvement and to be shared with the Clinical Board. DK advised of the new terminology around 'expectation goals' for 2018 rather than expected reduction figures. Improvements noted in the return rate for RCA's to understand any potential learning, with only 6 outstanding. These have been shared with the relevant Senior Nurses for escalation. Psuedamonas and Klebsiella will be Tier 1 targets from this year with RCA's required. With the changes to E Coli RCA's no longer being required it is anticipated that the workload would not increase as the number of Pseudamonas and Klebsiella cases reported are minimal. E Coli will remain a Tier 1 performance indicator. Expectation goals for 2018 are yet to be decided. DK advised that following a review of the Bacteraemia RCA's learning was identified for the following: • Use of PVC pack stickers which does not allow for a clear audit trail • Utilisation of blood culture packs and stickers RA commented that further re-enforcement with the clinicians is required. DK asked to email concerns to RA and RE so that this can be widely cascaded across the Board.	
DIGNIFIED CARE			
5.0	East 8 project up date	ED shared a progress up date for a project being undertaken on East 8 known as 'CWDTCH'. Project has been established since February 2018 with an expected time frame of a year. There has been a slight changes in the nursing establishment with increased HCSW based on the acuity of the patients, and the introduction of activities co-ordinators based on the model ward theory. Aims and objectives are based on the prevention of deconditioning and improvement of patients who are cognitively impaired. Key performance indicators are being monitored around patient falls, healthcare acquired pressure damage, nutrition and length of stay. Meetings are held fortnightly with the nursing staff where staff are free to discuss any concerns that they may have. To date the main concerns noted have been around the acuity of the patients versus the number of registered nursing staff. Patient acuity audit being undertaken. RA recognised that this is an excellent project with the aim of improving how patients with cognitive problems are cared for. Environmental assessments are being undertaken in line with Kings Fund and how to provide care for dementia patients.	
5.1	Engagement with MHSOP – Healthcare support worker exchange programme	ID provided an overview of how UHL and Hafan Y Coed sites can improve working relationships and the care provided to patients. An exchange programme has been established for HCSW to work in clinical gerontology and older mental health wards to share learning and experiences of working in these environments. Competencies and a training package has been undertaken. RA commended this piece of work.	

5.2	HIW feedback Elizabeth Ward	EM provided feedback from the recent HIW inspection of Elizabeth ward. On the whole the feedback report was excellent. Following the report several actions were identified which included environmental decluttering, which has been completed. The provision of medical cover out of hours and access to timely social work input. GP cover is provided by CaV Primary Care during out of hours and weekends. For more urgent advice access to the H@N team based at UHW is available. Written sheets are being reviewed and will be re-issued. Discharge processes are currently being reviewed. The provision of timely speech and language therapy has been identified as a deficit with discussions ongoing with the Directorate and Clinical Board to discuss further. Pressure damage is monitored via the UHB Task and Finish Group recommendations/best practice and shared as part of the wards Tier 1 performance indicators. Bed linen remains an area of concern. KP advised the meeting that a procurement order has not been submitted for the new sheets so would not be available for the next year. RA to raise with RW. IP&C audits continue as part of the wards best practice in conjunction with IP&C colleagues. Medicines management, all staff have been reminded of their responsibility of medication storage at safety briefings. DoLS paperwork, staff have been reminded on safety briefings to ensure that referrals are keep in the front patients' notes for easy access. EM raised concerns regarding the number of documents that required access in this manner, such as DNAMR. The assessment of patients pain, PPDN in conjunction with the Senior Nurse to ensure that the ward are using the approved pain tool and the trigger for the use of the tool is via intentional rounding. Integrated assessment, discussed at safety briefing the importance of completing this assessment in a timely manner. Spot audits to be undertaken. Oral Bundle, the Clinical Board is in the process of rolling out the All Wales Oral Bundle.	RA
TIMELY CARE			
6.1	Emergency Medicine: 'Report on monitoring: Stop Clock'	No information provided. Escalated to newly appointed Directorate Manager AT. To ensure that this information is available and shared at each meeting.	AT
INDIVIDUAL CARE			
7.1	National User Experience Framework Feedback from 2 minutes of your time survey – relevant improvement plans	May's returns were discussed response rate noted to be 68%. Lots of positive feedback noted. On going negative feedback regarding how cold some of the wards are. On patient notes: 'I don't want to complain bit I do feel a little cold. I came in in a hurry so didn't bring a cardigan'.	
7.2	Complaints and trends Compliments & Good news	Continued improvement noted in concerns response rate. Currently 27 open concerns. For May, formal concerns response for 30 days 62%.	

		Lovely compliments shared with the group. Particular reference was made to a poem written by a patient following their stay on West 2 UHL.		
Staff and Resources				
8.1	Staffing levels – All Wales Staffing Act	RA deferred until next meeting in August. To discuss staffing and patient acuity.		
AOB				
'Read about me' flag is on CWS and can be used. Discussions around the fact that it needs a proper launch including the Comms team. Should be linked with the Enhanced Supervision Framework as a means of monitoring compliance.				
PART 2: Items to be recorded as Received and Noted for Information by the Committee				

Date and time of next meeting: 16th August 2018 Right Hand Side Pathology Room

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 8th May 2018, 08:00-10:30 hours
Seminar Room B, A Block, UGF, UHW

CONFIRMED MINUTES

Present:

Richard Hughes	Chair, Consultant Anaesthetist	RH
Linda Walker	Director of Nursing, Surgery CB	LW
Gillian Edwards	Lead Nurse, T&O	GE
Mark Bennion	Clinical Governance Facilitator, Perioperative Services	MB
Rafal Baraz	Consultant Anaesthetist	RB
Catherine Bradshaw	Professional Practice Development Nurse, Surgery	CB
David Scott-Coombes	Quality & Safety Lead, General Surgery	DSC
Catherine Evans	Patient Safety Team	CE
Susan Mogford	Senior Nurse, SSSU, PCAC & Pain	SM
Babs Jones	Perioperative Care	BJ
Simon White	CD, Trauma & Orthopaedics	SW
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Ophthalmology	AJ
In attendance:		
Edwina Shackell	PA, Surgery Clinical Board	ES

	Actions
18/55 Patient Story: General Surgery Incident: In53668 CB provided the timeline of the incident which concerned a colorectal cancer patient admitted for laparascopic surgery. There had been no post-operative bed available on the dedicated ward, T2, resulting in transfer of the patient to ward A2. A doctor review was requested on the Saturday in question. Junior Drs were on duty, the take was busy, resulting in no review being undertaken. The next day, Sunday, the patient was still awaiting medical review. The nurse on duty phoned the duty Dr. The nurse decided to give an enema which they felt was prescribed. The Registrar saw the patient on the Sunday evening, and raised no concerns regarding the giving of the enema. On the Monday afternoon, the patient had chest pain and was reviewed and was thought to have an anastomatic leak. An emergency laparotomy was performed on the Tuesday morning, an anastomotic leak was found which resulted in the patient requiring formation of a stoma. Key findings: 1. The enema had been given without a valid prescription. An enema had been given in pre-operative period and had been signed for. The Nurse felt that the Dr had signed in the wrong place for the enema. 2. There was a clear lack of knowledge from the Nurse's perspective, and the F1 Dr could not recall the giving of the enema being discussed. 3. There was a poor knowledge of the Enhanced Recovery After Surgery (ERAS) protocol, so the notes were non-contemporaneous. Root causes:	

1. The nurse had been slightly preoccupied dealing with patients' concerns, and had lost objectivity. The nurse knew after the enema had been given, that it should not have been given and this constituted a medication error. 2. The lack of a consultant review on the Saturday probably contributed to the incident. 3. Poor understanding of ERAS documentation. 4. The F1 who reviewed the patient on the Sunday evening had been a colorectal F1, so should have known the care pathway. 5. There had been no handover by the SpR to the surgical team, who did not know about the enema. Actions: 1. Prominent posters are in place, that enemas are contraindicated. 2. The member of staff involved will be managed by the Medication Error Management Policy. 3. Teaching on post-operative care incorporated in Drs Training.		
PART 1: PRELIMINARIES *(Chair)*		
18/56	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
18/57	**Apologies for Absence** Received from Carol Evans, Ceri Chinn, Adrian Turk, Clare Wade, Sally Finlay, Graham Roblin, Chris Williams and Claire Mahoney.	
18/58	**Declarations of Interest** None declared	
18/59	**Deployment of Neuraxial ISO 80369-6 devices in the Welsh NHS** The background of this work was described. The NPSA published a series of alerts in 2009 and 2011 requiring the UK NHS to use non-Luer devices for neuraxial bolus doses and infusions. In Wales, the decision had been made to wait for the new International Standard. The group of standards for small-bore connectors for medical use is known as the ISO 80369 series and addresses connectors including Neuraxial applications and major regional anaesthesia (NRFit) (ISO 80369-6) Published March, 2016, for all neuraxial and major regional anaesthesia. Looks like a Luer connector, but is 20% smaller. Unique design features that reduce cross-connections, especially with Luer connectors. Now NRfit will be incompatible with intravenous connectors. Some key suppliers will not have devices ready until end of 2018. Spinal aspiration – needles will be relabelled Long Luer. Epidural infusion in bags/reservoirs: It is acknowledged that epidural infusions would be safer if the reservoirs (bags) could not be attached to an IV giving set, reducing the risk of IV infusion of bupivacaine. The replacement of IV ports or additive ports with neuraxial port connectors on epidural infusion bags is not anticipated in the near future. For the time being, NRFit giving sets will have the usual spike at the reservoir end, and an NRFit connector at the patient end. These bags are kept in Recovery, so still present a risk, but minimized as far as is possible. Availability of devices were summarised, 2 not yet available from current suppliers, Unresolved issues:Hanging drop technique: there is no appetite form industry to make a specific giving set for paeds - CSE NRfit needle through needle (locking) is not currently available - GBUK produces NRfit syringes but stability testing is a problem (24 hours, max 72 hours)	

	- BBraun produce NRfit syringes with good stability testing up to one month but failed on microbiological testing (using GBUK caps) - BD plastipak have not yet produced NRfit syringes Deployment of devices: Aneurin Bevan rolled out, Cwm Taf next to go, then Cardiff, probably mid 2019, in order to wait for all kit to be available and learn from others' feedback. Cardiff: • Neuraxial Task and Finish Group (appointed by the Medical Director) • Chaired by C Morley-Jacob and R Baraz • Regular meetings (multidisciplinary) • Aim to coordinate safe transition Welsh Neuraxial Connector Reference Group: The decision was taken in March 2018 to cease surveillance due to insufficient funding and poor clinician engagement (5%). It was recommended departments do audits on changeover. Discussion: It was acknowledged around the table that identifying and quarantining existing kit at changeover would be challenging. RB explained that it was likely that small discrete areas would be addressed first, e.g. CAVOC. It was agreed that the practicalities would need to be worked out. Financial implications: suppliers would exchange unopened old kit for new.	
18/60	**Approval of the minutes of meeting held 27th March 2018** Approved as an accurate record.	
18/61	**Matters Arising:** To receive Action Log from the above meeting Item 2.1.3 17, May 2011. Checking pregnancy before surgery. LW had emailed Carole Evans on behalf of the Clinical Board. The Anaesthetists had made the decision to follow the guidance and so whist it caused some noise in the system initially this appears to have reduced. This policy remains with C&W to resolve. When LW has received a response, this item will be closed, at next meeting. 17/090: Line insertion service. LW explained current situation. It was recognised that T&O patients at UHL needed a service provided at UHL. Currently patients are transferred from UHL to UHW and back. Dr Turley is working on this. The service would be solely for T&O. Currently anaesthetic colleagues do insert lines on a good will *ad hoc* basis. **Action: SW to speak to Dr Turley to gain clarity** 18/11 Perfusion Cleaning Protocol. The updated protocol had been returned to Perioperative care, BJ had sent to Infection Prevention & Control (IPC) for comment. Update next meeting. **Action: BJ** 18/12: NG77 – October 2017. Management of cataracts in adults. **Action: Chris Williams to provide a response.** 18/31: Workplan 2018-19. Updated. **CLOSED.** 18/32: Terms of Reference Annual Review. No comments received to date. All to check and send comments to ES prior to next meeting. To be signed off next meeting. **Action: ALL** 18/37: PCA Morphine stickers – discussed at Anaesthetic Q&S. **CLOSED**. 18/38: Change from Luer to non-Luer & SBAR. Agenda item. **CLOSED.**	**SW** **CW**

	18/41: NICE Guidance. AWMSG 3035, AWMSG 2224, TA460, TA486, TA467 TA369. **Action: Chris Williams to respond.** 18/41: Patient Safety Notice 040: confirming removal or flushing of lines and cannulae after procedures. New anaesthetic chart designed. **CLOSED.** **Action: MB to carry out a risk assessment and add to the Risk Register**. 18/48: Pressure Damage Report: Agenda item. **CLOSED**.	**MB**
18/62	**Work Plan 2018 – 2019 – for approval** **APPROVED**	
18/63	**Terms of Reference – for approval** Action: All to review and comment. Sign off next meeting.	**ALL**
PART 2: PATIENT SAFETY AND QUALITY		
18/64	**Standing Item: NatSIPPS Progress report** Next meeting 23rd May. All areas converting to LOCSIPPS, a significant piece of work. Link was shared, but it appears not all had access to the link. Perioperative LOCSIPPS in hand, and available to support others.	
18/65	**Director of Nursing Q&S Report March 2018** **Serious Incidents (SIs)@** Open: 15, complex Reported to WG, March: 2 Closures submitted in previous month:4 In37239: infarct of spine In42308: diagnosis of cardiac failure In61850 pressure damage In63626 pressure damage Unopened e-Datix incident forms: 114 – all to open and review as soon as possible. Clinical Audit: nil outstanding Medication errors – 9, which is average for the Board POVAs – 0 VTE assessment documented on drug chart – 80% Noted that A6S (Stroke) should not be included. National Patient Surveys – on S Drive. Concerns: 51. An improvement, 71% responded to within 30 days. Significant progress in directorates to address concerns as informal, 90% of which achieve compliance. Active redresses – 17 Active claims – 135 IPC – 1 x C Diff, B6; 5 E coli, RCAs underway HH – needs to be 100% Duthie – 35% Ward Sister challenging Doctors. General Surgery Microbiology and pharmacy review of drug charts in SAU, and post ICU, patients is which has been a success. However this has now been withdrawn due to microbiology staff shortages.	
18/66	**Healthcare Standards Audit: Actions from Directorates** **Pressure Damage.** 2.3.1 General Surgery, Urology, Head & Neck 2.3.2 Trauma and Orthopaedics	

	Reports were received. LW noted the scale of the work completed within the Clinical Board. Prevalence had improved significantly. This would be discussed at the forthcoming Nursing and Midwifery Board. **Action: LW to report back to next meeting.** The UHB had been successful in securing Hi Lo beds and Promat mattresses for all inpatient beds. Roll out was planned initially for UHL, focussed first on T&O, moving sequentially to Barry, St David's, and finally UHW.	**LW**
18/67	**Directorate Assurance Reports:** 1. General Surgery & Wound Healing – Report to follow. Nil of significance reported. 2. ENT – Report received and noted. 3. Perioperative Services – Report received and noted. Key issues: - QUAD audits currently being undertaken in every theatre. - Robotic surgery SSSU – missing specimen. There had been a 2 day delay in being notified of this due to the mechanism for transporting specimens to the Royal Gwent. Investigation underway. - HSDU is monitoring protein residue on reusable surgical instruments. - EPIPAC. Professor Torkington is working through safety issues with Anaesthetic colleagues. The SOP requires tight fit masks; relevant staff have yet to be fit tested. A start date cannot yet be identified. - Retained arterial cannula tip, main theatres. The cannula had been sent to SMTL for analysis 4. Anaesthetics. Report received and noted. Assurance was received re: - PSN040/Jan 2018 – confirming removal or flushing of lines and cannulae after procedures – circulated 4/4/18 - Letter from the Medical Director regarding staff accessing their own records – circulated 4/4/18. - SBAR "The UK is changing to safer equipment for neuraxial procedures in 2018". **APPROVED** by the Surgery Quality & Safety Sub Group. RB would now take this to Matt McCarthy, Patient Safety. 5. Trauma and Orthopaedics. Report received and noted. Key issues: - Management of Paeds fractures in the Emergency Department (ED).Significant numbers could have had fractures manipulated in the ED. Need to ensure that X-rays are reviewed there, instead of taking patients back to theatre. - One Mandatory training module is covered every month at audit. This practice was commended by LW. The directorate advised that the Safeguarding condensed session completed at last audit had been positively received by medical staff. Perioperative Care had significantly improved compliance through use of e.g. reward certificates. 6. Urology & Ophthalmology. Report to follow.	**AJ**
18/68	**Exception reports from Directorates/Working Groups** ▪ General Surgery, Vascular, Wound Healing - nil ▪ Head & Neck, Maxillo Facial and Ophthalmology- nil ▪ Urology. 2 patients, managed through SSSU, had had robotic partial nephrectomy procedures. ▪ Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: - It was reported that difficulties were being experienced by theatre stores staff in collecting kit from Lakeside stores in a timely fashion. There was a significant backlog in Lakeside stores. NWIS are involved in finding a solution. - Two reports of children with chlorhexadine burns/marks from adhesive on drapes. One had been a 6 hour procedure with the	

	requisite checks for skin integrity throughout. This currently sits with Women & Children. RCA underway. ▪ Trauma and Orthopaedics - nil ▪ Anaesthetics – reported incident in another Health Board where Oramorph had been given intravenously. The advice is always to use an oral syringe for drawing up an oral drug drug. Wards to double check that all wards have oral syringes. **Action: Lead Nurses.**	**LNs**
18/69	**Alerts and other Safety Notices** <u>NICE Guidance</u> 1. Surgery CB summary spreadsheet – see log 2. *IPG601: Dec 2017: Transcutaneous microwave ablation for severe primary axillary hyperhidrosis.* (response to Clinical Audit provided – for Dermatology) <u>Patient Safety Notice</u> 3. *PSN041 March 2018: Risk of Death and Severe Harm from Failure to Obtain and Continue Flow from Oxygen Cylinders harm.* When cylinders stored, turned off, so turn on when administering. 4. *Safe Practice reminder April 2018: for all staff who use portable oxygen cylinders* Received and noted. 5. *International Dysphagia Diet Standardisation Initiative.* To ensure the patient is assessed correctly. New descriptors, changed thickening product, lid does not look to be tamper proof which is a concern given the incidents of patient incidents occurring due to ingestion or breathing in of the powder. Nursing staff to be aware. <u>Internal Safety Notice</u> 6. *ISN: 2018/001: Nursing Staffing Levels (Wales) Act 2016* It was explained that this was in force for staff on staffing on surgical and medical wards. The biggest change was that all Ward Sisters/Charge Nurses will be supervisory, which was to be a cost pressure on the Clinical Board of £0.5m however corporate financial support has been gratefully received. The task now if for each ward to recruit 0.8wte Band 5 to backfill. <u>Other Alerts</u> 7. *Urgent POCT Communication to ALL Glucose and Urine Meter Users* The Surgery Clinical Board had not been invited to this Group. CB is attending. It was emphasised that the patient Case Number bar code must be input and not the NHS number. Any instances of staff badge sharing will be addressed. <u>Welsh Health Circular</u> 8. *WHC 2018/12, March 2018: Never Events List 2018 and Assurance Review Process* Slight changes to all of these were noted. There had been some new never events included such as wrong site blocks and injections, retained surgical devices such as swabs not classed as never events. **Action: All to read**	**ALL**
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
18/70	<u>Key Messages from Board/ Committees/ Groups</u> 1. <u>Medical Equipment Group feedback</u> RH referred to the poorly attended April meeting. All medical equipment related incidents are to be brought to this group, and thence to the MEMG. Thanks were extended to Clinical Board colleagues for their success in submitting equipment bids. 2. <u>UHB Medicines Management Group 19 April 2018</u> To note: the Chronic Pain meeting with Primary Care and colleagues had been deferred to May 16th 2018 at the request of Primary Care colleagues.	

	a. Pharmacy Report to Clinical Board 27 April 2018. Received and noted. b. Clinical Board IP&C Group 23rd April 2018. Minutes to be provided when available. c. Clinical Board H&S Group. Minutes of 7th March received and noted. Verbal update from 18th April 2018 It was noted that the refurbishment of the male changing rooms, Main Theatres, was complete; the female rooms were in progress. Work on the theatre corridor was complete including patient friendly decor; the administration team was due to move imminently. A recent flood via the ceiling in the male changing rooms had unfortunately negatively impacted the new décor. d. UHB Water Safety Group update. No meeting e. Safeguarding Steering Group update. he Group had met at the end of March. Key issues: - New procedure for responding to unexpected death in childhood. - There had been an increase in referrals to the Domestic Violence Adviser (15 referrals per month). - A decrease in DOLS applications was noted, although there was a high volume of patients. f. 12th Neuraxial Task and Finish Group Agenda & Minutes 20th March. Received and noted g. Robot Nephrectomy Operational Group Mr Narahari had submitted a pathway for partial nephrectomy procedures. The following were received and noted: 1. Minutes 27th March 2018 2. Minutes 24th April 2017 3. Minutes 22nd May 2017 4. Trust Policy for New Interventional Procedures. This should read University Health Board (and not 'Trust'). 5. Clinical Pathway for Patients Undergoing Robotic Partial Nephrectomy (RPN) in South Wales An all Wales meeting was noted to be scheduled for Friday 11th May to review M & M data regarding robotic prostate procedures. .	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
18/71	**IP&C RCA database** The following were highlighted: MRSA – 1, Duthie Ward. No evidence of cannula pack used. LW reviewed the incident. There had been poor compliance from medical staff putting stickers in patients' notes, and poor VIP scores which will be addressed. It was highlighted that several wards had been MRSA free for over a year – this would be reviewed and the achievement appropriately celebrated. E .coli - 2 cases.	
18/72	**National and UHB Audit Reports** National Audit of inpatient falls 2017 It was noted that Mr Antony Johansen had presented this at T&O Audit. For the whole of 2017-18 the CB had reported 6 injurious falls. To date the CB has reported 3 which is of significant concern. It was anticipated that the implementation of low rise beds may positively impact on reducing the number of injurious falls. A review of the RCAs will be undertaken to identify the root causes. There were occasions when patients were placed in wrong areas, where patients at risk of falls could not be cohorted. **Action: AJ to liaise with Oliver Williams, Falls Strategy Implementation Lead.**	**AJ**

	It was noted that with effect from 1/4/2018 the Clinical Board and Director of Nursing were mandated to comment if non-compliance with the Nurse Staffing Act was a contributory factor to falls and pressure damage.	
18/73	LIPS Progress Report – End of year progress report Last cohort had not presented due to adverse weather. **Action: GE liaise with Joy Whitlock to determine when this would be rescheduled.**	**GE**
18/74	**Transfusion Committee** 1. Blood Transfusion Committee Minutes of meeting 24th January 2018. Received and noted: - Massive Haemorrhage Policy. A 'dry run' is planned for staff in high risk areas. The impact on Theatres to be considered. 2. Traceability Non-Compliance for April 2018. Failure to confirm one transfusion was noted 3. Blood Transfusion Incident Report 1/12/17 – 28/2/18 Received and noted that there had been a significant improvement	
18/75	Health Care Standards Self-Assessment This had been completed and was ready for submission. Teams were thanked for the information supplied.	
18/76	All Wales Stage 2 Mortality Review Tool Developed and recommended for use. Circulated to CDs. SW and DSC would ensure that this is implemented.	
PART 5: GOVERNANCE		
18/77	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. Open SIs, No Surprises Total 19 outstanding. 2 closures. It was anticipated that the target of 5 closures should be reached for May. It was noted that longstanding SIs were complex. 2. Regulation 28 report & Open Inquests Two inquests: 1 - One date to be confirmed. 2 - Urology 24/5/18. A request had been made for support from the Legal and Risk team. 3. Serious Incidents 1. Closure forms sent to WG since 1st January 2018 – noted. 2. Ombudsman's Report: 201700813 – presentation and actions for noting. In the absence of Mr Chris Williams, a summary of this incident was described by LW which concerned an ophthalmic patient who had been referred between clinics, missed appointments, and subsequently had lost the sight in one eye. The actions required by the Ombudsman had been implemented. 3. Ombudsman's Report: 201701433. The actions required by the Ombudsman were noted. 4. A Just Culture Guide – supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents. Received and noted. 4. Falls Report. Year to date, 3 injurious falls (compared to total of 6 for the previous year). RCAs were underway. 5. Complaints, Claims and other Concerns 1. All New Clinical Negligence claims opened 23/3/18 – 26/3/18	

	2. All Clinical Negligence Claims Settled 23/3/18 – 26/4/18 Received and noted. No themes.	
18/78	**Patient Surveys:** National Survey Report for Surgery (March 2018) "2 Minutes of your Time" (March 2018) Noted.	
18/79	**Research & Development** A Policy for Research Consent and Standard Operating Practice had been circulated by LW for comment. **Action: for comment.** It was noted that this was a requirement for all involved in research trials, including a specific SOP for sponsored research.	**All**
PART 6: DATES OF NEXT MEETING **Tuesday, 3rd July 2018, 08.00 – 10.30. Seminar Room B, UGF, A Bl, UHW.**		
PART 7: URGENT BUSINESS		
18/80	Organ Retrieval. RH informed colleagues that the practice of a receiving visiting surgical transplant team was to use a personal mobile device to record an echo scan on a donor's heart to provide a receiving consultant with an up to date Echo, received in turn on their own personal device. This raised serious concerns regarding Caldicott and patient confidentiality. It was agreed that only a UHB approved device should be used; retrieval teams needed to provide a device approved by the UHB. On a separate issue, SW emphasised the need for a decision regarding the use of 'Whats App'. This had been escalated to the Medical Director. **Action: LW to raise these issues with Specialist Services.**	**LW**
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
18/81	**Recent Reports & Communications** Medical Director's Bulletin April 2018. Received and noted.	
18/82	**Directorate Q&S Minutes.** The following were received and noted for information. 1. Perioperative Care 6th April 2018 2. Anaesthetic Agenda Q&S 17th April 2018 3. Anaesthetic Minutes 17th April 2018 4. Trauma & Orthopaedics Minutes and supporting documents 17th April 2018	

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE (H&S FOCUS)
Tuesday 22 May 2018
8.30am, Council Room, A Block, Upper Ground Floor, Main Hospital UHW

Preliminaries		ACTION
	Welcome & Introductions Cath Heath, Director of Nursing (Chair) Meriel Jenney, Clinical Board Director Mary Glover, Lead Nurse, ACH Directorate Louise Young, Safeguarding Heather Gater, Interim Head of Therapies, Acute Child Health Matt McCarthy, Patient Safety Team Rachael Sykes, Health & Safety Advisor Rim Al-samsam, Interim Clinical Director, Acute Child Health Jane Maddison, Interim Head of Therapies, Community Child Health Paula Davies, Lead Nurse, Community Child Health Cheryl Evans, Directorate Head of Operations & Delivery, Obstetrics & Gynaecology Laura Bassett, Risk Manager, Obstetrics & Gynaecology Eirlys Ferris, Senior Midwife, Obstetrics & Gynaecology Angela Jones, Senior Nurse, Resuscitation Service Alison Jones, Health & Safety Representative, RCN Michelle Abel, Infection Prevention Control Nurse **In Attendance** Kirsty Hook, Board Secretary Linda Hughes-Jones, Safeguarding (presentation) Michelle Moseley (presentation)	
	Apologies for absence Rachel Burton, Ian Sprigmore, Sarah Evans	
	To receive a presentation on the Safeguarding Supervision Project A presentation was provided on the safeguarding supervision project. It was noted that following review of the current programme, the processes for supervision needed review and a pilot study was therefore put into place which has been taken forward over the last 18months. The study was undertaken to review options for group supervision, however acknowledging that 1:1 supervision would still be available if required. Focus groups were set up with the health visiting teams and safeguarding advisors in order to understand the needs for the supervision and evaluate the effectiveness of group supervision. The recommendations from the focus groups was that group supervision would be launched, with a re-evaluation of this in 12months time. The process has changed from 6 monthly on a 1:1 basis to 3 monthly on a group basis. 1:1 supervision is still available should there be a need. It was also noted that peer support is being received by all group members as well as shared learning. On the phone advice is also available to ensure support where required.	

	Signs of Safety Model has been introduced by Cardiff Council across all Cardiff areas and discussions are in process to review options for roll out training across all areas.	
PART 1: HEALTH & SAFETY		
1.1	**To note any specific Matters Arising from the last CB H&S Meeting dated 27th February 2018** **Memorandum of Understanding CCNS** Noted and approved at the last meeting. **Archiving at Lansdowne** This is an ongoing issue due to reduced options for alternative storage at Nant Garw. There are ongoing discussions as to the management and access of the filing facilities. Concerns were raised with regards to the length of time that it is taking to access records and the health and safety risks associated due to poor filing and storage. It was noted that any incidents should be recorded on Datix so that this can be raised appropriately with the Medical Records Department. Discussion ensued with regards to destruction of medical notes and it was acknowledged that the Destruction of Notes Policy is available on the Information Governance Section of the Intranet.	
1.2	**Feedback from UHB Health & Safety Operational Group Meeting** The summary of the points of the meeting were noted for information and a further meeting is scheduled for next week. Refresher Training for Manual Handling & violence and aggression training was discussed and the following noted: - Completion of the Awareness Sessions Module A in both subjects is only required on Induction with no requirement to refresh. - Manual Handling and Violence & Aggression Tutor led foundation courses should continue to be on an assessment basis and to progress this, work is being undertaken within LED on competency needs. - Refresher period for both Manual Handling and Violence & Aggression modules B&C should be reviewed to 2yrly which may be completed by either Classroom update training or competency assessment (undertaken by Link-workers or H&S training staff). - V&A intervention courses such as Level D mental health remain unchanged Legionella Flushing - there was discussion as to the responsibility for flushing. It was noted that the responsibility of the manager for the area to undertake the flushing however this can be delegated as appropriate. Unused outlets should be flushed x3 per week and the use of others is evaluated to ensure there are appropriate flushing mechanisms in place. **Control of Contractors Guidance** The control of contractors' guidance was shared for information to reiterate the requirements and responsibilities for all areas in relation to use of contractors for work that is being undertaken outside of the Capital Estates Department.	
1.3	**To note the latest Health & Safety Report** The report was noted for information. It was acknowledged that there have been significant improvements made in the number of open incidents and work continues to close and action appropriately.	
1.4	**C&W Clinical Board Health & Safety Report Update** The Health & Safety Improvement plan for the Clinical Board was shared for information. The group were asked to review all the information and provide updates back to HG. Reviews of the current risk registers are being undertaken with a deadline of November 2018 for completion. Work is progressing and it was acknowledged that this is a significant piece of work to ensure that the risk register is meaningful.	**ALL**

	It was agreed that the improvement plan would be brought back to the next H&S meeting for ratification.	**HG**
1.5	**COSSH Report for Noting** Noted for information. All were asked to review and ensure that COSSH assessments are carried out appropriately to ensure that all areas are compliant.	**ALL**
1.6	**H&S Alerts** **Sharps on Roof Areas** It was noted that there have been a number of needles etc found on the radiology roofs. A walk around is being undertaken to review areas and undertake some education and raise awareness of responsibility of appropriate disposal of sharps.	
1.7	**Workplace Inspections Update** Work is progressing across all areas and there were no specific issues to report for this meeting.	
1.8	**Feedback from H&S Staff Side** No items to note for this meeting.	
1.9	**Exception Reports and Escalation of key H&S issues from Directorates** Noted as part of item 2.3.	
1.10	**To note the Lone Worker Compliance** Noted for information. It was acknowledged that there has been an improvement of usage for the Clinical Board.	
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**To receive the Minutes of the previous meeting dated 24th April 2018 for approval** The minutes of the last meeting were agreed to be an accurate record.	
2.2	**QSE bring forward action log / Matters Arising** It was agreed that an update on all actions would be provided following the meeting and the action log circulated with the minutes for information.	
2.3	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **ACH** • 5 RCA's ongoing. • NATSSIPS work is ongoing. • Hand Hygiene compliance continues to be high. • There has been an increase in tenfold medication errors and information sharing and shared learning is being undertaken with staff as part of the staff forum. • Therapies RTT is currently at 4 weeks and is from date of referral received. Work is ongoing to deliver zero patients waiting 36 weeks for the end of quarter 1. • Child City Friendly Initiative work is progressing well. • Recruitment processes continue and vacancies are being progressed within nursing and also across therapies services. **O&G** • Safer Pregnancy Clinic Evaluation has been received and it was agreed that this would be shared at the next meeting for information. • Grade 2 pressure area has been reported in Gynaecology associated with a complex patient.	

	• There have been a number of falls have been reported in month, all of which have been investigated. • BFI Accreditation has been received and an action plan is in place to take forward • Formal Opening of the FGM Service has been undertaken • Perinatal Mental Health Service – reviews are being undertaken to determine what is required with regards to a Tier 4 service. • Joint working is being taken forward with Cwm Taf regarding patient safety & quality • Middle tier gaps anticipated for August/September 2018 and a business case is being produced to outline the risks associated with this. **CCH** • Ongoing risk management being undertaken with regards to the Rover Way Gypsy Traveller Site. There have been no further issues reported from Social Services however it was felt that a further meeting was required to risk assess restarting the primary birth visits on site. • Security are now on site at Global Link and a receptionist has also commenced in post which is hoped will improve access to the site. • Use of clinical portal at Ysgol y Deri is problematic and concerns have been raised with regards to access of information. Work is ongoing to resolve this issue. • All therapies waiting lists are being reported under 14 weeks • Statutory Notice for Ty Gwyn Special School has been received due to gaps in therapy services available at the school. There is no additional funding available to support the increased requirements and this will also have an impact on school nursing services. A response has been produced to the recommendations outlined within the School Nursing Framework as there will be significant risks. • 1 RCA has been completed with regards to influenza vaccination being received due to a miscommunication of consent. A full investigation was undertaken and no harm was caused to the patient. • LAC Out of County assessments being required for children placed in ABMU is progressing • Children's Rights work is progressing well and it was agreed that a presentation would be provided at a future meeting in order to provide a detailed update of the work being taken forward.	**PD**
2.4	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** No items to note for this meeting.	
2.5	**Paediatric Surgery Update** Risks continue however a positive report has been received from the Deanery and an action plan has been developed to progress the recommendations and requirements. The junior staff position is anticipated to be improved from July 2018 and further consultant appointments due to commence in July 2018.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	Initiatives to promote health and wellbeing of Patients / Staff • Resilience day held on May 4th in line with International day of the Midwife supported by the RCM Cardiff Branch	
SAFE CARE		
4.1	**Update on Serious Incidents** 7 open at present and x2 closure forms are with the Nurse Director for sign off. Good progress has been made and it was noted that all incidents prior to 2018 have now been actioned.	
4.2	**SBAR wrong route medication error Datix 259247** The case involved a patient being given the standard epidural solution through the intravenous venous cannula as opposed to the epidural catheter. The error was immediately and the	

	administration was discontinued. Maternal observations and wellbeing were assessed and the error reported to the anaesthetic registrar and the coordinator. Review of the patient was undertaken immediately and the patient informed of the error. **Root causes** • There was a delay in going to theatre due to the obstetric team being in theatre with another case resulting in the midwife administering a standard epidural top up to the patient in the room following an anaesthetic review. • The midwife did not undertake a full assessment prior to the administration of the epidural solution and due to distractions at the time this was administered intravenously. • Although human error occurred if there was an appropriate physical safety mechanism available to prevent misconnection this medication error would have been avoidable. **Lessons Learnt** • It would have been common practice for the attending anaesthetist to administer the epidural top up prior to transferring to theatre himself so that midwife 3 could focus on preparing LH for theatre. However, due to an anticipated delay in transferring LH to theatre, it was reasonable for the anaesthetist to ask midwife 3 to administer a routine 10ml epidural top up to ensure LH was comfortable prior to her transfer to theatre. • Midwives should, however, be encouraged to request help if they feel that this is required. • Clarity is required to ensure that both anaesthetists and midwives are aware of their roles when a decision has been made to transfer a patient to theatre. In times of peak activity it is important to ensure clear role distinctions and ensure any potential risk to patients are minimised through appropriate escalation if these roles cannot be fulfilled safely. The SBAR was approved and it was agreed that the closure form would be submitted to Welsh Government for sign off.	**MM**
4.3	**Infection Prevention Control Update** The report was noted for information. • New faecal testing will be introduced from July 2018 and for paediatrics under 2yrs will not be tested and will follow the current C Diff algorithm • Study Day for Infection Control has been shared for information • Assessment of infectious status for all patients should be completed and paperwork is available on the intranet pages • Antibiotic audit continues in Obstetrics & Gynaecology and feedback has been provided on the last 3 months of data which has improved significantly and continues	
4.4	**Safeguarding** Standard Operational Procedure has been produced for the Clinical Board and outlines the safeguarding programme and training being taken forward throughout the year which is available for all staff. It was agreed that this information would be circulated following the meeting. **Violence Against Women – Ask & Act Training** It was noted that this training will be required for all staff and this will be rolled out from September 2018– March 2019 for the first tranche of training as per requirements from Welsh Government. This is a significant piece of work that will be required to be taken forward, however it was acknowledged that the training resources have not yet been developed.	**LY**
4.5	**Patient Safety / MDA Alerts (internal/external)/WHC** • MDA/2018/012 - BD Vacutainer® EDTA & BD Vacutainer® Lithium Heparin Tubes – risk of incorrect results for lead testing or other assays using ASV methodology • MDA/2018/013 - cobas b 221 instruments with AutoQC module – software limitation affecting automatic QC measurements	

	• MDA/2018/014 - Infinity Acute Care System and M540 Patient Monitors software versions VG2.2-VG6.0 – risk that alarms are not activated • Internal Safety Notice 2018/002 - IDDSI Texture descriptors • Public Health Link - Valproate Contraindicated In Women Of Childbearing Potential Unless There Is A Pregnancy Prevention Programme The above patient safety and medical device alerts were shared and noted for information. There were no exceptions to report and the group were asked to ensure that all alerts are widely disseminated.	**ALL**
5.1	**Latest Cleaning Scores Report** The latest cleaning scores report was shared for information. The Clinical Board are currently reporting a position of 97%.	
6.1	**Update on latest 2 minutes of your Time feedback.** Work is progressing across all three Directorates in relation to 2 minutes of your time. There was no specific feedback to note for this meeting.	
STAFF AND RESOURCES		
7.1	Feedback on current position for PADR and Sickness was noted. With regards to PADR, figures for April have been reported by 62% and work is progressing to further improve the compliance. It was noted that within England, the pay award has been linked to PADR and further information is awaited as to whether this position will be the same within Wales. The breakdown position by Directorate was noted: ACH – 65% CCH – 63% O&G – 65% In relation to Sickness – improved sickness figure for April has been reported at 4.1%. There were no specific issues to note.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
8.1	**To note the Screening Annual Report for Public Health** Noted for information. It was noted that cervical screening has decreased slightly however there are no specific issues that need to be highlighted.	
ANY OTHER BUSINESS		
	Update on the Paediatric Resuscitation Practitioner Business Case AJ agreed to forward the business case through for comment and once agreed this would be taken to the Resuscitation Committee for final approval.	**AJ**
DATE AND TIME OF NEXT MEETING		

The next meeting is scheduled for **Tuesday 26th June, 8.30am, Meeting Room, Clinical Board Offices, Lakeside (Quality & Safety Focus)**

<u>Remaining 2018 Meeting Dates</u> (4th Tuesday of the Month, between 8.30 – 10.30am unless otherwise stated below)

Tuesday 24th July, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 28th August, Venue to be confirmed (H&S Focus)
Tuesday 25th September, Meeting Room, Clinical Board Offices, Lakeside

Tuesday 23rd October, Venue to be confirmed
Tuesday 27th November, Meeting Room, Clinical Board Offices, Lakeside (H&S Focus)
Tuesday 18th December, Meeting Room, Clinical Board Offices, Lakeside

Dental Clinical Board

Minutes of Quality, Safety & Experience Committee Group Meeting
Thursday 28 June 2018 ~ 8 – 10 am
Annexe Seminar Room, University Dental Hospital

Present:

Andrew Cronin (Chair) (AC)	Rowena Griffiths (RG)	Catherine Evans (CE)
Gurcharn Bhamra (GB)	Julia Charles (JC)	Barbara Chadwick (BC)
Caroline Sutton (CS)	Shannu Bhatia (SB)	Emma Stone (ES)
Nick Drage (ND)		

Apologies:

Eira Yassien (EY)	Ivor Chesnutt (IC)	Diana Wakefield (DW)
Dinah Jones (DJ)	Mike Lewis (MAOL)	James Gillespie (JG)

In Attendance:
Ruth Taylor (RT) - Minutes

		ACTION
PRELIMINARIES		
1.1	**Welcome & Introductions** AC welcomed everyone to the meeting of the Quality, Safety and Experience Group. AC welcomed CS, Medicine Supply Manager, to her first meeting as Pharmacy Representative following an update to the Terms of Reference. The group provided brief introductions.	
1.2	**Apologies for absence** Received as above.	
1.3	**To receive the Minutes of the previous meeting** The minutes of the Quality, Safety & Experience meeting held on the 3 May 2018 were reviewed and confirmed to be accurate and correct. **Matters Arising** There were no matters arising.	
MONITORING & REPORTING – DENTAL CLINICAL BOARD SUB GROUPS		
2.1	**Oral Surgery, Medicine, Pathology & Radiology** **- Mr N Drage** The minutes from the OSMP Audit Group meetings held on 16 May 2018 and 14 June 2018 were received and noted. ND reported that Joelle Mort presented a completed audit on sharps incidences at the May audit. This compared the number of sharps incidences before and after the implementation of the adapted WHO checklist in Oral Surgery. This showed a marked improvement with 30 incidences occurring prior to implementation and only 10 afterwards. It was noted that there was no pattern to the injuries, but following implementation, it was noted to be the DCTs who were suffering the injuries rather than any other staff group. It was noted that there were 22 incidences of sharps being left on trays (near miss) prior to the checklist being implemented and this reduced to 7	

	afterwards. The question was raised as to whether there were any repeat offenders and AC will discuss this with Niki Wood. It has been agreed to roll out the adapted WHO checklist to all areas where extractions occur. This will include deciduous teeth. AC has agreed to compose an email to all staff informing them of the introduction of the form to all areas, and this will be circulated by RT. Phil Atkin chaired the June OSMP audit meeting where the break glass presentation was given. Melanie Wilson presented the initial findings of the antimicrobial audit and the final data should be available for presentation at the end of the year. Discussion was had over previous audit presentations and where they were stored. RT has agreed to speak with Debbie Preece/Jonathan Peck to ensure they are all stored centrally and can be easily accessed.	**AC** **AC/RT** **RT**
2.2	**Restorative Dentistry - Mr G Bhamra** The minutes from the Restorative Audit Group meeting held on 23 May 2018 and 21 June 2018 were received and noted. Emma Stone gave presentations on DATIX incident reporting and patient identification and MAOL gave a presentation on Never Events. Wayne John from Colten gave a presentation titled 'Brilliant Crios; Reinforced composite Bloc for permanent CAD CAM restorations'. Projects have been arranged with the undergraduates and DCTs for September looking at using composite rather than ceramic. This change is likely to lead to a significant cost saving. Fitzroy Hutchinson attended the June meeting to provide a presentation on Environmental Management. There was also a case presentation by Polyvios Charalambous on an 'Integrated restorative case; Holistic Approach'. Abdullah Al Telmesari presented a 'Retrospective audit on the incidence of root canal flare-up associated with patients seen in MClinDent endodontic programme by postgraduates at Cardiff University from September 2014 to July 2017. This showed that we are within the reported standards. It was suggested that we evaluate how antibiotics are being prescribed and look at the details as to how we manage these patients in future.	**MAOL**
2.3	**Joint Orthodontic and Paediatric Dentistry - Ms S Merrett & Mrs S Bhatia** The minutes of the Joint Orthodontic and Paediatric Dentistry Audit Group meeting held on 16 May 2018 were received and noted. The first part of the meeting was used as a specialist training session. Jeni Bone from Action on Hearing Loss attended and provided a very interesting presentation on treating patients with hearing loss. MAOL attended to provide a Never Event presentation. The minutes from the meeting held on 14 June were not available due to lack of secretarial support. The handwritten notes of this meeting are however available. The meeting was split into two with paediatric staff attending paediatric BLS for the latter part of the meeting. There was one patient story presented which related to safeguarding concerns around a paediatric patient with multiple caries. The patient had been treatment planned, including requiring GA, but DNA'd multiple appointments. The father also exhibited aggressive behaviour. The main issues related to parental responsibility and the father requesting a change of address. The case is to be discussed with the social worker to see if dad should be included in correspondence, along with the social worker, to try and encourage attendance. Yvonne Jones presented a completed retrospective audit on twin blocks appliances on behalf of a final year student. This showed a 17% DNA rate with an overjet recorded in 100% of patients. It showed that girls were more successful than boys. This audit will be repeated in future as part of a final year project.	

	New guidance from WG on the prevention of dental caries in the 0 – 3 year age group was tabled and staff have been asked to ensure they are up to date with the changes. Concerns were raised with regard the recording of audits whilst JP has been away. AC has requested that each audit lead send a list of all completed audits to JP in order for the database to be updated accordingly. There had been concern that a cost was going to be incurred for the provision of mouth guards. The lab have now confirmed that patients requiring a mouth guard as part of their treatment will not be charged.	
2.4	**Community Dental Service - Mr J Gillespie** The unconfirmed minutes from the CDS Quality and Safety Meeting held on 15 March 2018 were received and noted. JG was not in attendance and no report was provided.	
2.5	**Occupational Health and Safety Advisory Group (OHSAG) – Dr M Wilson** The unconfirmed minutes from the Dental Clinical Board and School Health and Safety Advisory Group held on 6 June 2018 were received and noted. MW was not in attendance and no report was provided.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	**Health and Care Standards Monitoring data** Not discussed	
3.2	**Consent** Not discussed	
3.3	**Patient Identification Policy** ES gave an informative presentation on a patient identification audit that had recently been undertaken. This audit was undertaken on the back of an improvement plan following an investigation in to a never event relating to wrong site surgery. As part of the improvement plan, we are required to review our identification policy and how it applies to our practice and ensure it is reinforced throughout the Clinical Board. ES performed an audit whereby she observed 70 patient interactions. She was looking to see whether the clinician asked the patient to confirm their name, address and date of birth. Out of the 70 observations, there was only 3 occurrences whereby the clinician asked all three questions. This highlights a limited understanding of the patient identification policy within UDH and that staff need to be aware of these guidelines and that they are best practice. The policy is available for all staff on CAVWeb. JC confirmed that an electronic wrist band printer is due to be installed in GA Theatres shortly. SB has requested that ES present this again at the Paediatric audit.	**ES**
3.4	**Audit Plan** Not discussed	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		

4.0	**WHC/2015/001 - Improving Oral Health for Older People Living in Care Homes in Wales – Dinah Jones** DJ sent her apologies. This was not discussed. **WHC 2008 (008) – Designed To Smile – Dinah Jones** DJ sent her apologies. This was not discussed.	
SAFE CARE		
5.1	**Risk Register- Rowena Griffiths** RG confirmed that this is being reviewed and revised.	
5.2	**Incident Reports** The incident report dated May – June 2018 was received and noted. JC stated that In69353 did not occur in GA Theatres and therefore the location needs to be amended. ES presented her investigation into the never event that occurred on the Sedation Suite on 8 November 2017. The improvement plan recommended the Dental Clinical Board should: • Consider the roll out of the adapted WHO checklist across all clinical areas that carry out extractions • Identify invasive dental procedures and develop Standard Operating Procedures. • Review the role and responsibility of the Dental Nurse in their role of assisting during dental procedures and the second person in tooth identification for dental extractions. • Review the methods used for sharing the learning from Never Events and other incidents to ensure all staff are made aware of any changes to practice to reduce the risk of a reoccurrence. In response to these recommendations, it was confirmed that Matthew Thomas and Leili Sadaghiani are taking the lead on developing a LocSSIP for root canal treatment. The GDC have confirmed that a dental nurse is able to second check a tooth prior to extraction/dental work and a presentation on never events has been added to all DCT/student inductions. An educational day is scheduled to take place in July and never events will be on the agenda to raise awareness, especially with restorative tutors.	
5.3	**Medicines Management Audit Report – Rowena Griffiths** Not discussed.	
5.4	**New Medical alerts** The following Patient Safety Notices were reviewed and noted. • **PSN042 / April 2018** Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids • **PSN043 / May 2018** Supporting the introduction of the Tracheostomy Guidelines for Wales • Tracheostomy Guidelines for NHS Wales	
5.5	**Medical devices/equipment issues**	

	The following medical device alerts were noted: • **MDA/2018/012** BD Vacutainer® EDTA & BD Vacutainer® Lithium Heparin Tubes – risk of incorrect results for lead testing or other assays using ASV methodology • **MDA/2018/013** cobas b 221 instruments with AutoQC module – software limitation affecting automatic QC measurements • **MDA/2018/014** Infinity Acute Care System and M540 Patient Monitors software versions VG2.2-VG6.0 – risk that alarms are not activated • **MDA/2018/015** Gambro Ultrafilter U9000 microbial water filter for haemodialysis – risk of hypovolemia due to filter leaks during use • **MDA/2018/019** JM103 and JM105 Jaundice Meters – risk of misinterpretation of measurement in hyperbilirubinemia cases	
5.6	**Decontamination CDS WHTM01-05** Not discussed	
5.7	**HIW Inspections and report** There was nothing to discuss.	
5.8	**Infection, Prevention & Control** **Clinic inspection reports and improvement plans** Nothing to discuss	
5.9	**NatSSIPs – Julia Charles** The LocSSIPs Tookit for Dental Extractions was circulated prior to the meeting. AC has requested that this is reviewed by the group and any comments are passed to RT for further discussion at the next meeting.	**ALL**
EFFECTIVE CARE		
6.1	**Monitoring of CB Clinical Audit plan** Not discussed	
6.2	**Research and development** Not discussed	
DIGNIFIED CARE		
7.1	**Initiatives to improve services for people with:** • **Dementia** Not discussed. • **Sensory loss**	

	Not discussed • **Mental Capacity Act** Not discussed.	
TIMELY CARE		
8.1	**RTT – Mrs E Yassien** EY sent her apologies. No report was provided.	
8.2	**LIPS Bariatric Pathway** Not discussed	
INDIVIDUAL CARE		
9.1	**Concerns** The concerns report dated February – June 2018 was received and noted. RG noted that a concern relating to an oncology patient has now been taken out of redress and will be pursued through the Claims Court. This is likely to have a larger impact on the Clinical Board.	
9.2	**Compliments** The compliments report dated May - June 2018 was received and noted.	
9.3	**Safeguarding – Professor B Chadwick** The Safeguarding Team Newsletter – Spring 2018 was circulated and noted.	
STAFF AND RESOURCES		
10.1	**Employee of the Month** May 2018 – Sheila Oliver, Consultant in Special Care Dentistry June 2018 – Julie Andrus, Dental Nurses, Peripheral Hospital Dental Service.	
10.2	**Staffing levels – Eira Yassien** EY sent her apologies. This was not discussed.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
	The following documents were tabled at noted: • WHC/2018/020 - AMR improvement goals & HCAI reduction expectations by March 2019: Primary & secondary care antimicrobial prescribing goals; C.Difficile, S.Aureus bacteraemias and gram negative bacteraemias • WHC/2018/021 - Raising awareness of Lyme disease and ensuring prompt and consistent diagnosis and treatment • WHC/2018/023 - The National Influenza Immunisation Programme 2018-19 • Public Health Link from the Chief Medical Officer for Wales - Influenza Season 2017-18 – Cessation of use of antivirals now recommended • Adapted WHO Checklist It has been agreed that this will be rolled out to all areas that undertake extractions, including deciduous teeth. Official correspondence will be circulated by AC/IC.	IC/AC

Any Other Business		
	A Safety Walkaround is due to take place in OMFS on 12 July 2018. AC requested that the following documentation is reviewed prior to the next meeting: • WHC(2018)009: Dental Services - Service Standards for Conscious Sedation in a Dental Care Setting RG wished to remind the group about the DSDU repair and replace form. This follows on from an incident relating to a rubber dam clamp breaking. Staff are reminded to ensure that floss is attached to the clamp before use. Broken items should not be disposed of, but returned to DSDU with a repair/replace form. This ensures that clinics are not issued with a non-conformance for lost equipment. Carol Evans and CE are preparing a written summary of all our never events for Ruth Walker. Carol has asked for the approximate number of tooth extractions and RCTs that we do each year. It was agreed that this data should be obtainable, but it should also include figures from SSSU and CHfW.	

Date and time of next meeting:

Thursday 30 August 2018	8.00 -10.00 am	TBC