Bundle Quality, Safety and Experience Committee 19 February 2019

Agenda attachments

00 - Agenda QSE February v3.docx

1	PRELIMINARIES
	Susan Elsmore
1.1	Welcome and Introductions
	Susan Elsmore
1.2	Apologies for Absence
	Susan Elsmore
1.3	Declarations of Interest
	Susan Elsmore
1.4	Minutes of the Committee held on 18 December 2018
	Susan Elsmore
	1.4 - Minutes December v3.docx
1.5	Action log from 18 December 2018
	Susan Elsmore
	1.5 - Action Log v2.docx
1.6	Chairs Action taken since last meeting
	Susan Elsmore
1.7	GOVERNANCE, LEADERSHIP & ACCOUNTABILITY
1.8	Patient Story
	Kay Jeynes
	1.8 - Patient Story.pptx
1.9	PCIC Clinical Board Assurance Report
	Kay Jeynes
	1.9 - PCIC Assurance Report Feb 2019 v2.docx
	1.9.1 - PCIC Assurance Report Feb 2019 - Appendix 1 (003).docx
1.10	Revised Board Assurance Framework - Quality, Safety and Experience Focus
	Nicola Foreman
	1.10 - BAF - covering report[2290].docx
	1.10.1 - BOARD ASSURANCE FRAMEWORK (JAN 19).docx
1.11	Gosport Independent Panel Report
	Carol Evans
1.11	Gosport War Memorial Hospital; the Report of the Gosport Independent Panel
	Carol Evans
	1.11 - Gosport Inquiry.docx
1.12	Committee Governance:
1.12.1	Work plan
	Nicola Foreman
	1.12.1 - QSE Work plan 2019.20 - covering report[2289].docx
	1.12.1.1 - QSE workplan v2 19.20.xlsx
1.12.2	Terms of Reference
	Nicola Foreman
	1.12.2 - QSE Terms of Reference - covering report[2288].docx
	1.12.2.1 - QSE Terms of Ref Feb 2019.docx
1.12.3	Annual Report
	Nicola Foreman
	1.12.3 - QSE Annual Report - covering report[2291].docx

1.12.3.1 - QSE Committee Annual Report.docx

1.12.4 Effectiveness Review

Nicola Foreman

1.12.4 - QSE Self Assessment - covering report[2290].docx

1.12.4.1 - QSE Self Assessment (Short Version)-blank[2287].docx

1.13 Policies for Approval:

1.14 THEME 1: STAYING HEALTHY (HEALTH PROMOTION, PROTECTION AND IMPROVEMENT

1.14.1 No papers to be submitted

2 THEME 2: SAFE CARE

2.1 Assessment Unit University Hospital of Wales - response to the Community Health Council concerns

Rebecca Aylward

2.1 - Assessment Unit.docx

2.1.1 Assessment Unit Response to CHC - Appendix 1

2.1.1 - Updated - CHC ASSESSMENT UNIT IMPROVEMENT PLAN OCTOBER 2018 (003) 4th F.._.docx

2.2 Concerns and Clinical Negligence Claims

Angela Hughes

2.2 Claims and Concerns.docx

3 THEME 3: EFFECTIVE CARE

3.1 Mortality and Harm:

3.1.1 National Emergency Laparotomy Audit

Graham Shortland

3.1.1 - QSE NELA 18.02.19.docx

3.1.2 Heart Failure Services

Graham Shortland

3.1.2 - QSE heart failure 18 02 19.docx

3.1.2.1 - QSE Heart failure - Appendix 1.doc

3.1.2.2 - QSE heart failure - Appendix 2.xlsx

4 THEME 4: DIGNIFIED CARE

4.1 No papers to be submitted

5 THEME 5: TIMELY CARE

5.1 Management of Endoscopy Surveillance Patients

Steve Curry

5.1 - Management of endo surveillance QSE report (Final).docx

6 THEME 6: INDIVIDUAL CARE

6.1 S16 Ombudsman Report

Angela Hughes

6.1 - Ombudsman sec 16 report QSE Feb 19.docx

6.1.2 - ACTION PLAN 201706982.pdf

7 ITEMS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE

7.1 Minutes from Clinical Board Quality, Safety and Experience sub Committees - Exceptional items to be raised by teh Assistant Director, Patient Safety and Quality

Carol Evans

7.1.1 Clinical Diagnostics and Therapeutics - after July 2018

Steve Curry

7.1.1 - CDT CB - Minutes 12.12.18.docx

7.1.2 Mental Health - after July 2018

Steve Curry

7.1.2 - 13 Sept 2018 Minutes.doc

7.1.2.1 - 17 October 2018 Minutes.doc

7.1.2.2 - 15 November 2018 Minutes.doc

7.1.3 Primary, Community and Intermediate Care - after May 2018

Steve Curry

7.1.3 - PCIC QSE Committee DRAFT mins July 2018 v2 KJ.docx

7.1.3.1 - PCIC QSE Committee DRAFT mins Sept 2018 (002) KJ.docx

7.1.3.2 - PCIC QSE Committee DRAFT mins Nov 2018 (2) KJ.docx

7.1.4 Specialist Services - After July 2018

Steve Curry

7.1.4 - CF - SS Minutes Draft QSE 9th August 2018.doc

7.1.4.1 - SS Minutes QSE 31st August 2018 (Autosaved).doc

7.1.4.2 - SS Minutes QSE 20.09.18.doc

7.1.4.3 - SS Minutes QSE 12.10.18 final.doc

7.1.4.4 - SS Minutes QSE 01.11.18 Final.doc

7.1.5 Medicine - After June 2018

Steve Curry

7.1.5 - Medicine Clinical Board QSE Minutes 20.12.18.doc

7.1.6 Surgery - after May 2018

Steve Curry

7.1.6 - SCB QS Minutes 2018 11 06.docx

7.1.7 Children and Women - after May 2018

Steve Curry

7.1.7 - Att 6 C&W QSPE Minutes 26.06.18.docx

7.1.7.1 - Att 1 C&W QSPE Minutes 28.08.18.docx

7.1.7.2 - Att 1 CW QSPE Minutes 27.11.18 (002).docx

7.1.8 Dental - after June 2018

Steve Curry

7.1.8 - Dental CB - Q&S Minutes - 10.1.19.docx

8 ITEMS TO BRING TO THE ATTENTION OF THE COMMITTEE AND THE BOARD

8.1 Nothing to report

9 REVIEW OF THE MEETING

Susan Elsmore

10 DATE AND TIME OF NEXT MEETING:

10.1 17 April 2019 at 9.00am, Corporate Meeting Room, UHW

Susan Elsmore

AGENDA
QUALITY, SAFETY & EXPERIENCE COMMITTEE
19th February 2019 at 9am
Corporate Meeting Room, HQ, University Hospital of Wales

1.	**Preliminaries**	
1.1	Welcome & Introductions	Susan Elsmore
1.2	Apologies for Absence	Susan Elsmore
1.3	Declarations of Interest	Susan Elsmore
1.4	Minutes of the Committee Meeting held on 18th December 2018	Susan Elsmore
1.5	Action Log from 18th December 2018	Susan Elsmore
1.6	Chairs Action taken since last meeting	Susan Elsmore
1.7	**Governance, Leadership & Accountability**	
1.8	Patient Story	Kay Jeynes
1.9	PCIC Clinical Board Assurance Report	Kay Jeynes
1.10	Revised Board Assurance Framework – Quality, Safety and Experience Focus	Nicola Foreman
1.11	Gosport Independent Panel Report	Carol Evans
1.12	Committee Governance • Work plan • Terms of Reference • Annual Report • Effectiveness Review	Nicola Foreman
1.13	**Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)**	
1.14	No papers to be submitted	
2	**Theme 2: Safe Care**	
2.1	Assessment Unit University Hospital of Wales – response to the Community Health Council concerns	Rebecca Aylward
2.2	Concerns and Clinical Negligence Claims	Angela Hughes
3.	**Theme 3: Effective Care**	
3.1	Mortality and Harm • National Emergency Laparotomy Audit • Heart Failure Services	Graham Shortland
4.	**Theme 4: Dignified Care**	
4.1	No papers to be submitted	
5.	**Theme 5: Timely Care**	
5.1	Management of Endoscopy Surveillance Patients	Steve Curry
6.	**Theme 6: Individual Care**	
6.1	S16 Ombudsman Report	Angela Hughes
7	**Items Received and Noted for Information by the Committee**	
7.1	Minutes from Clinical Board Quality Safety and Experience Sub Committees – Exceptional Items to be raised by the Assistant Director, Patient Safety and Quality	Carol Evans
7.1.1	Clinical Diagnostics and Therapeutics – after July 2018	Steve Curry
7.1.2	Mental Health – after July 2018	
7.1.3	Primary, Community and Intermediate Care – after May 2018	
7.1.4	Specialist Services – after July 2018	

7.1.5 **7.1.6** **7.1.7** **7.1.8**	Medicine – after June 2018 Surgery – after May 2018 Children and Women – after May 2018 Dental – after June 2018	
8	**Items to bring to the attention of the Board/Committee** Nothing to report	Susan Elsmore
9	**Review of the Meeting**	Susan Elsmore
10	**Date and time of next Meeting: 17 April 2019 at 9.00am, Corporate Meeting Room, UHW**	Susan Elsmore

MINUTES OF A MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON 18TH DECEMBER 2018 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:		
Maria Battle	MB	Chair
Abigail Harris (Part)	AH	Director of Planning
Akmal Hanuk	AK	Independent Member – Community
Dawn Ward	DW	Independent Member – Trade Unions
Professor Gary Baxter	GB	Vice Chair/Independent Member – Cardiff University
Dr Fiona Jenkins	FJ	Director of Therapies and Health Sciences
Dr Graham Shortland	GS	Medical Director
I Wile	IW	
Angela Hughes	AH	Asst. Director Patient Experience
Carol Evans	CE	Asst. Director Patient Safety and Quality
Michael Imperato	MI	Independent Member – Legal
Ruth Walker	RW	Executive Nurse Director
Nicole Foreman	NF	Director of Corporate Governance
Jayne Tottle	JT	Clinical Board Nurse – Mental Health
Susan Elsmore	SE	Councillor – Independent Member
Jennifer Jenkins	JJ	Director of Therapies & Health Science
Secretariat:	HB	Helen Bricknell
Apologies:		
Annie Proctor	AP	Clinical Board Director
Fiona Kinghorn	FK	Consultant in Public Health
Robert Chadwick	RC	Director of Finance

QSE 18/185	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
QSE 18/186	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
QSE 18/187	**DECLARATIONS OF INTEREST** There were no declarations of interest made.	
QSE 18/188	**MINUTES OF THE MEETING HELD ON 16 OCTOBER 2018** The minutes of the meeting held on 16 October 2018 were reviewed and confirmed to be an accurate record. **Resolved that**:	

	The minutes of the meeting held on 16th October were approved by the Committee as an accurate record.	
QSE 18/189	**ACTION LOG FOLLOWING THE LAST MEETING** **QSE 18/144** – Work to support the Blood Inquiry was ongoing. **QSE 18/138** – Cleaning Standards - There are some excellent patient stories to share from Estates and Facilities. They have a great performance data dashboard. Action complete. **QSE 18/135** - Still awaiting Ombudsman Public letter to be released by the Ombudsman. **QSE 18/155.1** –Welsh Government package of deals around securing urgent monies for urgent capital clinical schemes is being taken forward. Update to be provided at the February meeting. **QSE 18/177** - Hot Topics – action would be discussed later in the meeting. **Resolved that:** Members of the Quality, Safety and Experience Committee received and noted the action log.	RW AH
QSE 18/190	**PATIENT STORY** The patient story was introduced and the following comments were made: • A letter had been received from the daughter of a patient with Alzheimer's Disease where all teams (including the ELPOP team support workers) had worked together to get the very best results for the patient. • Referrals were made to Third party services such as the British legion Admiral service on discharge to support the patients and families and to help to reduce length of stay. • Work was currently being undertaken within Mental Health Services inpatient areas which had led to a significant reduction in specialising, money savings and improved quality of care to patients. This work included an In-Reach service Clinical Model at Llandough. • There was dementia training for CAV UHB staff but training was enhanced when the team train staff on-the-job whilst they are supporting the patient **Resolved – that:** (a) The Mental Health Clinical Board provided good assurance that they are taking learning and taking action from patient stories. (b) Assurance was required that the Clinical Board had an agreed plan for Medical Care at Hafan y Coed and the Llanfair Unit.	SC

QSE 18/191	**MENTAL HEALTH CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE ASSURANCE REPORT** The Mental Health Clinical Board introduced their assurance report and the following comments were made: • Length of stay for older people was almost double the national average so a Project Manager had been appointed to undertake improvement work to try to the reduce length of stay over the next 12-month contract. There were only two Senior Nurses so a Band 7 has been appointed to work closely with the Project Manager. The Complex Care Commissioning Team has also expanded. • Working Time Directive - small progress had been made with some shift pattern changes on some of the wards which allowed the UHB to be compliant with the Health & Safety regulation in allowing staff to have meal breaks off the ward. The Clinical Board will continue to look at this but were struggling to meet complete compliance due to funding restrictions. This was discussed at the Strategy & Delivery Group and the Clinical Board agreed to address this in their IMTP. • Adult Care admissions were discussed and it was noted that on a particular day 27% of patients did not need to be in on that day. • Nurse recruitment was good in this area because the nursing staff were well supported, therefore there were no issues recruiting nurses to the Clinical Board. • Concern was expressed that the percentage of the staff responding to the staff survey was disappointingly low and also the responses were disappointing. Issues such as sickness and bullying were of particular concern. • Police forces were doing a lot of training with regard to supporting the UHB when issues occur. One policewoman would be based in an office at Hafan y Coed. **Resolved – that:** (a) The Committee approved the actions being taken by the Mental Health Clinical Board. (b) The action update be noted. (c) The Committee would like to see the Project Plan at the April Committee Meeting.	SC
QSE 18/192	**PRESENTATION ON PATIENT SUICIDE (TOLERANCE)** The presentation was introduced and the following comments made. • The background of the suicide was that approximately every 2 months 11 community deaths of patients known to the mental health services are reported as SI's. Not all the deaths are suicides. Mental Health Capacity Act Committee members had been invited to attend the presentation. • NCAS report for last year had been recently published. This showed that there were 11 suicides from January to October which was just slightly under the national average for the UK. Most	

	instances of death were drug overdoses or natural causes. 73% of suicides were people not known to the mental health services. • There were approximately 5,000 people on community caseloads across adult and older people services in any one year. • Referral rates seemed to be doubling every 4-5 years; 35,000 were currently being referred annually. • Chaplaincy had been very helpful at the Llandough site but this had been more difficult in the community. **Resolved – that:** The Committee noted the presentation on patient suicide.	
QSE 18/193	**TAWEL FAN REPORT** The report was introduced and the following points raised during discussion by Committee Members: • In North Wales there had been a number of reports about the care provided by Tawel Fan. The biggest issue was that the patient's relatives' voices were not being listened to when they were raising concerns about patient care. • The Mental Health Clinical Board shared with QSE Committee the actions they were taking in order to prevent the poor practice in Tawel Fan occurring in Cardiff & Vale University Health Board. They explained that data was being collated from patient satisfaction surveys. There was a social group for carers to meet every fortnight outside the hospital called ICAN. ICAN feedback concerns or areas of good practice some issues are raised there and actioned. • 15 carers group in the Vale were visited last year and the UHB gained some useful feedback from this exercise which had led to changes in service. • The Committee were asked to note the baseline assessment which had been undertaken in relation to learning from the Tawel Fan situation and note the actions which were being taken to progress the work so that CAV UHB did not find itself to be in the same position. **Resolved – that:** The Committee noted the report.	
QSE 18/194	**POLICIES FOR APPROVAL** The following policies were put forward for Committee approval I. Being Open Policy II. Being Open Procedure III. Confirmation on an Expected Death by Nurses Policy and Procedure **Resolved – that:** The Committee approved The Being Open Policy The Committee approved The Being Open Procedure The Committee approved Confirmation of an Expected Death Policy	

QSE 18/195	**HEALTH AND CARE STANDARDS SELF-ASSESSMENT TIMETABLE FOR 2018/19** The Health and Care Standards Self-Assessment Timetable for 2018/19 was discussed and the following comments made: • The report set out the timeline for completion. • w/c 13th May – during this week work would be happening with Executive members to sign off standards relating to the Quality, Safety and Experience Committee • w/c 20th May – during this week work would be taking place with Independent Members to sign off the files. **Resolved – that:** The Committee approved the approach and timeframe.	
QSE 18/196	**EMERGING THEME FROM UK MATERNITY SERVICE REVIEWS** The report on Maternity Service Reviews was discussed and the following comments made: • Following the Morecombe Bay investigation into the deaths of babies at Morecombe Bay Hospital and emerging themes coming out of Shrewsbury and Telford and over the last few weeks an emerging theme from Cwm Taf Health Board the Executive Nurse Director felt it was timely to meet with the Children and Women Clinical Board and particularly Midwifery to go through all of the reports. Key areas to note were Medical staffing, lone working, ante-natal clinic transitional care and Maternity lifts. The Committee considered the areas and the actions that the Clinical Board were putting in place were robust. The Executives of the Health Board saw the report and were satisfied with the work being progressed and therefore the UHB was able to demonstrate that the learning the UHB has so far from one health board and two trusts in England was being addressed. • The CEO of the Royal College of Midwives had visited and spoke positively about CAV UHB. This was important as it was the practice and failure of the midwives in Morecombe Bay to work as an MDT and assess their own practice. • There had been no response from Cwm Taf UHB to CAVs Commissioning Officer with regards to the 80 women from CAVs community who chose to deliver in Cwm Taf. A formal request would go to Cwm Taf regarding this issue. • Regarding the Deanery, CAV UHB was undertaking a recruitment phase early next year for senior Grades in Obstetrics & Gynaecology. The service was currently safe but there was a cost as it was not uncommon for Consultants to act down at registrar grade so CAV were paying a premium when this is occurring. The Clinical Board was hoping to fill more posts rather than expanding the number of trainees. • Regarding the Ante-natal clinic at Llandough a question was raised regarding where Mums would go to in the Vale and there was a request that Barry Hospital should be considered as an important hub. The Executive Director of Strategic Planning would consider	SH

	this action. • The lifts were part of a refurbishment programme and there was a contingency in place. The priority on this was to be raised. The Executive Director of Strategic Planning was asked to report back progress at the next QSE meeting in February 2019. **Resolved – that:** (a) The Committee considered the priority areas identified. (b) The Committee noted the baseline position and the Safety Improvement Plan that was being taken forward.	AH AH
QSE 18/197	**ANNUAL QUALITY STATEMENT 2018/2019** The Annual Quality Statement 2018/19 was discussed the following comments made: • The report provided the timetable for development of 2018/2019 AQS. This would be the final year of production of the statement in this way. In the future the UHB would be expected to set up a live internet site providing this sort of information on an ongoing basis. Thereafter the AQS would be produced following patient stories through the year. **Resolved – that:** (a) The Committee approved the plan and timescale**.**	
QSE 18/198	**THEME 1: STAYING HEALTHY (HEALTH PROMOTIOIN, PROTECTION AND IMPROVEMENT)** There were no papers to discuss under this theme.	
QSE 18/199	**THEME 2: SAFE CARE** There were no papers to discuss under this theme.	
QSE 18/200	**HIGH VIGILANCE ARRANGEMENTS REQUIRED FOR THE USE OF SYNTHETIC VAGINAL MESH AND TAPE** The report was discussed and the following comment made: • Vaginal Mesh was a high profile issue and it was confirmed that CAV UHB did have a good register and significant expertise in this area and there was confidence that the UHB had met the conditions set out by Chief Medical Officer. **Resolved – that:** (a) The Committee noted the actions put in place by Medical Director	
QSE 18/201	**INFECTION PREVENTION AND CONTROL** The Infection Prevention and Control report was discussed and following comments made: • Twice a year an IP & C detailed report was presented to the	

	Committee with progress made. Welsh Government were happy with the progress being made. • Work had been undertaken regarding UTIs in care homes • C Section infection rates had seen dramatic improvements • The IP & C team asked that the logos and the approach which CAV UHB was taking be refreshed. **Resolved – that:** The Committee accepted the report.	
QSE 18/202	**MEDICATION** The report provided a six monthly update on the Medicines Management and how well it was progressing. **Resolved – that:** (a) The Committee **NOTED** the actions and progress made.	
QSE 18/203	**POINT OF CARE TESTING** This was discussed: • The report had already been discussed at HSMB. Point of Care Testing was reviewed periodically by the Quality and Safety Team. All POCT testing systems do go into our Central Laboratory System. Systems from across the whole of the UK were considered to be quite innovative. However, it had revealed that CAV UHBs adherence to putting in the correct information such as patient number and staff ID was poor. Until there were improvements in the Audit outcomes it was important to support the POCT Teams in not allowing any further POCT testing developments. • CAV UHB are strengthening the process which Clinical Boards will be asked to sign off at their Quality and Safety Committees. The POCT applications will go through the POCT team. • Point of Care Testing would be reviewed again in 6 months. **Resolved – that:** (a) The Committee noted this report	RW
QSE 18/204	**THEME 3: EFFECTIVE CARE** There were no papers to discuss under this theme.	
QSE 18/205	**CANCER PEER REVIEW – BREAST** The Cancer Peer Review on breast was reviewed: • The Lead Cancer Nurse had assisted in writing the report and reported that there was improvement since the Peer review and so this was now a second cycle of many of the cancer Peer Reviews. Good practice was noted and significant achievements had been made. There were some concerns which were dealt with in the Action Plan.	

	Resolved – that: (a) The Committee noted the report and agreed that appropriate assurance had been provided and the Welsh Peer review framework was noted.	
QSE 18/206	**CANCER PEER REVIEW – ACUTE ONCOLOGY SERVICE** The Cancer Peer Review of the Acute Oncology service was discussed and the following comments made: • A Business Plan had been developed by Medicine to sustain the service. This was a fragile service and had made a real difference in terms of length of stay, identification of sepsis and the outcomes for patients with cancer. CAV UHB would continue to support this service and look at the benefits. **Resolved – that:** (a) The Committee noted the report.	
QSE 18/207	**CLINICAL AUDIT PLAN PROGRESS** Progress on the Clinical Audit Plan was discussed and it was reported that: • CAV UHB was making progress, particularly around the National Clinical audit and the structures in place. • More work would be carried out on the Fractured Neck of Femur audits where mortality was satisfactory but could improve on aspects of care. • Previously around 60% of clinical audits didn't complete the cycle and this was considered to be a waste of resources, CAV UHB was now in a much better situation. **Resolved – that:** (a) The Committee noted the progress.	
QSE 18/208	**THEME 4: DIGNIFIED CARE** The following was discussed: • A hospital based ward review would be undertaken at some point in the future. **Resolved – that:** (a) The Committee noted this ongoing work.	
QSE 18/209	**HIW ACTIVITY** This was discussed and it was reported that: • Corporately the UHB were satisfied that assurance had been met and Clinical Board and monitoring **Resolved – that:** (a) The Committee noted the ongoing work in relation to HIW activity.	

QSE 18/210	**SENSORY LOSS** The sensory loss report was discussed and the following was noted: • The report indicated good progress over the last couple of years and particularly the work now being undertaken by the Patient Experience Team with the deaf community • The Committee felt that this work should be put this forward as a Health Service Recognition Award **Resolved – that:** (a) The Committee **NOTED** progress being made.	
QSE 18/211	**THEME 5: TIMELY CARE** There were no papers to discuss under this theme.	
QSE 18/212	**THEME 6: INDIVIDUAL CARE** There were no papers to discuss under this theme.	
QSE 18/213	**ITEMS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE** Exceptional Items: • Issues dealt with in a timely manner. • Increase in medication errors in the paediatric setting regarding the decimal place (so getting 10x). This would go forward to the Medication Safety Group. **Resolved – that:** (a) The Committee approved the actions being taken by the Mental Health Clinical Board.	
QSE 18/214	**MINUTES FROM CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE SUB COMMITTEES – EXCEPTIONAL ITEMS TO BE RAISED BY THE ASSISTANT DIRECTOR, PATIENT SAFETY AND QUALITY** Assistant Director of the Patient Quality & Safety gave an overview of the minutes from the following QSE meetings: • 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 • CE to get more timely minutes for the public domain • The corporate template for the clinical board be refreshed from time to time • Uniformity and standardised minutes - review being carried out	

QSE 18/215	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD** • There was an ongoing theme which came through in the meeting which was – listen to patients and staff. The Committee agreed it was important to continue to listen. • The Committee had received a review of the Community Deaths of patients known to the Mental Health Services and had learnt that in the first 9 months of the year there had been 11 suicides which was less than the national average.	
QSE 18/216	**AGENDA FOR THE PRIVATE QSE** • Safeguarding • Insourcing Ophthalmology Concerns	
QSE 18/217	**DATE OF THE NEXT MEETING OF THE BOARD** Thursday 19 February 2018, 9.30am – 12.00pm Corporate Meeting Room, Headquarters	
QSE 18/218	**ANY OTHER URGENT BUSINESS** There was no other business raised.	

ACTION LOG

QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING
18 DECEMBER 2018

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
QSE 18/102	Update to come to QSE in autumn	Ophthalmology Presentation	12/06/18	S Curry	**COMPLETED**
QSE 18/104	Update in 6 months' time	Sensory Loss	12/06/18	S Curry	**COMPLETED**
QSE 18/178	Presentation on patient suicide by Mental Health	Analysis of Trends and Themes in Concerns and Negligence Claims	16/10/18	R Walker	**COMPLETED**
QSE 18/179	Ophthalmology Insourcing	Analysis of Trends and Themes in Concerns and Negligence Claims	16/10/18	R Walker	**COMPLETED**
QSE 18/138	Cleaning Standards	Staff stories shared	18/09/18	A Harris	**COMPLETED**
QSE 18/144	Blood Products	Ongoing discussions at National level	18/09/18	M Battle	**COMPLETED**
QSE 18/177	Hot Topics-Cwm Taf Maternity Service	Discuss monitoring of approximately 80 maternity patients in Cwm Taf	16/10/18	R Walker	**COMPLETED**
QSE 18/088 **QSE 18/126**	CHC Reports Scrutiny Overview	Discuss with END – set up meeting	12/06/18 18/09/18	R Walker	**COMPLETED** **Meeting with CHC on 8 January 2019**
QSE 18/087	CD &T QSE Report	Digitalization of medical records to ensure no duplication	18/09/18	M Battle	**31 October 2018 meeting COMPLETED**
QSE 18/133	CRAF	Present new BAF format to Board	18/09/18	N Foreman	**COMPLETED** **Board November 2018**
QSE 18/138	Cleaning Standards	Share staff stories with Rachel Gidman to link with values/behaviours work.	18/09/18	L Wyatt	**COMPLETED**
Actions In Progress					
QSE 18/053	Quality Safety &	Receive detailed outcome based report	17/04/18	C Evans	**QSE June 2019**

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
	Improvement Framework				
QSE 18/135	Ombudsman Annual letter	Present update	8/09/18	R Walker	Awaiting final letter to be released by the Ombudsman Waiting QSE & Board decision
QSE 18/155.1 **QSE 18/155.1**	CD & T Minutes	Obtain environmental update re BMT WG package of deals have been taken forward in regard to securing monies for urgent capital clinical schemes	08/09/18 18/12/18	A Harris A Harris	**Verbal Update - QSE February 2019** **Verbal Update - QSE February 2019**
QSE 18/190	Patient Story	Assurance required from the Mental Health Clinical Board that an agreed plan was in place for medical care at Llanfair Unit, Hafan y Coed	18/12/18	SC	
QSE 18/191	Mental Health Clinical Board, QS&E Assurance Report	The Committee to have sight of the Project Plan in regard to reducing Length of Stay	18/12/18	SC	
QSE 18/196	Emerging Theme from UK Maternity Service Reviews	A formal request would be made to Cwm Taf regarding women in CAVs community who choose to deliver in Cwm Taf To consider where mothers would go in the Vale for ante natal clinics To provide an update on the lifts refurbishment programme at the next Committee meeting	18/12/18	SH AH AH	**Update at QSE February 2019 meeting**
QSE 18/203	Point of Care Testing	To be reviewed in six months' time.	18/12/18	RW	**Update at QSE June 2019 meeting**

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions referred to committees of the Board					
QSE 18/148	Care of Deteriorating Patient/Hospital at Night	Further assurance report required with timescales	18/09/18	Dr G Shortland	**Update to be presented at Board meeting March 2019**

Cardiff and Vale UHB
Quality, Safety and Experience Committee

PCIC Clinical Board
Patient Story
19th February 2019

Patient story

‘This is Sally's story’

Sally is 28 year old lady who lives alone at home supported by a comprehensive package of care funded by Continuing Health Care.

Sally was diagnosed with an eating disorder at 16 years of age and was admitted to a specialist unit for treatment.

At the age of 18 years Sally was diagnosed with Multiple Sclerosis (MS). Due to her poor physical health from her eating disorder she could not be actively treated to prevent the onset of deterioration from the MS.

Following her diagnosis Sally spent a considerable amount of time in Rookwood Hospital for rehabilitation.

Patient Story

‘This is Sally's story’

Sally is significantly physically disabled as a result of the sudden and rapid onset of MS, her rehabilitation potential has been poor and she is completely dependent on others to meet her daily living and care needs.

Sally has a high level of physical disability, a history of challenging behavior, obsessive compulsive disorder, anxiety and experiences depression. Her eating disorder has remained a feature and her weight fluctuates.

Sally’s relationship with her family is complex and their support has not been consistent.

Sally is often non complaint with care and treatment with varying capacity in relation to the risks she takes, and with regard to non compliance with her treatment plan.

Patient Story

‘This is Sally's story’

Following her stay in Rookwood, Sally was eventually discharged home to her own bungalow where she lived alone, supported by a CHC funded package of care and the extended multi-disciplinary team.

MDT include her GP, District Nurses, Nurse Assessor Team (CHC), Rehabilitation Consultant and MS Team, Mental Health Team (Adult Service and Eating Disorder Service), Specialist Domiciliary care provider.

Patient Story

‘This is Sally's story’

In 2015 Sally’s care at home broke down, when her non compliance with care and treatment resulted in her BMI falling to an unacceptable level and she developed an extensive non healing grade 4 pressure ulcer to her sacrum.

Admission to UHL was agreed and IV antibiotics and recovery care was provided.

Sally’s wished to be discharged home very quickly, her capacity was reviewed by those teams involved in her care and it was agreed that Sally lacked capacity to make the decision that going home was a safe option.

A specialist care home placement was made in her best interests.

Patient Story

‘This is Sally's story’

Sally settled into the care home placement reasonably well but continued to ask to go home. The DOLS team were involved and her capacity was periodically reviewed. An independent advocate was involved in her care and support.

Over time Sally’s physical health improved significantly, with her weight improving and her pressure ulcer healing, she still asked to go home.

‘I want to return home, being cared for at the care home is not helping my wellbeing, progress and recovery, I would feel more in control of my life at home’

Patient Story

‘This is Sally's story’

Sally’s capacity was reviewed and the MDT agreed that she was now able to decide where her care was best met and understood the consequences of non compliance with her care and treatment.

Sally returned home in 2017 after being in the care home for a year.

‘*I have learnt my lessons from not complying with my care and treatment, being placed in the care home has made me turn a corner. I will never let myself get back to that stage again. I want to be fit and healthy, I am nearly at my goal weight, I am happy with myself’*

Patient Story

‘This is Sally's story’

Sally has been living at home in the community for the last two years.

She has a comprehensive care package in place from a care agency and her nursing needs are met by the District Nurses.

Sally has regular respite in a specialist care home for younger people.

Her pressure ulcer has healed and she is now able to spend more time in her wheelchair. Sally’s weight has remained stable over the last two years, her BMI is within normal limits and she is eating normally. She has been discharged by CMHT.

The level of Sally’s health needs has decreased and she is awaiting a reassessment to establish whether she continues to meet the criteria for Continuing Health Care funding.

Patient Story

‘This is Sally's story’

“ Since I have been at home my confidence has grown and I feel more relaxed. I didn’t like being in the care home but I recognise that I wasn’t helping myself and that I was really low when I went into hospital.

I just couldn’t talk about how I was feeling. I try not to think about the past but I have learned lots of lessons from it and I feel I have moved on.

I try not to let my MS take over my life and I don’t dwell on things now.

There have been so many positive things since I came home .

I’m actually going out and making my own choices about what food I buy and helping the carers with the cooking, which is something I never thought I’d be able to do.

I love being more independent.”

Patient Story

‘This is Sally's story’

“I get a bit anxious when I am going in for respite but I understand why this is arranged and I made an agreement that I would go when I came home. I promised to help myself and I understand how it gives me a break from my normal routine . I can talk to the staff there about my feelings which really helps me to cope with things.

If someone offered me a million pounds to go back or to stay at home; I would chose to stay at home every time. Being at home and keeping my independence is the most important thing in the world to me.

I am looking towards the future and I would love to be able to do some voluntary work and make some new friends.”

Report Title:	**PRIMARY , COMMUNITY AND INTERMEDIATE CARE CLINICAL BOARD (PCIC) QSE ASSURANCE REPORT**							
Meeting:	**Quality, Safety and Experience Committee**					**Meeting Date:**	**19/02/19**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	
Lead Executive:	**Executive Nurse Director**							
Report Author (Title):	**Director of Nursing, Primary , Community and Intermediate Care Clinical Board**							

SITUATION

This report has been prepared to provide assurance to the Executive Committee that Quality, Safety and Patient Experience (QS&E)is at the centre of the delivery of services across PCIC clinical board for patients and service users living in the Cardiff and Vale UHB geographical area. This report provides a summary of the work undertaken by the PCIC Clinical Board over the last year. The PCIC Clinical Board provides all of its services within the community setting either directly providing services or commissioning services from Independent and Third Sector providers which links very clearly with the 'home first' strategy of the UHB and is in keeping with the Social Services and Wellbeing Act (Wales) 2014.

REPORT

BACKGROUND

The PCIC Clinical Board was set up in 2010 and is clinically led by the Clinical Board Director, who works part-time for the Clinical Board while being a GP Partner in a University Health Board-contractor Practice, and is supported by the Head of Operations and Director of Nursing (DoN). The PCIC Triumvirate team has co-opted the Head of Finance and Head of WOD into the PCIC Senior Management Team who are responsible for the following directly provided services within the Clinical Board, including District Nursing (In and Out of Hours); Community Resource Teams (two in Cardiff and one in the Vale of Glamorgan); Specialist Nursing Services - Acute Response Team (ART); Continence and Wound Healing; Homelessness Services; Department of Sexual Health; Cardiff Health Access Practice (CHAP); HM Prison Cardiff Healthcare (HMP Cardiff); GP Out of Hours (OOH) Services; Pharmacy Advisory; GP Sustainability Services. There are also a significant number of commissioned services for the local Cardiff and Vale population which include GP's, Dentists, Optometrists & Pharmacists (all are Independent Contractors); Specialist Palliative Care Services, including the Inpatient Specialist Palliative Care Team; Independent Sector care home placements (Nursing Homes).

A number of national processes are in place to support the QS&E agenda for the commissioned services through regulatory mechanisms monitored by the Clinical Board and through Welsh Government agreed delivery plans.

The Clinical Board has a formal Board Meeting held bi-monthly attended by the Senior Management Team, Executive representative (acting as an independent member) and staff side organisations. The formal Clinical Board requires assurance from all its Groups and sub-Groups in relation to the effective, safe and sustainable operation of all delivered and commissioned services.

ASSESSMENT
The key risks identified are:

- GMS Sustainability(Risk Register Score 20)
- Continuing Health Care commissioning and contracting capacity and availability of suitably competent staff to sustain packages of care within the community(Risk Register Score 20)
- Primary Care Estates/Infrastructure(Risk Register Score 20)
- LDP Growth (Risk Register Score 20)
- Workforce(Risk Register Score 20)

ASSURANCE is provided by: Please see attached supporting documentation (Appendix 1).

RECOMMENDATION
The Committee is asked to:

- **APPROVE** the actions being taken by the PCIC 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	X	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	X	Integration	X	Collaboration	X	Involvement	X

Equality and Health Impact Assessment Completed:	No

Trust and integrity Ymddiriedaeth ac uniondeb | Personal responsibility Cyfrifoldeb personol

PRIMARY, COMMUNITY AND INTERMEDIATE CARE CLINICAL BOARD (PCIC) QSE ASSURANCE REPORT

APPENDIX 1

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

The Clinical Board meets on a bi-monthly basis as part of the Quality, Safety and Experience arrangements (QS&E). There is a set agenda with that follows the Health and Care Standards with the Business Unit Management Teams and heads of profession attending. The Business Unit QS&E agenda will follow the same template agenda and cascade lessons learnt and key messages to staff within their area of responsibility.

Key risks

- GMS Sustainability (Risk Register Score 20)
- Staffing – Band 5 recruitment and retention, District Nursing Principles , HMP Cardiff (Risk Register Score 20)
- Continuing Health Care commissioning and contracting capacity and availability of suitably competent staff to sustain packages of care within the community (Risk Register Score 20)
- Primary Care Estates/Infrastructure – GP Premises and UHB Community buildings not being fit for purpose impacting on patient care and staff morale (Risk Register Score 20)
- LDP Growth (Risk Register Score 20)

COMPLIANCE WITH THE HEALTH AND CARE STANDARDS

Compliance with the Health and Care Standards is overseen by the PCIC Quality, Safety and Patient Experience Group, which is led by the Director of Nursing (DoN) on behalf of the Clinical Board. Terms of Reference for the Group are in place and are regularly reviewed. The Director of Nursing takes the lead role for QS&E and is supported by the Senior Management Team. Specific roles within the Clinical Board supporting the Director of Nursing and involved in the QS&E agenda across the Localities are:

- Clinical Director, Clinical Governance - Dr G Hayes (Chair, PCIC QS&E Group)
- Assistant Director of Operations - C Darling
- Quality and Safety Manager - H O'Sullivan
- Quality and Safety Officer – R Armitage
- Locality Lead Nurses (Cardiff North and West, Cardiff South and East and Vale of Glamorgan).

The Lead Nurses and Head of Primary Care within PCIC Clinical Board have a lead role in supporting the QS&E agenda. The Clinical Board works very closely with the Corporate Patient Safety Team and Patient Experience team. There are also close links in place with safeguarding teams both within and external to the organisation, as well as with Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW).

The Clinical Board has spent the last 12 months developing a high level clinical Dashboard that represents performance against the agreed KPI's across the diverse services of the clinical board, which is divided for management purposes into Business Units. The DoN, Quality and Safety Manager and Assistant Head of Operations have been reviewing all groups reporting to the PCIC QS&E Group and updating agenda templates, Terms of Reference and Risk Registers. There is good attendance and representation at the QS&E

Group and sub-Groups and non-attendance and Group/sub-Group membership is reviewed on a regular basis.

Safe Care

The Clinical Board encourages a culture of reporting incidents and the Dashboard highlights the Clinical Incidents reported by the Clinical Board. There has been a marked and consistent improvement in managing incidents within the agreed timescales. These incidents relate mainly to pressure damage, while the Interface Incidents (a mechanism for primary care contractors to report to secondary care) relate mainly to the Communication Standards as set out in the *All Wales Communication Standards between General Medical Practitioners and Secondary care*. The clinical board has recently received a limited assurance report on the Interface Incident process and is awaiting the roll-out of Datix to Practices to be able to provide assurance in relation to a robust process to support GP reporting. The Clinical Board, with the corporate Patient Safety Team, has developed a Pressure Ulcer Reporting guidance document to improve understanding of the required reporting processes. All Grade 3, 4 and unstageable pressure ulcers are reported via Datix, to Safeguarding and as Serious Incidents (SIs). A revised process of reporting agreed in November 2018 has been rolled out across PCIC and Medicine Clinical Boards resulting in Safeguarding referrals now only being made if there is clear establishment of neglect by UHB staff. This has resulted in a significant reduction in numbers of Safeguarding referrals, and there is an expectation that SI reporting to Welsh Government will be brought into line with Safeguarding reporting in 2019.

A number of Business continuity events have been undertaken, including a joint exercise with Third Sector and Local Authority representatives. Business continuity planning is progressing with some further exercises to be undertaken in 2019, supported by detailed review of business unit action cards and documentation, including detailed planning for the role of Barry Hospital and the implications of the Welsh Government guidance on dispersal of inpatients to primary care in the event of a mass casualty incident. The Vale Locality has an integrated structure to enable working in partnership with the Local Authority which has had benefits specifically in adverse weather planning and joint use of resources.

The GP OOH peer review undertaken in November 2018 identified an improving picture of delivering sustainable OOH care for patients, patient outcome measures have improved against the All Wales GP OOH measures and the development of escalation cards to support particular service pressures have been shared widely across Wales.

Effective Care

The Clinical Board has been involved in working with the All Wales Healthcare Acquired Infections (HCAI) Collaborative over the last two years; a small task and finish group has been reviewing performance using improvement methodology and PDSA cycles to reduce *C. diff*, MSSA and *E. coli* infection rates and ensure learning is shared across the PCIC community and All Wales Community. Antimicrobial Resistance (AMR) is a key part of this work: UHB prescribers have excellent performance and benchmark well within Wales (second lowest prescribers of antibiotics) as well as with English Primary Care Trusts. Root Cause Analysis (RCA) processes to review *C. diff* infections have been in place for some time, and a similar RCA process for MSSA commenced in 2018 as part of the

Medicines incentive scheme to see what learning could be established. The *C. diff* RCA process is to cease from April 2019 due to the excellent evidence in relation to appropriate AMR; there is still some further work to complete with the MSSA PDSA cycle. The Clinical Board has seen a 24% reduction of *E. coli* incidence in the last 8 months, while a number of projects are ongoing to continue the improvement work and provide clinical staff within Primary Care and GP OOH with evidence-based guidance, particularly in relation to identifying Urinary Tract Infections (UTI's). A separate guidance document has been developed for Nursing Home and community staff in preventing UTI's. ANTT Compliance has been over 70% for the clinical board services and facilitators have been identified within all Nursing homes across Cardiff and Vale whilst delivering Wound care training and basic principles of ANTT.

Dignified Care

The Clinical Board has focused on establishing Dementia Friends and Dementia Champions across the provided and commissioned services. At December 2018 (latest available data) compliance with mandatory training, which includes Dementia awareness, stood at 76.22% The Clinical Board continuously encourages compliance with mandatory training for all staff, and reviews performance at its Board meetings and QS&E Group meetings.

A dementia action plan has been developed which has embedded dementia within existing public health programmes of work and 21 GP Practices have signed up to the mental health Direct Enhanced Service. A number of supporting work streams are under way with the emphasis on the dementia 'team around the individual' across the range of independent contractors. The Consultant Nurse for Older Vulnerable Adults has been working with the Corporate Patient Experience Team on behalf of the Clinical Board in developing an independent, volunteer-based patient feedback project enabling patients and their families to be able to provide feedback on their experience of living in a care home. There is also ongoing work to ensure that carers will be offered an assessment of their own needs and, if eligible, a support plan will be developed with them to identify appropriate support (in line with the Social Services and Well-being (Wales) Act 2014. This work stream will be overseen by the PCIC QS&E Group.

The Clinical Board has successfully retendered for the Specialist Palliative care contracts with the independent sector for 3 years. The process of tendering was very robust with a change of provider for Cardiff residents based on the comprehensive qualitative outcomes of one of the organisations in particular. Due to the change in RISCA legislation this provider has now fallen out of the regulation framework by CIW, an alternate solution is being sought for 2019 onwards.

Timely care

The PCIC Optometry Advisor has been leading on a project reviewing the quality of referrals to secondary care from Optometrists. In 2016, when the project was set up, only 25% of the referrals met the required standards for referral to secondary care. As of December 2018, 99% of referrals now meet the required standards. This work has allowed further testing which has identified outlying practitioners so that targeted improvement work can be undertaken. In 2019 practice visits will take place to enable a

more formal discussion with practitioners on referral pathways and general governance issues.

Infrastructure issues are beginning to seriously impact on the delivery of timely, effective and safe care to residents of North & West Cardiff particularly, which affects other clinical boards operating from joint community facilities (CD&T, Children and Woman Clinical Boards). The closure of Parkview Health Centre due to flood damage has meant that services and community based staff have had to be temporarily dispersed into other community facilities such as Riverside Health Centre and St Davids Hospital. This is impacting on existing services and is a short term plan with the long term plans not coming to fruition until 2020/21. The additional pressure on these sites has resulted in poor staff morale, a recent IPC report on Riverside Health Centre has identified a number of serious issues due to the age of the building that may necessitate ceasing some patient facing activity and also affects staff being based at the sight. There are many more examples of very poor estate within the community across the Localities which is a serious stumbling block in being able to support the UHB Clinical Services strategy of providing care closer to home.

Individual care

The QS&E Group continues to receive patient stories at its meetings, patient experience is a standing item on its agenda, and there are regular updates on the work done in each Business Unit. The North and West Locality has established a quarterly Patient Experience Group to share and develop a variety of mechanisms for acquiring patient feedback, and a real time “Happy or Not” machine has been placed in Riverside Health Centre and the Department of Sexual Health, while a survey about the Acute Response Team recorded a 95.83% “very good” rating. A survey undertaken by one of the third sector Specialist palliative care organisation in relation to the Hospice at home service has demonstrated a high level of satisfaction from families receiving this service who have chosen to die at home.

Staff and Resources

Workforce plans have been developed for District Nursing and GP OOH (unscheduled care), and sustainability plans have been developed for commissioned Primary Care contractor services, which have involved scoping the use of the whole multidisciplinary team in place of more traditional medical models. Two formal transformation projects will commence in 2019, rolling out direct musculoskeletal and Mental Health access for GP Practices. Workforce plans are in development for the Department of Sexual Health, CHAP and HMP Cardiff. A GP OOH external peer review in autumn of 2018 demonstrated that the UHB is leading the way in developing new roles within the GP OOH environment.

Of the clinical board’s employed workforce 42% are aged 51 years or over. Some of the the biggest staffing challenges include:

- North and West Locality where there is high turnover at Band 5 level in two of the DN teams – recruitment is being progressed as quickly as possible. In addition, Radyr District Nursing team a formal 6-month project has commenced aiming to support 12 hour shift patterns in District Nursing as a result of a number of staff

leaving owing to 12 hour shifts not being available; this will be fully evaluated in 2019.

- In the South and East Locality the Roath team has had to be disbanded temporarily as staffing was unsafe. The team has been integrated into the other 4 teams and staff shared between the teams. The team will be reinstated at the end of January 2019. In the interim, some teams are only undertaking essential calls.
- In the Vale, District Nursing teams are experiencing challenges regarding staffing. Several team members are on maternity leave/due to go on maternity leave and owing to the turnover of staff teams now have less experienced staff and more new starters, which has affected the skill mix. 3 WTE Novice Band 5 will join the service in January 2019.

The Clinical Board continues to work flexibly to improve the clinical vacancy position particularly for Band 5 posts. A number of recruitment events have been held and recruiting band 5 staff is reasonably consistent; however, **r**etention of staff remains a significant challenge. At the most recent UHB recruitment event on the 26th January 7 new band 5 staff were offered posts. A review of induction processes for new staff and students has been undertaken to ensure that staff are being supported when commencing employment in the Clinical Board. Exit questionnaires and 1-1 conversations with staff have been reviewed. A number of work-life balance and flexible working options are considered for all clinical services, the clinical board is particularly successful in securing many experience staff to retire and return to working in the Clinical Board..

Report Title:	Board Assurance Framework – Safety and Regulatory Compliance								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	19.02.19	
Status:	**For Discussion**	x	**For Assurance**	x	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee with the opportunity to review the risks on the Board Assurance Framework which link specifically to the Quality, Safety and Experience Committee.

REPORT

BACKGROUND

The Board Assurance Framework has now been presented to two Board Meetings after discussion at the Executive Management Team on what the key risks are impacting upon the Strategic Objectives of Cardiff and Vale University Health Board as set out in Shaping Our Future Wellbeing.

ASSESSMENT

There are currently six key risks set out within the Board Assurance Framework and the risk which relates to the Quality, Safety and Experience Committee is the risk in relation to **Safety and Regulatory Compliance**. The risk is currently rated at 12 after the current controls in place however, the target rating for this risk is 4.

The role of the Committee in relation to the risk is to review it, check that that the controls are in place and working and agree any further actions which are required in order to mitigate the risk further. The Committee can then provide further assurance to the Board that the risk is being managed or mitigated as much as possible at the current time.

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

REVIEW the attached risk in relation to Safety and Regulatory compliance thereby providing further assurance to the Board.

Shaping our Future Wellbeing Strategic Objectives			
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	x

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	

Five Ways of Working (Sustainable Development Principles) considered

Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

BOARD ASSURANCE FRAMEWORK 2018/19 – JANUARY 2019

It is essential that Cardiff and Vale University Health Board is aware of the major risks which could impact upon the delivery of Strategic Objectives as set out in Shaping Our Future Wellbeing.

Strategic Objectives

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

Principle Risks

Risk	Gross Risk	Net Risk	Target Risk	Context	Executive Lead	Committee
1. Workforce	**25**	**15**	**10**	Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff. Staff costs represent the largest expense for the NHS in Wales. The pay bill has continued to increase year on year, with a significant increase over the last three years.	Executive Director of Workforce and OD	Strategy and Delivery Committee
2. Financial Sustainability	**25**	**10**	**5**	Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing prudent healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future.	Executive Director of Finance	Finance Committee

3. Sustainable Primary and Community Care	**20**	**15**	**10**	The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.	Chief Operating Officer	Strategy and Delivery Committee
4. Safety and Regulatory Compliance	**16**	**12**	**4**	Patient safety and compliance with regulatory standards should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.	Executive Nurse Director	Quality, Safety and Experience
5. Sustainable Culture Change	**16**	**12**	**8**	In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which continues to build upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.	Executive Director of Workforce and OD	Strategy and Delivery Committee
6. Capital Assets (Estates, IT Infrastructure, Medical Devices)	**25**	**20**	**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.	Executive Director of Strategic Planning, Deputy Chief Executive, Executive Director of Therapies and Health Science	Strategy and Delivery Committee, IG & T Committee, Quality, Safety and Experience Committee

Safety and Regulatory Compliance

Patient safety and compliance with regulatory standards should be above all else for the Cardiff and Vale University Health Board.
Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and feedback. Undertaking a high quality level of investigation to identify the root causes. Implementing solutions to minimise/mitigate the risk of them recurring.

Risk **Date added:** 12.11.2018	There is a risk that systems of safety and regulatory compliance are potentially not as robust as they could be and this has been demonstrated by the HTA Review, poor decontamination systems and the commissioning of services outside the Health Board which were not of a high quality.		
Cause	Non-compliance with regulatory or statutory requirements Non-compliance with effective decontamination processes to support the delivery of high quality patient care Appointment of contractor without required quality checks being in place to ensure service delivered was of a high standard		
Impact	Harm and distress caused to patients and their families Reputational damage to the Health Board Increase in clinical claims Financial consequences		
Impact Score: 4	Likelihood Score:4	Gross Risk Score:	**16 (Extreme)**
Current Controls	Human Tissue Act HTA Licencing Standards Statutory Designated Individual in post Clinical Board QSE arrangements; CD&T – regulatory compliance group Quality, Safety and Experience Committee in place supported by robust governance and reporting structure Office of Professional Leadership shares responsibility for Quality Agenda (Medical Director, Executive Nurse Director, Executive Director of Therapies and Health Science) Quality and Safety Team Patient Experience Team Health and Care Standards Decontamination and reusable devices procedure in place Decontamination Group Weekly Executive led concerns/claims and serious incidents meeting Monitoring of ongoing investigations Quality control system that triangulates areas of concern		
Current Assurances	Annual Report to Quality, Safety and Effectiveness Committee on key quality and safety areas External accreditation processes Monitoring of incident trends, noise in the system or any concerns arising from inspections Heath and Care Standard Self-Assessment undertaken on key areas and reported into the Quality , Safety and Experience Committee Internal Audit reviews on quality and safety Health and Safety Committee		
Impact Score: 4	Likelihood Score:3	Net Risk Score:	**12 (High)**

Gap in Controls	Lack of central decontamination Unit Lack of robust QSE criteria/monitoring in procurement and commissioning processes Capacity of the Patient Safety and Patient Experience team to enable more proactive approach to quality improvement and data analysis Limited Assurance Internal Audit Report on Legislative/ Regulatory Compliance			
Gap in Assurances	Robust ongoing monitoring and assurance reporting on historical areas of concern Internal audit programme needs to be more closely aligned to areas of greatest risk			
Actions		**Lead**	**By when**	**Update since 29.11.2018**
1. Discuss and agree a way forward in relation to central decontamination unit		RW / FJ	31/12/2018	
2. Review of procurement and commissioning processes to be undertaken to ensure that robust quality, safety and experience criteria and included		RW/ RC	31/03/2019	Ongoing
3. Review of capacity of Patient Safety and Patient Experience Team to be undertaken		RW	31/03/2019	Ongoing
4. Actions within Limited Assurance Internal Audit report on Legislative and Regulatory Compliance to be completed		NF	28/02/2019	New action added Jan 2019
5. Internal audit plan to be aligned to areas of greatest risk		RW/NF	31/03/2019	New action added Jan 2019 2019/20 Internal Audit Plan currently been developed to be signed off by Management Executive and Audit Committee
Impact Score: 4	Likelihood Score:2	Target Risk Score:		**8 (High)**

REPORT TITLE:	**Gosport War Memorial Hospital; the Report of the Gosport Independent Panel**						
MEETING:	Quality, Safety and Experience Committee				**MEETING DATE:**	**19.02.18**	
STATUS:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
LEAD EXECUTIVE:	Ruth Walker, Executive Nurse Director						
REPORT AUTHOR (TITLE):	**Assistant Director of Patient Safety and Quality**						

PURPOSE OF REPORT:

SITUATION:

The pupose of this paper is to provide the Committee with an initial overview of the main findings of the **Report of the Gosport Independent Panel** and to provide a level of assurance in relation to the systems and processes that are in place within Cardiff and the Vale UHB to monitor the appriopriate use of opioid analgesics particularly in rehabilitation or repsite settings.

This report does not set out to provide assurance in relation to the role of external regulatory and professional regulatory organizations or specifically the role of the police other than in relation to the UHBs Safeguarding arrangements.

BACKGROUND:

In February 1991, a staff nurse working at the Gosport Memorial Hospital raised concerns over the prescribing and administration of drugs with syringe drivers. Between that date and January 1992, a number of other nurses also raised concerns about the prescribing of drugs, in particular diamorphine. In addition to this, families had also sought answers to legitimate questions and concerns and had become frustrated by senior figures within the organisation. In choosing not to act on these concerns, the opportunity was lost, deaths resulted and, 22 years later, it became necessary to establish an Independent Panel in order to discover the truth of what happened. Over 100 families were contacted as part of the review and the Independent Panel concluded that the lives of 450 patients were shortened while in hospital.

The Panel's main findings in relation to the prescribing and administering of drugs were as follows:

- Opioid usage without appropriate clinical indication
- Anticipatory prescribing with a wide range of doses
- Continuous opioid usage for patients admitted for rehabilitation or respite care
- Continuous opioids started at inappropriately high doses
- Opioids combined with other drugs in high doses
- Few patients survived long after starting continuous opioids
- The prescription and administration of drugs contravened guidelines

In addition to this, the panel highlighted concerns about the occurrence and certification of deaths. Until 1992, the number of deaths per year was fairly steady at about 100 per year but from 1993 to 1998 the annual death rate rose steadily to just over 200 in 1998. There were also concerns over the frequent occurrence of bronchopneumonia as a cause of death in over 39.5% of the patients who died at the Hospital.

The Panel concluded that in short, during the period between 1989 and 2000 at Gosport War Memorial Hospital, which appears to cover the start and end of the pattern of opioid prescribing of concern:

- There was a disregard for human life and a culture of shortening the lives of a large number of patients
- There was an institutionalised regime of prescribing and administering *"dangerous doses"* of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff.
- When the relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions.
- The senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.

The report of the Gosport independent Panel was published in June 2018 and can be read here

ASSESSMENT:

Although the report does not make specific recommendations, a number of conclusions are drawn. With respect to the UHB, those that are of most relevance relate to**:**

- The prescribing and administration of controlled drugs – specifically anticipatory prescribing and opioid use without clinical indication
- Failure to act on the concerns of nurses and of families
- Delays in identifying the serious problem with services at the hospital (Ineffective clinical governance and the culture of challenge)
- Mortality rates
- The professional accountability of nurses
- Death certification
- Safeguarding processes

The prescribing and administration of controlled drugs

The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 came into force on 9 January 2009. These Regulations relate to arrangements that support the safe management and use of controlled drugs in Wales.

There is a robust framework in place for the management of controlled drugs (CDs) in Secondary care. This is set out in Chapter 9 of the UHB Medicines Code.

The UHB has identified the Executive Medical Director as the Accountable officer, responsible for all aspects of the safe and secure management of CDS. The Accountable officer chairs the Local Intelligence Network (LIN). The purpose of the LIN is to share information about incidents and concerns relating to the use and possible abuse of controlled drugs including potential or actual systems failures. The Network:

- agrees local principles for sharing controlled drug (CD) intelligence between agencies
- actively shares intelligence regarding use and potential abuse of CDs
- discusses and agrees systems for reporting concerns
- agrees procedures for investigation and participate in incident panels
- agrees on the management of incidents affecting more than one agency
- receives reports from an investigation subgroup/Incident Panel and decisions of the Network Chair
- advises on monitoring processes and audits of CD management
- advises on training requirements for CD handling and undertake joint training
- advises on policy requirements

The registered nurse, midwife or clinical lead in charge of a ward or department is responsible for the safe and appropriate management of CDs in that area.

There are ward based pharmacists who visit ward areas on a daily basis during the week on thw main hospital sites, to scrutinize prescriptions, review patients and liaise with clinicians. There is more limited cover at weekends where the priority is to review new patients.

There is pharmacy support provided to all of the community hospitals but this is more limited than in the main hospitals.

Controlled drugs such as morphine that are often used in syringe drivers for end of life symptom management are kept as stock on the wards and ordered through the CD requisition books in the usual way. Patients may therefore be started on treatment before the pharmacist visit. This is consistent with the situation in other UHB areas however pharmacist visits are less frequent, due to it being a less acute setting with less frequent admissions and discharges.

Primary care - Prescription monitoring

As part of the monitoring process established following the Shipman report and the issue of The Controlled Drugs (Supervision of Management and Use)(Wales) Regulations 2008, controlled drug prescriptions issued in primary care are monitored on a quarterly basis regardless of the indication they are for.

Prescribing data obtained from CASPA is used to produce league tables to look at the variation in prescribing across the Health Board. Utilising on line applications, each controlled drug prescription, issued during one month of the previous quarter, is plotted on a graph. All prescriptions issued for quantities greater than three standard deviations above the mean for that preparation are reviewed individually.

In addition the on line prescribing catalogue is used to identify five random prescription for each controlled drug which are also individually reviewed.

If there are any concerns with these prescriptions either a letter is sent to the prescriber asking them to review the prescription and state that they are clinically happy or a prescribing advisor will investigate directly with the practice.

Failure to act on the concerns of nurses and of families

The UHB has a wide range of processes and systems to act on concerns raised by staff and by families. These include:
A well embedded electronic reporting system with appropriate escalation of serious issues
A well embedded Being Open Policy with strong Executive support and leadership
A Freedom to Speak up process and Whistleblowing policies
The Safety Valve procedure in which any member of staff has direct access to the UHB Chair should they wish to raise a safety concern.

The UHB has implemented the All Wales Framework for Assuring Service User Experience which describes four quadrants which grouped together provide a wide range of feedback including **real time**, **retrospective, proactive/reactive** and **balancing**. The UHB employs a wide variety of methods across the four quadrants in order to gain the views of service users so that this rich, qualitative information can be considered and used to act on concerns and improve services.

Delays in identifying the serious problem with services at the hospital (Ineffective clinical governance)

The Committee will be aware of the QSE arrangements which are in place across the organization with QSE groups established at Directorate, Clinical Board and UHB level. Reporting arrangements are clear and the minutes of the Clinical Board QSE meetings are reported to and published alongside the UHB QSE Committee. These are subject to internal audit assessment and in the last assessment in 2016, all Clinical Boards were rated as having either substantial or reasonable assurance in relation to their QSE governance arrangements. There is a weekly Executive- led concerns meeting where all serious incidents, complaints and emerging trends and themes are discussed.

There is a QSE dashboard in place and Clinical Boards are held to account for performance against a range of QSE KPIs at Executive Performance Monitoring meetings**.**

Executive Safety Walkrounds are carried out. There are 11 teams consisting of an executive and Independent member, who carry out a monthly visit to areas across the Health Board to meet staff and talk about safety issues and concerns.

There is also a program of Internal unannounced, Observation of Care visits which are carried by senior clinical staff across clinical departments in a variety of settings across the UHB. The Executive Nurse Director may also commission an unannounced visit to any area which gives cause for concern.

In addition to this, the UHB is subject to external scrutiny and inspection, by it's regulator Healthcare Inspectorate Wales and Medicines Management is a key area of unannounced inspection. In addition to this wards are regularly visited by the Community Health Council and although they do not have a role in scrutinizing medicines practice they are able to visit areas on an unannounced basis and talk freely with staff, patients and relatives.

Mortality rates

Mortality rates are reported regularly to Board as part of performance monitoring.

All in-patient deaths are subject to a Level 1 review and this is recorded on the UHB Electronic Mortality Audit Tool (EMAT). There are triggers in place for a more detailed Level 2 review by a senior clinician if there are concerns about care. A paper on Mortality and Harm is presented to the QSE Committee twice a year.

The most recent internal audit of Mortality Reviews was rated with reasonable assurance and there is an improvement plan in place to address the recommendations.

Roles and responsibilities of nurses

Until very recently nurses were bound by the NMC Standards for Medicine Management. These Standards were withdrawn on 28th January 2019 and all UHB nurses have been advised that until further information is available that medicines related practice refers to the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS Policy) and the UHB's Medicines Code. The UHB is advised that at some point there will be All Wales Standards made available.

The registered nurse, midwife or clinical lead in charge of a ward or department is responsible for the safe and appropriate management of CDs in that area.

All post registration nursing and midwifery staff joining the organisation attend medicines management education, this includes a skills assessment document which is completed in the appropriate clinical area. Underpinning knowledge of CD practice and observation of CD administration practice is included in this.

The NMC code, the Being Open Policy and Duty of Candour in relation to medicines practice is emphasized, as part of medicines management education for nurses and midwives,

Nursing staff are expected to report incidents of concerns in line with the UHB Incident, hazard and near miss reporting policy

Death certification

The arrangements for scrutinising Medical Certificates for Cause of Death (MCCDs) have remained largely unchanged for over 50 years and it is widely accepted that there are concerns about their efficacy and efficiency, particularly for those cases which are not referred to a coroner. From April 2019, the role of the medical examiner will be introduced to Wales on a non-statutory basis. The role of the medical examiner will be to conduct independent medical scrutiny of cause of death in all non-coronial cases. The role of Medical examiners is described by the Royal College of Pathologists as the last piece of the jigsaw of ensuring patient safety when someone dies; their role is ‘’not to investigate but to detect and pass on." Over the next three months, the UHB will need to agree the governance arrangements that will be put in place to support the role of the medical examiner and to ensure the independence of the role and the way in which it will support internal governance and patient safety systems.

Safeguarding processes

The UHB has robust safeguarding processes in place in line with National and Welsh Legislation; All Wales procedures and guidance, as well as additional local policies and procedures.

Safeguarding reports are presented to every private session of the QSE Committee (because of the sensitive nature of their content) but the public Committee also receives an annual report.

The UHB works closely with the South Wales Police and information is exchanged as part of Professional Strategy meetings.

Professional Concerns/Part 1V: This multi-agency process is enacted when the UHB is notified of employees arrested, charged or other safeguarding issues are brought to the UHBs notice. The All Wales Child Protection Procedures (2008) are enforced for professionals employed in a child caring capacity; the process is led by the Safeguarding Officer within the Local Authority. For professionals employed in an adult caring role within the UHB, the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (2013) is followed and led by the UHB Head of Safeguarding. Police and LA are invited to all health led meetings. This process may change with the implementation of the new Wales Procedures that are scheduled to be introduced in 2019.Robust working arrangements with partner agencies is facilitated by the Multi-Agency Safeguarding Hub (MASH) in Cardiff.

While a high level of assurance can be provided in relation to many of the issues identified by the Independent Panel report, further work is required to provide assurance in relation to the following areas:

- The prevalence of and controls in place in relation to anticipatory prescribing and to prevent the use of opioids without appropriate clinical indication - with specific focus on rehabilitation and respite settings
- Mortality relates in community hospitals, rehabilitation settings and respite care
- Trends and themes in death certification

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

NOTE the contents of the report and **AGREE** that a further assurance report is presented to the June 2019 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	√	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.

Report Title:	Work Plan 2019/20 – Quality, Safety and Experience Committee								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	19.02.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee with the opportunity to review the Quality, Safety and Experience Committee Work Plan 2019/20 prior to presentation to the Board for approval

REPORT

BACKGROUND

The work plan for the Committee should be reviewed annually by the Committee prior to presentation to the Board to ensure that all areas within its Terms of Reference are covered within the plan.

ASSESSMENT

The work plan for the Quality, Safety and Experience Committee 2019/20 has been based on the requirements set out within Quality, Safety and Experience Committee Terms of Reference which assumes that the Committee meets six times a year

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

REVIEW the Work Plan 2019/20
APPROVE the Work Plan 2019/20
RECOMMEND approval to the Board of Directors

Shaping our Future Wellbeing Strategic Objectives			
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	x
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	

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

Quality Safety and Experience Committee Work Plan 2019 - 20		
A -Approval D- discussion I - Information	**Exec Lead**	**16-Apr**
Agenda Item		
Standing Items		
Sub Committee Assurance Reports from Clinical Boards		
Community Health Council Reports		
Patient Story		
Quality Governance		
Quality, Safety and Improvement Framework Standard 3.1		
Patient Experience Framework		
Annual Quality Statement		
Health Care Standards Self Assessment		
Policies		
Key External Reports		
Health Promotion Protection and Improvement		
Safe Care		
Serious Patient Safety Incident Report		
Patient Safety Solutions		
Blood Management		
Patient Safety Walkarounds		
Infection Prevention and Control		
Cleaning Standars		
Patient Falls		
Medication		
Nutrition and hydration		
Safeguarding		
Protecting patients from pressure damage		
POCT		
Care of deteriorating patient (NEWS)		
Medical Devices		
Claims and Concerns		
Effective Care		
Mortality and Harm		
Clinical Audit Plan		
Cancer reviews		
Research and Development		
LIPs		
NICE Guidance		
Dignified Care		
HIW activity update 4.1		
Carer Measure 4.1		
Timely Care		
Outpatient follow up and surveillance processes standard 5.1		
Individual Care		
Sensory Loss standard 6.2		

Quality, Safety and Experience Committee Governance		
Chairs Action	SE	I
Annual Work Plan	NF	
Review of Meeting	NF	D
Self assessment of effectiveness	NF	D
Review Terms of Reference	NF	
Produce Committee Annual Report	NF	
Minutes of Audit Committee Meeting	NF	A
Action log of Audit Committee Meeting	NF	D

18-Jun	13-Aug	17-Sep	15-Oct	17-Dec	18-Feb

I	I	I	I	I	I
					A
D	D	D	D	D	D
					A
					A
					A
A	A	A	A	A	A
D	D	D	D	D	D

Report Title:	Terms of Reference – Quality, Safety and Experience Committee							
Meeting:	Mental Health and Capacity Legislation Committee					**Meeting Date:**	12.02.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**	
Lead Executive:	Director of Corporate Governance							
Report Author (Title):	Director of Corporate Governance							

SITUATION

In line with the UHB's Standing Orders, Terms of Reference for Committees of the Board, should be reviewed on an annual basis.

This report provides Members of Quality, Safety and Experience Committee with the opportunity to review the Terms of Reference prior to submission to the Board for approval.

REPORT

BACKGROUND

The Terms of Reference for the Quality, Safety and Experience Committee were last reviewed in January 2018.

ASSESSMENT

The Terms of Reference for the Quality, Safety and Experience Committee have been reviewed by the Director of Corporate Governance. There are a limited number of changes to the document, these have been tracked and left in the draft so Committee Members can identify the changes that have been made.

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

APPROVE the changes to the Terms of Reference for the Quality, Safety and Experience Committee and
RECOMMEND the changes to the Board for approval.

Shaping our Future Wellbeing Strategic Objectives			
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	x
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						
Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

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

Quality, Safety and Experience Committee

Terms of Reference and Operating Arrangements

Approved at QSE on 13th February 2018

1. INTRODUCTION

1.1 The University Health Board (UHB) Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders (and the UHB Scheme of Delegation), the Board shall nominate a Committee to be known as the **Quality, Safety and Experience Committee**. This Committee's focus is on ensuring patient and citizen quality and safety including activities traditionally referred to as 'clinical governance'. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Experience Committee "the Committee" is to provide:

- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to quality, safety and experience of health services;

- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality, safety and experience of public health, health promotion and health protection activities;

- ***assurance*** to the Board in relation to the UHB arrangements for safeguarding and improving the quality and safety of patient and citizen centred health improvement and care services in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales;

- ***assurance*** to the Board in relation to improving the experience of patients, carers citizens and all those that come into contact with our services including those provided by other organizations or in a partnership arrangement

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its ***provision of advice*** to the Board:

- oversee the initial development of the UHB plans for the development and delivery of high quality and safe healthcare and health improvement services consistent with the Board's overall Strategy and any requirements and standards set for NHS bodies in Wales;

- consider the implications for quality, safety and experience arising from the development of the UHB Strategy, Integrated Medium Term Plan or plans of its stakeholders and partners, including those arising from any Joint Committees of the Board;

- consider the implications for patient and citizen experience arising from internal and external review/investigation reports and actions arising from the work of external regulators;

- consider the outcomes for patient feedback methodologies in line with the National Service User Framework

- review achievement against the Health and Care Standards in Wales to inform the Annual Quality and Annual Governance Statements;

- consider and approve policies as determined by the Board.

- monitor implementation of the Quality, Safety and Improvement (QSI) Framework

3.2 The Committee will, in respect of its ***assurance role***, seek assurances that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and improvement services across the whole of the UHB activities and responsibilities.

3.3 To achieve this, the Committee's programme of work will be designed to ensure that, in relation to all aspects of quality, safety and patient and citizen experience:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;

- the organization, at all levels has a citizen centred approach, putting citizens, patients and carers, patient safety and safeguarding above all other considerations;

- the care planned or provided across the breadth of the organization's functions is consistently applied, based on public health principles, sound evidence, clinical effectiveness and meets agreed standards;

- the organization, at all levels has the right systems and processes in place to deliver, from a patient, carer and citizen perspective - efficient, effective, timely and safe services;

- the organization has effective systems and processes to meet the Health and Care Standards;

- the workforce is appropriately selected, trained, supported and responsive to ensure safe, quality and patient centred services ensuring that regulatory arrangements, professional standards and registration/revalidation requirements are maintained;

- there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organization;

- there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;

- risks are actively identified and robustly managed at all levels of the organization;

- decisions are based upon valid, accurate, complete and timely data and information;

- there is continuous improvement in the standard of quality and safety across the whole organization – continuously monitored through the Health and Care Standards in Wales;

- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that:

    - sources of internal assurance are reliable, e.g., internal audit and clinical audit teams have the capacity and capability to deliver;

    - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and

    - appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims, known collectively as ‘concerns’, (noting that concerns information is routinely included in the standing item on the Board agenda (Patient Safety Quality and Experience Report) and will not be duplicated in Committee)

3.4 The Committee will advise the Board on the adoption of a set of key indicators of safety, quality and patient and citizen experience against

which the UHB performance will be regularly assessed and reported on through the Annual Quality Statement.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee, Sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Board has approved the following sub-Committees:

- 8 Clinical Board Quality and Safety sub-Committees

3.8 The Committee has authority to establish short life working groups which are time limited to focus on a specific matter of advice or assurance as determined by the Board or Committee.

4. MEMBERSHIP

Members

4.1 A minimum of four (4) members, comprising:

Chair	Independent Member of the Board

Members	3 other Independent Members of the Board, to include a Member of the UHB Audit Committee. The Committee may also co-opt additional independent 'external' members from outside the organization to provide specialist skills, knowledge and expertise.

Attendees

4.2. The following officers **are required to be in attendance**:

- Executive Nurse Director (Lead Executive)
- Medical Director
- Director of Therapies and Health Sciences
- Chief Operating Officer
- Director of Public Health
- Director of Finance
- Director of Planning
- Board Secretary/Director of Corporate Governance
- Assistant Director of Patient Safety and Quality
- Assistant Director of Patient Experience

Key Directors should be represented if they are unable to attend a meeting.

Other Executive Directors or deputies should attend from time to time as determined by the Committee Chair.

4.3. By invitation:

The Committee Chair may extend invitations to attend Committee meetings as required from within or outside the organization to whom the Committee considers should attend, taking account of the matters under consideration at each meeting.

- 2 x Staff Representatives and
- the Cardiff and Vale of Glamorgan Community Health Council.

Secretariat

4.4 Secretary: as determined by the Board Secretary/Director of Corporate Governance.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board,

based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair and, where appropriate on the basis of advice from the UHB Remuneration and Terms of Service Committee.

Support to Committee Members

4.7 The Board Secretary/, Director of Corporate Governance on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of development for Committee members in conjunction with the Director of Workforce and Organizational Development.

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

5.2 Meetings shall be held bi-monthly, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB Annual Plan of Board Business.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the

quality and safety of healthcare for its citizens. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organization, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the UHB values, corporate standards, priorities and requirements, for example, public health, equality, diversity and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of the Annual Quality Statement.

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

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

7.3 The Board Secretary/Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

9. REVIEW

9.1 These Terms of Reference and operating arrangements shall be reviewed on a biennial basis by the Committee with reference to the Board.

The Board will keep under review the need for the 8 Quality and Safety Sub-Committees to ensure an alignment with accountabilities and responsibilities of the Clinical Board organizational model.

Report Title:	Draft Annual Report 2018/19 – Quality, Safety and Experience Committee								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	19.02.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee with the opportunity to discuss the attached Annual Report prior to submission to the Board for approval.

REPORT

BACKGROUND

It is good practice and good governance for the Committees of the Board to produce an Annual Report from the Committee to demonstrate that it has undertaken the duties set out in its Terms of Reference and provide assurance to the Board that this is the case.

ASSESSMENT

The attached Annual Report 2018/19 of the Quality, Safety and Experience Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference. The Committee has achieved an overall attendance rate of 83% and has met on six occassions during the year including a Special Meeting.

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

REVIEW the draft Annual Report 2018/19 of the Quality, Safety and Experience Committee.
RECOMMEND the Annual Report to the Board for approval.

Shaping our Future Wellbeing Strategic Objectives			
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	x
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	

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Annual Report of Quality, Safety and Experience Committee 2018/19

1.0 INTRODUCTION

In accordance with best practice and good governance, the Quality, Safety and Experience Committee produces an Annual Report to the Board setting out how the Committee has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

The Committee membership is a minimum of four Independent Members and during the financial year 2018/19 the Committee comprised six Independent Members. In addition to the Membership, the meetings are also attended by the Director of Nursing (Executive Lead for the Committee), Medical Director, Executive Director of Therapies and Health Sciences, Chief Operating Officer, Executive Director of Public Health, Executive Director of Finance, Executive Director of Strategic Planning, Director of Corporate Governance, Assistant Director of Patient Safety and Quality, Assistant Director of Patient Experience.

3.0 MEETINGS AND ATTENDANCE

The Committee met six times during the period 1 April 2018 to 31 March 2019 in line with its Terms of Reference and has discharged its responsibilities by requesting reassurances from Trust Officers and colleagues. The Quality, Safety and Experience Committee achieved an attendance rate of 79% during the period 1st April 2018 to 31st March 2019 as set out below:

	17/04/2018	12/06/2018	18/09/2018	16/10/2018	18/12/2018	19/02/2019	% Attendance
Maria Battle	√	√	√	X	√	√	**83%**
Gary Baxter	N/A	X	X	√	√	√	**60%**
Susan Elsmore	√	X	X	√	√	√	**67%**
Akmal Hanuk	√	√	√	√	√	√	**100%**
Michael Imperato	√	√	X	√	√	√	**83%**
Dawn Ward	X	√	√	√	√	√	**83%**
	80%	**67%**	**50%**	**83%**	**100%**	**100%**	**79%**

4.0 TERMS OF REFERENCE

The Terms of Reference were reviewed and approved by the Committee on 19th February 2019 and were approved by the Board on 31st March 2019.

5.0 WORK UNDERTAKEN

During the financial year 2018/19 the Quality, Safety and Experience Committee reviewed the following key items at its meetings:

Private QSE Committee

- Safeguarding Update
- Services for Transgender Patients
- Winter Pressures – Safety of patients and letter from Minister
- Concerns about Paediatric Surgery
- Governance Leadership and Accountability
- Insourcing Ophthalmology Concerns

Public QSE Committee

Clinical Board Reports

- Surgery Services Clinical Board QSE Report
- Clinical Diagnostics and Therapeutics Clinical Board QSE Report
- Children and Women's Clinical Board QSE Report

Inspections, Peer Reviews and other Reviews

- WAO Report on Discharge Planning
- Community Health Council
- Community Health Council report
- Cancer Peer Review – Head and Neck
- Cancer peer Review – Gynaecology
- Report on Outliers Cancer Peer Review – Cancer Pathways
- Healthcare Inspectorate Wales Annual Report 2016/2017
- HIW Activity Update
- Management of Outpatient follow ups and Endoscopy Surveillance
- Mortality Data and Mortality Review

Plans

- Committee Work plan for 2018/2019
- Clinical Audit Plan 2017/2018
- Clinical Audit Plan 2018/2019

Risk and Assessments

- Infection Prevention and Control Risk Assessment
- Care of Deteriorating Patient – Revised Risk Assessment

- Infection Prevention and Control – Revised Risk Assessment
- Pressure Ulcer Risk Assessment, Prevention and Treatment
- Revised Corporate Risk and Assurance Framework

Policies and Guidance

- Out of Date QSE Policies
- NSH Wales Prior Approval Policy
- All Wales Point of Care Testing Policy
- Intra Operative Cell Salvage Policy and Procedure
- Cleaning Standards
- Safer Patient Notice 24 – Patient Identification Bands
- Management of Healthcare Workers Infected with Bloodborne viruses
- WHC Integrated Guidance on Health Clearance of Healthcare Workers and

Other Reports

- Annual Quality Statement
- Ophthalmology Services Presentation
- Sensory Loss
- Out of Hours Interventional Radiology
- Medicines Management
- Medicines Management Review of Terms of Reference
- Update – Single Rooms Isolation Rooms and Decent Facilities
- Single Point of Entry for Children
- Patient Falls Exception Report
- Nutrition and Hydration
- Hot Topics – Serious Incident Involving WAST
- Endoscopy – Serious Incidents and Lessons Learnt
- Update - QSE Improvement Framework
- Patient Experience Framework Update

6.0 REPORTING RESPONSIBILITIES

The Committee has reported to the Board after each of the Quality, Safety and Experience Committee meetings by presenting a summary report (introduced from November 2018) of the key discussion items at the Quality, Safety and Experience Committee. The report is presented by the Quality, Safety and Experience Committee.

7.0 OPINION

The Committee is of the opinion that the draft Quality, Safety and Experience Committee Report 2018/19 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Susan Elsmore

Committee Chair

Report Title:	Self Assessment – Quality, Safety and Experience Committee								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	19.02.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee with the opportunity to discuss the attached self-assessment and associated process to be undertaken by the Director of Corporate Governance.

REPORT

BACKGROUND

It is good practice and good governance for the Committees of the Board to undertake an assessment of their effectiveness on an annual basis.

ASSESSMENT

Attached to the report is an effectiveness assessment to be undertaken by the Members and the Executive Lead of the Quality, Safety and Experience Committee. The assessment will be sent out to Members to complete and then the results will be analysed by the Director of Corporate Governance. The results of the review and an action plan to improve will then be reported back to the next meeting of the Quality, Safety and Experience Committee.

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

APPROVE that the attached effectiveness review is undertaken and results and action plan reported back to the next meeting of the Committee.

Shaping our Future Wellbeing Strategic Objectives			
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	x
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	

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

Quality, Safety and Experience Committee – Self Evaluation 2019

Key to status (shown in Status column where applicable): 1=must do 2=should do 3=could do

Establishment, Composition, Organisation, Resources, Duties		Status	Strong	Adequate	Needs Improvement	Comments
1	The Quality, Safety and Experience Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the committee and the full board.	1				
2	The board was active in its consideration of Quality, Safety and Experience Committee composition	2				
3	The Quality, Safety and Experience Committeeactions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.					
4	The Quality, Safety and Experience Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.	2				
5	Quality, Safety and Experience Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.	2				
6	Appropriate internal or external support and resources are available to the Quality, Safety and Experience Committee and it has sufficient membership and authority to perform its role effectively.	1				
7	The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees	2				

Establishment, Composition, Organisation, Resources, Duties		Status	Yes	No	Comments
8	Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?	2			
9	Are changes to the committee's current and future workload discussed and approved at Board level?	2			
10	Are committee members independent of the management team?	1			

Agenda Management and Oversight of Process		Status	Strong	Adequate	Needs Improvement	Comments
11	The Quality, Safety and Experience Committee agenda-setting process is thorough and led by the Quality, Safety and Experience Committee chair.					

Agenda Management, Oversight of the Financial Reporting Process, Compliance with the Law and Regulations Governing the NHS and Internal Control		Status	Yes	No	Comments
12	Has the Committee established a plan for the conduct of its work across the year?	2			
13	Has the committee formally considered how its work integrates with wider performance management and standards compliance?	2			
14	Has the committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?	2			
15	Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?	2			
16	Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?	2			

Continuous Improvement		Status	Strong	Adequate	Needs Improvement	Comments
17	The Quality, Safety and Experience Committee's self-evaluation process is in place and effective	2				

Overall Evaluation		Status	Strong	Adequate	Needs Improvement	Comments
18	What is your overall assessment of the performance of the Quality, Safety and Experience Committee?					

Additional Comments:

Name

Position

Report Title:	**Assessment Unit (AU) improvement plan**						
Meeting:	Quality, Safety and Experience Committee				**Meeting Date:**	19/02/2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:							
Report Author (Title):	**Director of Nursing MCB**						

SITUATION

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee assurance that appropriate action is being undertaken by Medicine Clinical Board (MCB) in relation to the Assessment Unit (AU) in UHW, following concerns being raised in relation to the quality of patient care, and the inappropriate footprint of AU via a number of sources, including an unannounced Community Health Council (CHC) visit in September 2018.

BACKGROUND

Medicine Clinical Board were requested to implement immediate actions in response to the recommendations made by the CHC following an unannounced visit which was carried out in the Assessment Unit on 2nd September 2018; in response to a number of concerns received by the Community Health Council in August via the Text Local Service, regarding poor patient experience when having attended the Unit, as well as concerns raised by the MCB, patients and staff.

Medicine Clinical Board, have commissioned an improvement work programme focusing on short, medium and long term improvements, highlighted within the report, which has been shared with the CHC.

ASSESSMENT

A number of key recommendations have been made by the CHC following their visit and an updated plan has been revised and sent back to the CHC to confirm that actions are being taken.

Some of the recommendations made have been addressed such as lack of water jugs, poor state of vending machines, need to review the AU food and drink policy, disrepair to floor and ceiling and a need to review the training requirements of staff.

There are however some recommendations requiring a longer term plan to implement. This includes recommendations made to provide a suitable waiting facility for people in AU, and the requirement to revise and implement procedures and processes to address inequalities of care during weekend periods, including the removal of discharge delays and availability of beds, treatments and services to those unfortunate to become seriously ill on the weekends.

MCB recognises the risks associated with maintaining the current AU lounge and a task and finish group has been established to review the footprint and patient pathways within the AU. This also sits under part of the improvement work being undertaken by MCB in collaboration with Lightfoot Solutions.

Discussion are ongoing with Surgery Clinical Board to consider establishing a surgical ambulatory care function within the surgical footprint at UHW during the weekend period to reduce overcrowding, delays and improve overall patient safety within AU and specifically the AU lounge.

The MCB recognise the AU requires environmental upgrade and is challenged by an increase in patient numbers, complexity of patients and the increasing demands on the service.

ASSURANCE is provided by: Medicine Clinical Board

RECOMMENDATION

The Committee is asked to support the actions that are being taken by MCB in relation to the recommendations made to the CHC.

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	
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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√

Equality and Health Impact Assessment Completed:	Not Applicable

This response outlines the immediate actions undertaken by Cardiff & Vale University Health Board to respond to the recommendations made by CHC Council following the unannounced visit which was carried out at the Assessment unit (AU) on 2nd September 2018; in response to a number of concerns received by the Community Health Council in August via the Text Local service, regarding poor patient experience and a lack of care and dignity.

Cardiff & Vale University Health Board are very concerned by the findings of the CHC members and the publics experience of the AU and are committed to improving patient and public experience when they visit our services and are in our care.

The Medicine Clinical Board, (MCB) have commissioned a focussed improvement work programme to focus on the short, medium and long term improvement and change of services highlighted by this report and also in response to concerns raised by the MCB, patients and staff.

Prior to receiving this report the MCB had sourced the 6 month interim appointment of an experienced Improvement Manager to review the footprint and patient pathways within the AU and the recommendations within this report will be included within this programme of improvement. The MCB recognise the AU requires environmental upgrade and is challenged by an increase in patient numbers, complexity of patients and the increasing demands on the service.

The MCB is committed to providing a high standard of care and experience to patients and the public. The enclosed Improvement plan addresses the broad actions, however many of the actions will require detailed and focussed work, which may be difficult to achieve within some of the time frames, due to the complex and whole system approach required to bring about the sustainable changes. However, the MCB would be happy to provide CHC with a 3 monthly progress briefing.

The UHB would like to clarify two references within the report;

The use of the questionnaires state SAU, Surgical Assessment unit, please can council confirm that the questionnaires are from patients cared for within the Assessment unit only.

The visit and report in 2015, refers to ward A1 link, where the assessment unit was located prior to its current location or is this a referral to the surgical assessment unit located on ward A1.

IMPROVEMENT PLAN

AREA VISITED: Assessment unit (AU) **DATE OF VISIT**: September 2nd 2018

Recommendations for Council:	Actions Undertaken by Health Board/Trust:	Person responsible	HB/Trust Timescale to address outstanding actions:
Revise and implement procedures and processes to ensure that patients receive timely and appropriate treatment and services during periods with no specific emergency i.e. no one having to stay on a trolley more than 12 hours and 6 hours in a chair. Any changes should not cause any increase in times delays for patients being allowed to enter hospital.	Clinical Board has led meeting to initiate focussed improvement work programme to identify short – medium and long term actions to reducing length of time patients wait on trolleys and in chairs. Actions undertaken include:- This includes learning from the Canterbury Model of care and sharing improvement practices to improve flow through the unscheduled care system. 3 work streams are in progress. - Admission Avoidance - Inpatient pathway management -Safer model of care – focus in patient Ward / Board rounds (i) An area of the AU will convert trolleys to beds. **Update – 28/12/2018** Following review agreed action is not to convert a specific area of AU to bed areas but review process of ordering beds to ensure there are no delays. A Meeting was undertaken in December 2018 with the UHB's contract company Medstrom in order to streamline the process to obtain hospital beds in a consistent and timely manner.	Director of Nursing Medicine Clinical Board - RA Director of operations Senior Nurse - LW Senior Nurse - LW	**24/10/2019 – Meeting held. Achieved** Winter programme of work Nov-end march 19 (See below) Update 28/12/2018 - **Achieved**

Recommendations for Council:	Actions Undertaken by Health Board/Trust:	Person responsible	HB/Trust Timescale to address outstanding actions:
	Stage 1:- Individual patient assessments are undertaken. If required x4 beds will be available on A7 corridor for collection. *(Monday to Friday Medstom will be contacted if further beds are required. Out of hours NIC to liaise with site nurse for availability within the hospital)*	Senior Nurse - LW	Update 28/12/2018 - **Achieved**
	Stage 2:- Option appraisal for converting AU to beds to be submitted to the MCB (ii) Review of function of MEACU / AU Lounge **Update – 28/12/2018** • Task and Finish Group established.	Lead Nurse WP Senior Nurse - LW Service Improvement Manager - SB	**4th March 2019**
	(iii) Review process for Non-Medicine patients waiting in AU **Update – 28/12/2018** • Information has been provided to the Director of Operations for Surgery outlining the patient safety issues that having surgical patients in the Assessment Unit Lounge brings.	Director of Operations – DA/ Service Improvement Manager - SB	**31st April 2019**
	(iv) Review criteria of lounge **Update – 28/12/2018** • SOP created for MEACU. This has been sent out to Consultants and DMT for comments. This plan relies on the Surgical Patients being treated in a different area to the Assessment Unit Lounge	Service Improvement Manager - SB	

Recommendations for Council:	Actions Undertaken by Health Board/Trust:	Person responsible	HB/Trust Timescale to address outstanding actions:
Revise and implement procedures and processes to address inequalities of care during weekend periods, including the removal of discharge delays and availability of beds, treatments and services to those unfortunate to become seriously ill on the weekends.	MCB have reviewed nursing and Medical cover and there are no inequalities of care delivery. (i)Review any inequality factors related to facilities, therapies, social care. **Update – 28/12/2018** • Winter funding monies have provided extra FOPAL cover at the weekends and therapy cover on a Sunday until 31st March 2019 • In addition Nursing establishments are regularly reviewed with focused recruitment plans including recruitment events and engagement with the all Wales Student Streamlining process.	Director of Operations – DA/ Service Improvement Manager – SB Director of Operations – DA/ Service Improvement Manager – SB Lead Nurse WP	2 months - Update – 28/12/2018 **Achieved** Update 28/12/2018 **Achieved**
Provide a suitable waiting facility for people in AU, for those that require a wait of greater than 2 hours, to be in an enclosed room, provided with a variety of comfortable seating including recliners, together with suitable facilities, lighting and décor that are appropriate to longer waits during daytime and night time hours, together with an area where conversations, monitoring and treatment can be carried out that allows privacy and dignity	This will be discussed and actioned as part of the improvement work programme to identify short – medium and long term actions. The ultimate plan is to shut the Assessment Unit Lounge and have 24 hours a day 7 days a week working in MEACU for Medical patients only. Update – 28/12/2018 • New seating has been ordered 29/11/8 for the AU lounge x20 chairs have been ordered through funding provided by the Medicine Clinical board – To cover the delay in delivery time chairs have been borrowed from other clinical areas that have excess seating in non-commissioned areas.	Senior Nurse LW	3 months Update 28/12/2018 **(This action may be difficult to achieve within 3 months as would require refurbishment of area within AU)** **Review 30/04/19** **11/01/19 Achieved** **All chairs in place**

Recommendations for Council:	Actions Undertaken by Health Board/Trust:	Person responsible	HB/Trust Timescale to address outstanding actions:
	• There are quiet rooms within the department where patients can have confidential discussions – This will be accommodated on individual need and assessment	Unit Manager / NIC	**25/10/18 Achieved**
	• Clinical Staff have been reminded of their responsibility to keep the noise and disturbance by night to a minimum	Senior Nurse LW	**25/10/18 Achieved**
	• In addition Ear plugs are also provided for patients if required/requested	Unit Manager / NIC	**25/10/18 Achieved**
Review and implement the management arrangements of the unit to ensure adequate reception cover and clarity of responsibility for the regular updating of patients on times and reasons for waits together with addressing their concerns in relation to food comfort and drink	**Update – 28/12/2018** • The AU Receptionist cover is in place 7 days a week 7am until 12pm; however, there is no cover overnight.		Update 28/12/2018 **Reviewed current cover. No further actions required.**
	• The standard process after midnight is all patients will be booked in at the main Emergency Unit reception area as the patient demand is significantly reduced.		
	• NIC in AU will be available for induvial enquiries		
	• Clinical Staff have been reminded of their responsibility to keep patients regularly updated with regard to waiting times, treatment plans and access to food and drink	Unit Manager EG	***See action below***

Recommendations for Council:	Actions Undertaken by Health Board/Trust:	Person responsible	HB/Trust Timescale to address outstanding actions:
Review the food and drink policy in relation to the AU to ensure that all those having to be within the unit including carers and family for more than 4 hours are provided with appropriate food and drink at all hours of the day and night. Clearly publicise the availability of food and drink.	The food provisions in AU were reviewed on 4th September 2018 in relation to patient experience and to reduce waste. At the review the Menus were reviewed to ensure patients were nourished and hydrated within the department.	Senior Nurse LW Senior Nurse LW	**Review meeting for food service provisions undertaken for in October 31st 2018 with Facilities Managers** Update 28/12/2018 – **will review new meal time arrangement by 31/02/2019**
	Update – 28/12/2018 **Nursing and Medical Staff** • **Meal Time Rounder's** – To continue support meal time rounder's service – This ensures that a specific HCSW is allocated to support patients who require assistance with nutrition and hydration. Each meal time rounder is allocated on the daily nurse roster for both the North and the South side. Nurse in charge to liaise with rounder's where there are specific needs in the Ambulatory areas within AU. • Unit Manager to support a revamp of all posters allergen awareness etc. throughout the AU. To allocate specific project lead to undertake a service improvement project on nutrition and hydration support for patients and relatives. • To provide new waiting room chairs with pull up table for those who require food in the lounge areas.	Unit Manager - EG Unit Manager EG Senior Nurse LW	**October 2018 - Achieved** **18/01/2019 Achieved** **Achieved 11/01/19**

Recommendations for Council:	Actions Undertaken by Health Board/Trust:	Person responsible	HB/Trust Timescale to address outstanding actions:
	Update – 28/12/2018 **Catering Team** **Review of bed plans to ensure patients are receiving correct diets. To include patients in waiting areas who request food or that nurses identify who require nutrition** **To ensure there is enough soup available on meal rounds. New soup rotation plan implemented** • 10oz double handled soup bowls purchased to provide sufficient portion sizes for all patients start date 2/11/18 of new mugs. Plastic cups to be removed as previously requested as this may pose an H&S risk. • Catering management team to review training requirements of catering staff, • To undertake regular communication meetings to pick up any issues. To regularly monitor the food provision service rectifying any issues. • SIP team will revisit some services to assess service and how winter pressures may be taking affect. **Update – 28/12/2018** **Dietetic Staff** • To provide the AU with dietetic assistants to provide/support nutrition and hydration assessments. *This will be in addition to normal expected nutritional support provided by nursing staff.*	Senior Nurse LW/Catering Manager KN Catering Manager KN SIP Manager SM Senior Nurse LW/ Catering Manager KN SIP Manager SM Nutrition & Dietetics lead JJ Nutrition & Dietetics lead JJ	**Achieved October 2018** **Achieved 01/11/2018** **31/02/2019** **Will review new meal time arrangement by 31/02/2019** Achieved January 2019 via Winter funding

Recommendations for Council:	Actions Undertaken by Health Board/Trust:	Person responsible	HB/Trust Timescale to address outstanding actions:
	• To bid for winter money to reintroduce dietetic assistant to support extra hydration rounds including supplements and milk rounds. • To re -audit changes in food provision service to ensure it continues to meet the *All Wales Food* and *Fluid standards* requirements and patient experience. **Corporate Support** • To provide a start date for the new vending machines this will allow a great improvement of the variety and availability of food and hot drinks for relatives and visitors. • Replenishing arrangements time frames and variety selections are within the vending machine contract **New Initiatives** The Red Cross is a new initiative via Welsh Government funding within the Assessment Unit to:- • To spend time with patients, families and carers whilst waiting for treatment. • To speak to medical staff on behalf of patients to explain their needs and find out information. • Provide practical assistance such as contacting a relative on the patient's behalf, providing drinks, food, blankets, collecting pharmacy prescription and accompanying patients whilst having tests. • Prompt and encourage any patients at mealtimes as guided by the Nursing staff.	Nutrition & Dietetics lead JJ Commercial Services Manager SW Senior Nurse JW	Achieved 28/1/19. X2 band 3 assistants hours of work are 8am to 4pm Monday to Friday **28/02/19** **Achieved 10/12/18 roll out of new vending machines** **Variety of payment methods to be agreed cash/card** **Achieved December 2019** **As above** **As Above** **As above** **As above**

Recommendations for Council:	Actions Undertaken by Health Board/Trust:	Person responsible	HB/Trust Timescale to address outstanding actions:
	• Can provided transport when needed to vulnerable mobile patients and settle them into their home		
Review the training and support for staff in the unit to address issues of stress, dementia and other challenging behaviours	Link roles/ champions include:- • Allocated Dementia Champions • Allocated Sensory loss champions and booklets Training and support in place includes:- • Staff have extensive training in place with a dedicated education team to support staff to develop managerial and clinical skills. • The Unit Manger undertakes daily open hubs at set time to provide staff support. Urgent support is provided outside these times. • Regular team away days are scheduled. • Staff have access to a work place stress assessment and access to employee health & wellbeing.	Nursing Sister CP Education Lead RG Unit Manager EG	Update 28/12/2018 **Achieved** **Update plan due to MCB 11/2/19** **As Above** **As Above** **All staff have access to Occupational Health/Employer Wellbeing Services. Stress assessments are carried out when required/appropriate**
Address the issues of disrepair to floor and ceiling, equipment out of order (hot drinks and vending machines, disposal unit and lack of water jugs)	Issues addressed following visit include:- • Reporting and repair of ceiling tile has been undertaken • Remedial repairs of the flooring have been undertaken – Unit manager to monitor and report any future deterioration	work to be undertaken Unit Manager EG	**Remedial work achieved. Dec 2018**

Recommendations for Council:	Actions Undertaken by Health Board/Trust:	Person responsible	HB/Trust Timescale to address outstanding actions:
	in flooring condition. (This is under capital estates and planning and will require closure of services to accommodate new flooring. This should be classed as a long term summer plan. Remedial repairs will be monitored by Unit Manger EG	Unit Manager EG	**Achieved 10/12/18**
	• Vending machines contract has been renewed and checks have been put in place to ensure prompt escalation of any issues with the vending machines and stock levels.	Commercial Services Manager SW	**Achieved December 2018**
	• Vending machines delivered on 18th December 2018; providing hot drinks and snacks in AU lounge, cold drinks and snack in MEACU. Food provision services as highlighted above will continue to be provided within the AU lounge area.	Unit Manager EG	**Achieved December 2018**
	• Machines allow both cash and card payment.		**Achieved December 2018**
	• Disposal unit has been repaired		**Achieved December 2018**
	• Water jugs are available and fresh water is regularly provided within AU trolley supported by all staff members.		
	• AU lounge has a dedicated water fountain which is easily accessible.	Unit Manager EG	
	• Extra blankets and pillows available following review of linen order.		**Achieved December 2018**
Review and update all signs and information to provide clear directions and details including food and drink availability and who to contact to obtain help and assistance.	• New signage has been requested and will be in place within 1 month.	Senior Nurse LW Unit Manager EG	**Achieved January 2019 awaiting order to be delivered.**
	• Patient and carer information will be reviewed in conjunction with patient experience team		**31/02/2019**

LW – Lisa Waters **SB** – Sam Barret **RA**- Rebeca Aylward **WP**-Wayne Parsons **SM**- Sarah Maggs

EG – Elinor Gerrard KN – Kevin Nunney **SW** –Simon Williams **RG** – Rochelle Griffiths **CP** – Ceri Pricesmith

DA – David Allison (now Sarah Follows as roles changed) **JJ** - Judith Jenkins

Green –Achieved Red – Not yet achieved

REPORT TITLE:	**CONCERNS AND CLINICAL NEGLIGENCE CLAIMS REPORT – 1st April 2018 – 31st December 2018**						
MEETING:	Quality, Safety and Experience				**MEETING DATE:**	**19 February 2019**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
LEAD EXECUTIVE:	Executive Nurse Director						
REPORT AUTHOR (TITLE):	Assistant Director Patient Experience - 029 2184 6108						

PURPOSE OF REPORT:

SITUATION:

The purpose of this paper is to present the Committee with a more detailed report of concerns and clinical negligence claims in the period 1st April 2018 to 31st December 2018.

REPORT:

BACKGROUND:

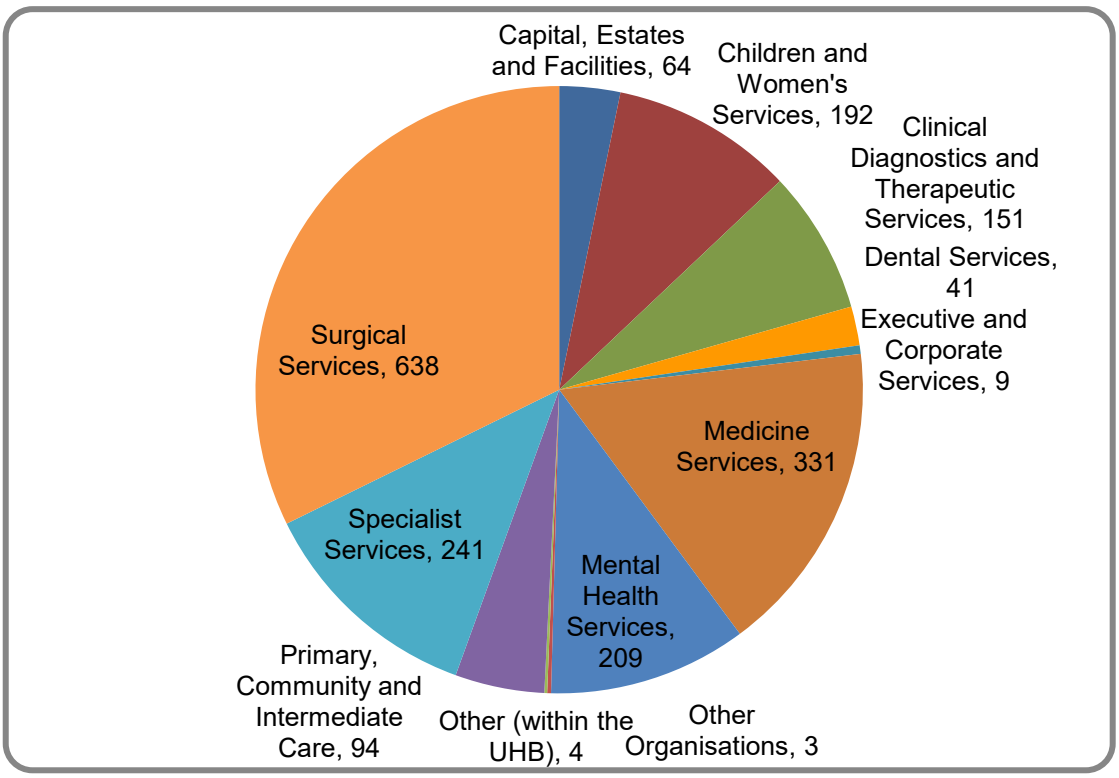
The UHB has a wide range of data which provides a level of assurance on the safety and quality of services, as well as on the experience of patients and families. This report provides an analysis of information drawn from the investigation of complaints and clinical negligence claims as well as examples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

ASSESSMENT:

Complaints

1st April 2018 to 31st December 2018 the UHB received 1977 concerns

The breakdown is as follows:



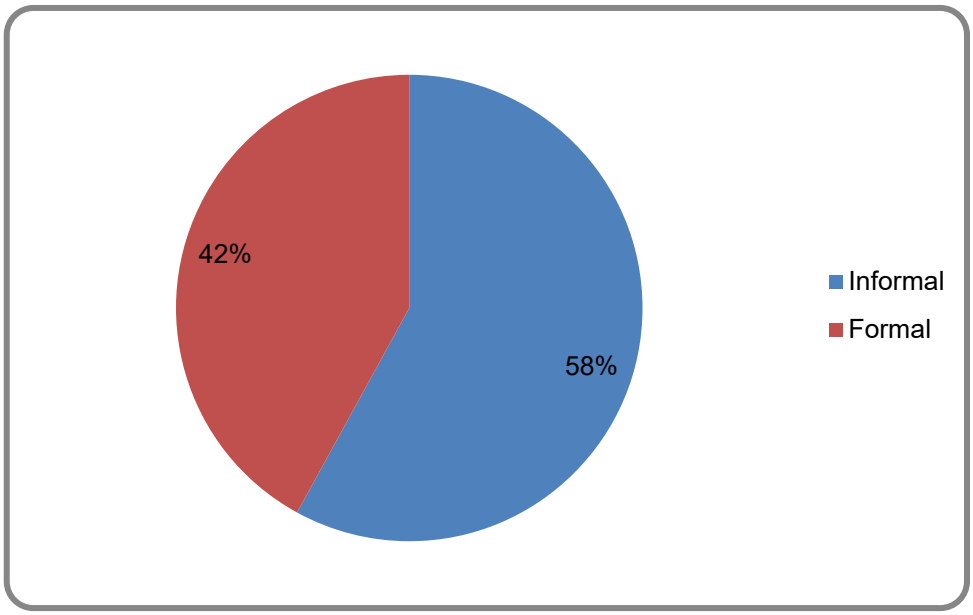
You will note from the figures above, that there is a significant difference in the number of concerns managed by the Surgical Clinical Board, This reflects the high number of contacts that this Clinical Board has in comparison to others.

The Health Board encourages the use of informal resolution wherever possible – this is both in line with the Putting Things Right Regulations (PTR) and the Keith Evans Review "the gift of complaints" where a proportionate and timely response was encouraged. The Key Performance Indicator for Informal resolution is 60%. During this time period, the Health Board managed 58 % of concerns via the Informal Process, with less than 2% being converted to a formal complaint.

It may be helpful to advise the committee that proposed guidance on an All Wales basis in relation to the
recording of concerns is likely to have an impact on the number of concerns recorded as informal. The changes will ensure consistent reporting across Wales in line with the PTR regulations in that early resolution will allow 24 hours to resolve "informal" concerns.

More concerns will be reported as being managed via the formal process, however, this will not change the way we manage concerns, with the emphasis on being early and appropriate

resolution for the Patient and we will continue to monitor the response time in relation to the grading of the concern to ensure that we continue to respond in a timely manner.

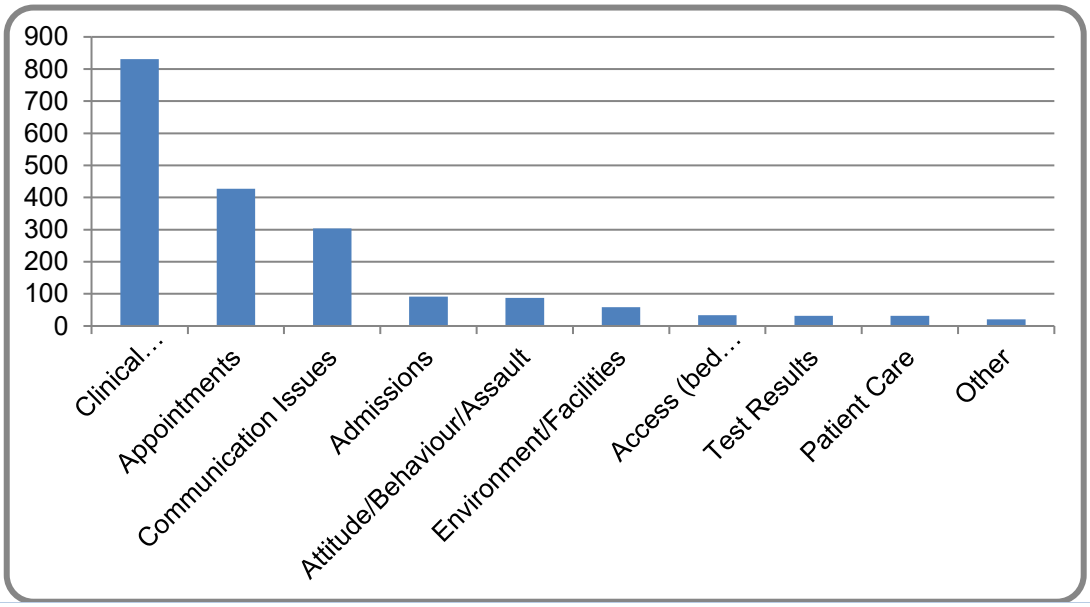


Response times

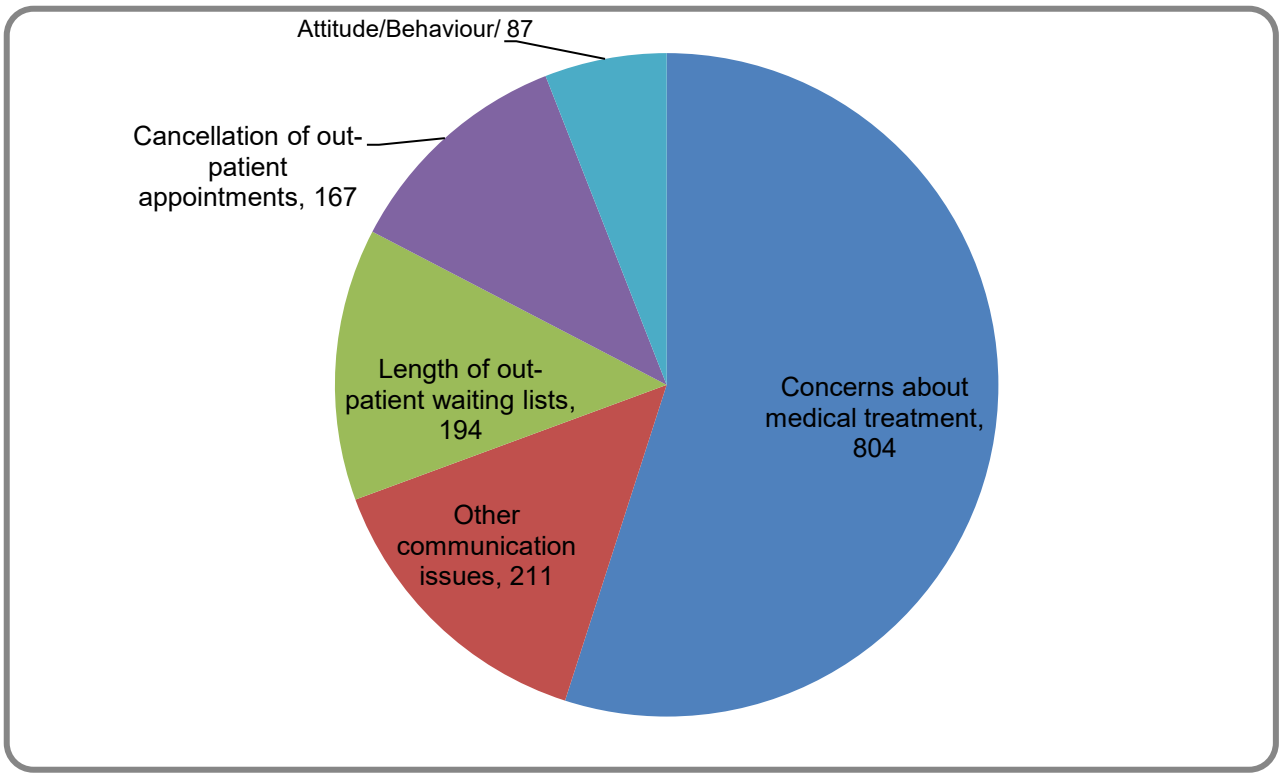
As reported in the last report, the Health Board had a trajectory of improvement in place to achieve a 30 working day response time of 80% across the Health Board by March 31st 2019. It is very pleasing to note that the current response time is 84%.

The aim for 2019 will be to maintain key working relationships with Clinical Boards and to sustain this improvement.

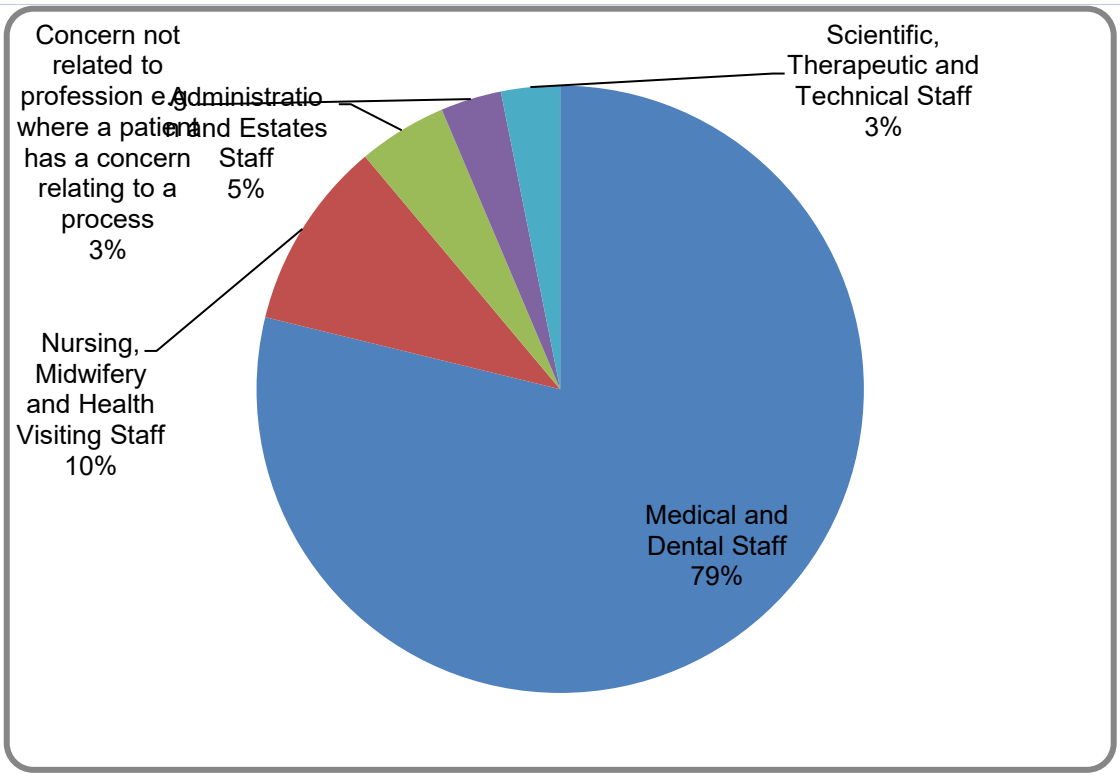
Top 10 Themes identified from Concerns in this time period 1st April – 31st December 2018



On deeper analysis it is evident that the clinical care concerns can be further categorized – top 5 sub subjects



When reviewed by Profession 79% of concerns relate to medical and surgical staff.



Surgery Clinical Board

The majority of Surgery concerns related to waiting times and cancellation of appointments, in this period many concerns were linked to the Ophthalmology Service.

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

Medicine Clinical Board

The highest number of the concerns raised related primarily to clinical diagnosis and treatment. However, some recurring concerns regarding poor patient experience and a lack of care and dignity within the Emergency and Assessment Unit have been noted. The Medicine Clinical Board, (MCB) recognise both the EU and AU are currently challenged by an increase in patient numbers, complexity of patients and the increasing demands on the service. In October, MCB commissioned an improvement work programme to focus on the short, medium and long term improvements required for environmental upgrade and a focus on improving the patient pathway.

The improvement programme is being led by the appointment of a new interim General Manager and Clinical Director.

Examples of some of the issues raised and action taken.

Concerns raised regarding unsuitable Waiting Area

Aim:

Provide a suitable waiting facility for people in AU, for those that require a wait of greater than 2 hours, to be in an enclosed room, provided with a variety of comfortable seating including recliners, together with suitable facilities, lighting and décor that are appropriate to longer waits during daytime and night time hours, together with an area where conversations, monitoring and treatment can be carried out that allows privacy and dignity.

Action Taken :

- New seating has been ordered 29/11/18 for the AU lounge, 20 chairs have been ordered through funding provided by the Medicine Clinical Board – to cover the delay in delivery time, chairs have been borrowed from other clinical areas that have excess seating in non-commissioned areas.

- There are quiet rooms within the department where patients can have confidential discussions – this will be accommodated on individual need and assessment.

- Clinical staff have been reminded of their responsibility to keep the noise and disturbance by night to a minimum.

In addition ear plugs are also provided for patients if required/requested.

Concerns raised regarding the lack of communication regarding waiting times and delays

Aim:

Review and implement the management arrangements of the unit to ensure adequate reception cover and clarity of responsibility for the regular updating of patients on times and reasons for waits together with addressing their concerns in relation to food comfort and drink.

Action taken:

- The AU Receptionist cover is in place 7 days a week 7am until 12pm; however, there is no cover overnight.

- The standard process after midnight is all patients will be booked in at the main Emergency Unit reception area as the patient demand is significantly reduced.

- NIC in AU will be available for individual enquiries

Clinical Staff have been reminded of their responsibility to keep patients regularly updated with regard to waiting times, treatment plans and access to food and drink.

Concerns regarding information available re clear directions and details, including food and drink.

Aim:

Review and update all signs and information to provide clear directions and details including food and drink availability and who to contact to obtain help and assistance.

Action taken:

New signage has been requested and will be in place within 1 month.
Patient and carer information will be reviewed in conjunction with the Patient Experience Team.

Stroke Rehabilitation Centre SRC

We have also noted a number of concerns relating to the nursing care on the SRC Ward. The Director of Nursing is fully aware of the issues and the Clinical Board have recently made staff changes in this area and appointed a new Lead Nurse and changed the Senior Nurse, who is due to commence her post in the next couple of weeks.

The clinical board has established a fortnightly quality and experience meeting to focus upon SRC to agree and implement the short and longer term actions.

Children and Women Clinical Board

We continue to closely monitor any concerns in relation to paediatric surgery and maternity care.

Fortnightly Executive review meetings continue with the Clinical Board. To date 26 meetings have been held with the Clinical Board and they will continue until both the Executive Nurse Director and Medical Director are assured that all actions have been concluded

In addition there is a Weekly review of any new concerns, feedback or “noise” in the system at the weekly executive concerns meeting chaired by the Executive Nurse Director.

There has not been any particular theme noted.

Clinical Diagnostics and Therapies Clinical Board

Radiology Directorate received the highest number of concerns. There has been an increase in concerns regarding the delay in reporting Radiology results. However, the Clinical Board has since appointed a new Radiologist so this should improve in the future.

Primary, Intermediate and Community Clinical Board

There has not been any particular theme noted.

Estates

As previously reported, since the introduction of the new parking system, there has been an increase in the volume of calls and emails to the Concerns Team relating to parking tickets being issued, both from members of the public and staff.

These now average between 3 – 6 calls per day. As complaints about parking fines cannot go through the Putting Things Right process each caller is advised to either contact the UHB's Parking Office by email or by visiting them at their offices in Concourse UHW. Many of these callers are unhappy that the UHB's parking office does not have a direct telephone number where they can be contacted. Some callers are elderly or disabled or do not have access to email so contact by telephone would be preferable.

Corporate Team review of concerns and improvements to our process

The Concerns Team have been contacting complainants to agree the specific issues that they would like addressing since April 2018 and have subsequently started sending out meeting forms to complainants with their response. We find that this helps focus complainants on what issues they feel have not been addressed or identify any issues that have arisen in the response. If complainants do request a meeting, this form is then returned to the Concerns Team and forwarded to the Investigating

Officer to ensure that they are adequately prepared for the meeting and that the appropriate people attend.

Public Service Ombudsman

From concerns received since April 2018, 23 people have referred their concern to the Ombudsman. This figure represents less than 1% of the concerns received in this period of time.

The ombudsman decided:

- 6 concerns are to be investigated
- 13 not to be investigated
- 2 were premature
- 2 were requests for information

The annual letter received for the Ombudsman in relation to the time period of 2017/18 provided the following information and indicates the All Wales position.

Complaints Received – Cardiff & Vale University Health Board

The number of complaints received in 2017/18 about Cardiff and Vale University Health Board,

was 94. This represents a very slight increase, of 3 complaints, from the previous year (2016/17), but the complaints remain below the Welsh average (adjusted for the Health Board's population).

The **subject** of complaints about the Health Board broadly reflect the Welsh average, subjects such as clinical treatment outside of hospital, confidentiality and continuing care.

It is pleasing that complaints received regarding the Health Board's handling of complaints have decreased by more than 50% over the previous year from 13 in 2016/17 to 6.

The complaints we receive are distributed evenly between a wide range of **services**. We do not identify any service that received particularly high numbers of complaints.

Complaints Closed – Cardiff & Vale University Health Board

The total number of complaints closed between April 2017 and March 2018 for Cardiff and Vale University Health Board was 81.

23% of cases with the Health Board were settled through either early resolution or voluntary settlement. No public interest reports were published regarding the Health Board. However, 16% of the complaints closed were upheld in whole or in part, with only 9% of cases not upheld following investigation.

Of the 15% upheld cases, 11 were upheld against University Hospital of Wales and 2 were upheld against University Hospital Llandough.

Section A

Health Board	Complaints Received	Average	Complaints Investigated	Average
Abertawe Bro Morgannwg University	121	127	37	44
Aneurin Bevan University Health Board	121	140	43	49
Betsi Cadwaladr University Health	186	167	70	58
Cardiff and Vale University Health	94	118	33	41
Cwm Taf University Health Board	74	71	32	25
Hywel Dda University Health Board	109	92	38	32
Powys Teaching Health Board	42	32	8	11

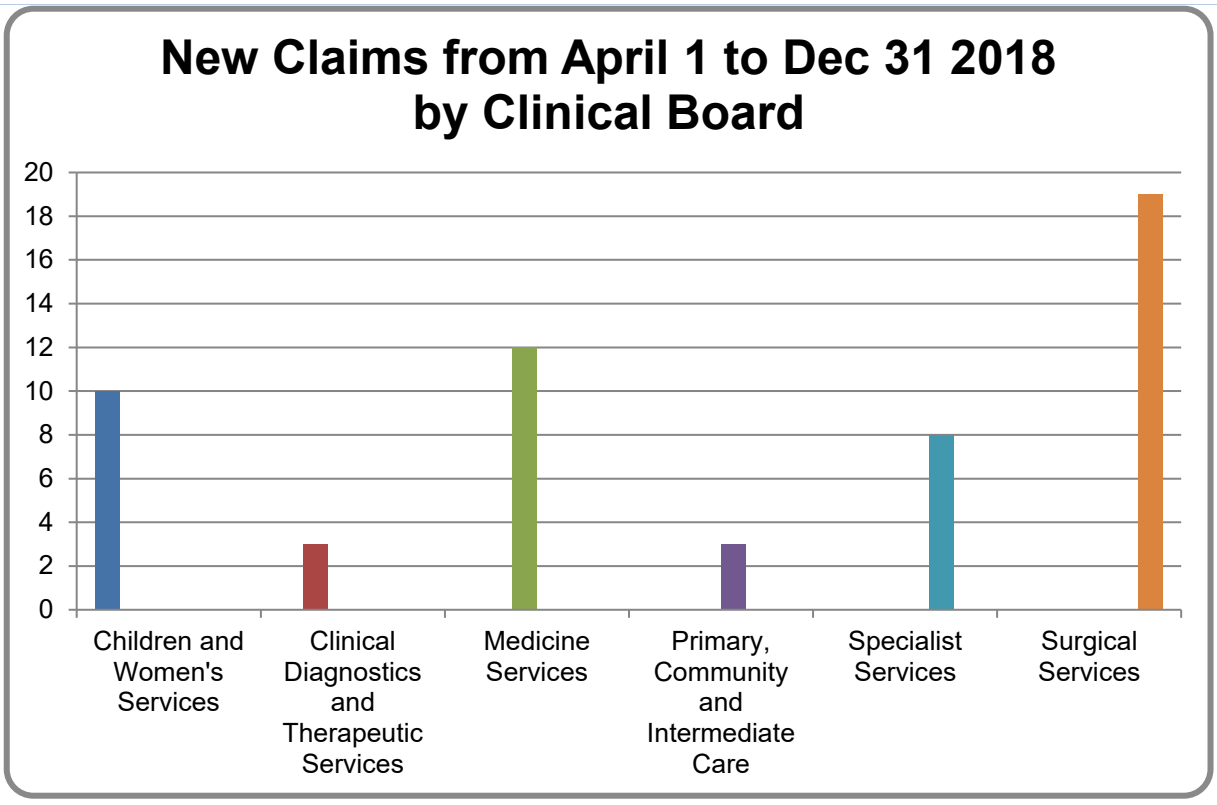
Section A compares the number of complaints against the Health Board which were received and investigated by my office during 2017/18, with the Health Board average (adjusted for population distribution) during the same period.

Section 16 Public Ombudsman Report

The Health Board had a section 16 Public Report issued in January 2019. This was a significant report and the compliance with the recommendations is ongoing. A detailed paper will form a subsequent agenda item.

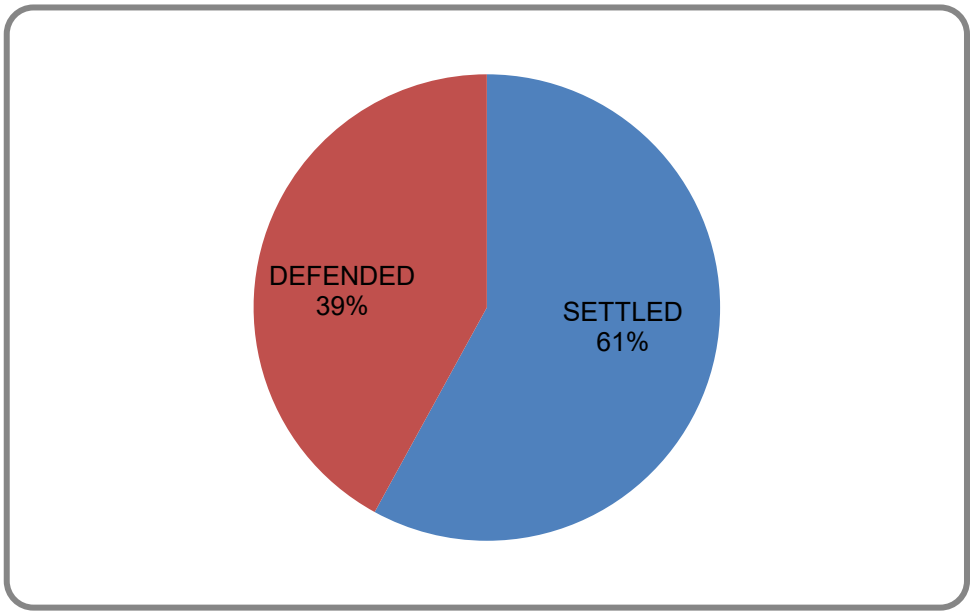
Clinical Negligence Claims

During the period 1/10/18 – 31/1/19 there were 14 new clinical negligence claims opened across the Clinical Boards.



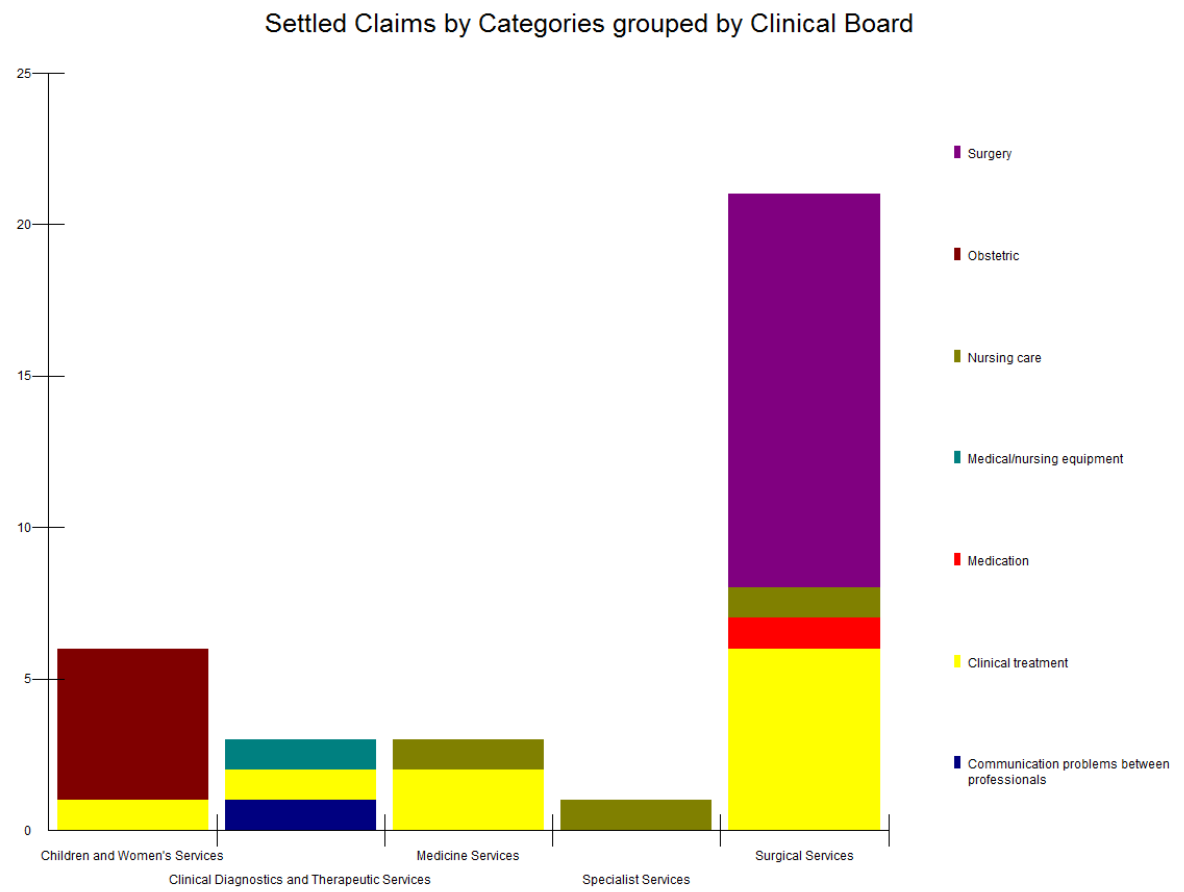
There was a slight reduction in the number of new claims received since the last report which was expected given the holiday time that occurred during the reporting period.

Analysis of Closed Claims



The Heath Board has defended 39% of claims over the last three years. It should be noted that the defended claims include cases that have been abandoned due to limitation expiring or where there has been no response following the Health Board issuing a denial to the claim. The

defended claims also include a small percentage of claims that were either withdrawn by the claimant or settled externally by another responsible party.



The claims profile remains consistent with previous reviews, with Surgery and Women and Children Services reporting the highest volume of cases.

Learning from Claims and Redress cases.

The main categories of claims are surgery and clinical treatment. In both these categories the overriding themes relate to individual clinical decision making or human error. In many of these cases there is already formal procedures, MDTs or NICE guidance that assists in ensuring that correct decision are made. However, where such individual errors are made, clinicians will reflect on their practice that may be discussed by peer review, revalidation or during their profession developmental plan. The Clinical Board's routinely discuss such cases at Quality and Safety, Audit meetings or specific clinicians have selected cases for review and for teaching purposes with their teams.

A secondary theme in many cases often surrounds consenting issues; this is being driven by Claimant Solicitors since the case of Montgomery and will remain an additional allegation bought in many claims. The Health Board has been active in undertaking training in Consent and in assisting in the All Wales Review of consent processes.

We have selected two clinical negligence cases that were settled, and outlined the actions taken.

Case 1

Patient attending Accident and Emergency with unexplained abdominal pain was discharged without examination following a second attendance with the same issues.

Action taken:

It has been agreed that following referral of a patient with abdominal pain; a decision is made based on the findings of the clinician during the clinical assessment re: referral to the surgical team

In addition guidance has been issued to staff that all patients who represent in the Emergency Unit with the same symptoms should be reviewed by a senior doctor (Middle grade or consultant).

The case was presented anonymously at the Quality and Safety meeting to ensure learning is shared across the directorate and that all relevant staff were aware of the actions taken.

Case 2

There was an accepted failure to anti-coagulate the patient post surgery. It was evident that standard procedure had not been followed.

Action taken

We have implemented changes to the process of prescribing of thromboprophylaxis and the checking of this pre-operatively:

In detail

- The Health Board's Thromboprophylaxis Risk Assessment form is attached to the inpatient medication prescription record chart.
- VTE risk assessment and prophylaxis prescription undertaken at the point of consent review and preoperative marking, by a member of the surgical team is completed.
- No patient is allowed to leave the ward to go to theatre until a VTE risk assessment form has been completed and mechanical and/or chemical prophylaxis appropriately prescribed.
- Thromboprophylaxis must be prescribed personally by the operating surgeon prior to anaesthesia commencing.
- If a surgeon deems it not necessary to prescribe thromboprophylaxis this clinical decision is recorded.

Further safeguards occur alter the 'sign in' process of the WHO checklist:

- Interim stickers are used to ensure VTE risk assessment and Prophylaxis prescription are completed

- 1st check gate that this has been completed on entry to anaesthetic room/waiting bay by anaesthetic practitioner.

- 2nd check gate during WHO 'sign in' process.
- Nurse led risk factor check inserted into the elective orthopaedic preadmission document.
- A Surgery Thromboprophylaxis and Anticoagulation Group (TaAG) was set up to ensure all work relating to this RCA was completed.

We have selected three redress cases that were settled, and outlined the actions taken.

Case 1

The patient, who was a child, was admitted for a diagnostic laparoscopy.

The surgery was uneventful however once the surgical drapes were removed, it was noticed that the patient had sustained two small burns to their upper thigh.

The tip of the endoscope had come into contact with the patient, unbeknownst to staff during the procedure.

Actions taken and shared with the family with the formal apology

A formal procedure on the management of laparoscopic equipment was drawn up.

Theatre training booklets were amended to include the potential risks of leaving unconnected light leads on a patient.

An internal safety notice was disseminated within the Peri-Operative Care Directorate to highlight the risks present when using light leads.

Case 2

During an operation, patient experienced a period of anaesthetic awareness.
The patient experienced pain and sensation of the cutting of skin, heard the conversations and background music, but was unable to communicate this to staff

Actions taken and shared with the patient with the formal apology

Following the incident, posters were designed and circulated in all operating theatres to place an emphasis on minimising distraction at the point of transferring the patient from the anaesthetic room and re-establishing anesthesia in the operating room.

Case 3

The patient was admitted to undergo right internal jugular vein central venous catheter insertion (CVC). A chest X-ray was performed to confirm the line position, but this X-ray was not reviewed.

Intravenous antibiotics were administered as prescribed to the patient for four days via the central venous catheter.

The patient complained of pain and swelling at the central line site. The chest X-ray was viewed and the line was found to be in the subclavian vein which was not the intended vein. Following this, the patient unfortunately developed a thrombus and required targeted thrombolysis to remove it.

Actions taken and shared with the patient with the formal apology

Guidelines have been drawn up for the insertion and checking of the position of CVC's, including clear instruction as to whether the CVC is safe to use.

Training and development in Claims

During the last year we have focused on the training requests for the Clinical Boards. Most recently Legal and Risk representatives and the Claims Managers attended the Women and Children Clinical Board to
provide training specifically to their needs. This training event was advertised to all staff in their area and was well attended. The agreed topics covered were, Consent, Montgomery, Breach of Duty and reinforcing the message for good communication and record keeping. The Claims Manager also provided a summary schedule of past claims data that was discussed.

The Claims Managers have also been assisting in the work being undertaken by the Welsh Risk Pool to review the Appendix S form. It is envisaged that a draft form will be produced soon.
The aim of the new format is that there will be Learning from Events form that will be completed at the point that it is decided a claim should be settled. This will ensure that learning and actions are captured at the earliest opportunity.

RECOMMENDATION:

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current position on all key indicators relating to concerns and to clinical negligence claims.
- Substantial assurance has been awarded for the most recent internal audit assessment of clinical negligence claims and for Management of Ombudsman cases.
- A culture of openness and transparency within the UHB to examine all available sources of information to provide assurance on the quality, safety and experience of services.

The Quality, Safety and Experience Committee is asked to:

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

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO 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.

REPORT TITLE:	**National Emergency Laparotomy Audit**								
MEETING:	Quality Safety and Experience Committee						**MEETING DATE:**	**18.02.2019**	
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 report to the committee the UHB performance in relation to the National Emergency Laparotomy Audit

REPORT:

BACKGROUND

The National Emergency Laparotomy Audit is published annually and provides the data to support benchmarking against a national standard. The primary aim of the audit is to review mortality rates. It also measures key aspects of care for the patient undergoing emergency laparaotomy. These include radiology reporting, risk documentation, timeliness of access to theatre, seniority of surgeons, anaesthetists and intensivists involved in perioperative care, access to critical care postoperatively and input by an elderly care physician for those over 70. It also measures length of stay. The 2018 NELA report details performance between 1st December 2016 and 30th November 2017 and the following performance was noted across the UK:

- 87% of patient received a pre operative CT scan
- The mean post operative length of stay is 11 days
- The 30 day mortality rate has fallen from 11.8% to 9.5%
- 27% of patients did not get their operation within the recommended timeframe
- 90% of patients with a pre operative risk score of 10% or over were admitted to critical care
- 21% of patient over 70 were seen by a geriatrician

ASSESSMENT

Between 1st December 2016 and 30th November 2017 the UHB undertook 255 emergency laparotomy cases and the data was captured in the NELA database, this makes the UHB one of the busiest NELA sites in the UK.

There has been a considerable amount of service improvement and work by the Surgical Clinical Board to produce significant improvements over the last few years. It is likely with continuing service change that there will be further improvements.

Mortality
Since 2014 significant improvements have been made in NELA outcomes both nationally and locally.
All cause 30 day mortality after surgery has fallen to 9.5% across the UK. Hospital level mortality is risk adjusted to account for variation in case mix, in 2014/15 the UHB risk adjusted mortality within 30 days of surgery was 13.3% reducing to 10% in 2015/16 and 7.5% in 2016/17, crude mortality rates have reduced to 11.6%. The improvement in the UHB risk adjusted mortality is among the best in the UK. Mortality rates vary by patient risk factors, increasing substantially with age, co morbidity and urgency of surgery. Patient older than 80 years have a 30 day mortality rate of twice the national average and patients with limiting co morbidities have a 30 day mortality rate of three times the national average. Pre operative risk assessments and MDT discussions have led to improved decision making around the benefits of surgery for very high risk patients. As a result there has been a sustained reduction over the past three years in the number of individuals undergoing surgery when their risk of dying post operatively is between 50 and 100%.

Time to Theatre
A delay to a patient undergoing emergency surgery is associated with lower rates of survival. The urgency with which surgery is required varies between patients and is based on evaluation of their condition. Arrival to theatre in the UHB has been static since 2014/15, The most recent report identifies that 58% of patient arrived in theatre within a time appropriate to the urgency of their condition. Since the audit, the service has benefitted from reconfiguration and investments in emergency surgical consultant presence at the front door and in theatre as well as increased CEPOD theatre capacity and this has demonstrated a significant improvement in time to theatre in the first quarter of 2017/18 which is expected to continue and will be reflected in the next annual report.

Completion of Risk Assessment
87% of patients have a risk assessment prior to surgery compared to 74% nationally. A programme of education across the Surgery Clinical Board as well as increased MDT decision making has resulted in significant improvements in preoperative risk assessments.

Critical Care Admission
Admissions of patients with a P Possum score of $\geq$10% to critical care post operatively was below the NELA target of 90% with figures unchanged at 72% between 2014 and 2017. Since Febraury2019 critical care capacity has increased from 26 to 32 staffed level 3 beds across UHW and UHL and further expansion is planned from 2020 onwards.

CT Reporting
CT is fundamental to providing a preoperative diagnosis in patients presenting with acute abdominal symptoms. 68% of CT scans within the UHB are reported prior to emergency laparotomy surgery compared with 64.4% nationally. There are discrepancies between CT scan and surgical findings in 6.3% of cases compared with 5.3% nationally. It is recognized nationally that discrepancy rates vary according to the designation of the reporting clinician. In house Consultants have the lowest rates of discrepancies nationally (5.2%) while registrar and out sourced scans have a rate of 6.2% nationally. Local CT reporting arrangements mean that consultant radiologists validate or second report all body CT scans, however consultant radiologist cover exists within the UHB from 09.00-17.00 Monday to Friday and Out of Hours arrangement for body CT scans involve senior trainees reporting CT scans and Consultants

undertaking second reporting the following morning. Quality assurance of body CT scans within the UHB identify discrepancies in reporting in 3% of first reports in 2014, this data will be re audited in 2019.

Length of Stay
Prolonged hospital admissions expose patients to increased risks as well as providing challenges to patient access. Length of stay varies according to a number of factors with longer lengths of stay associated with older patients and those with complex co morbidities. The mean length of stay within the UHB is 10 days compared with 11 days nationally.

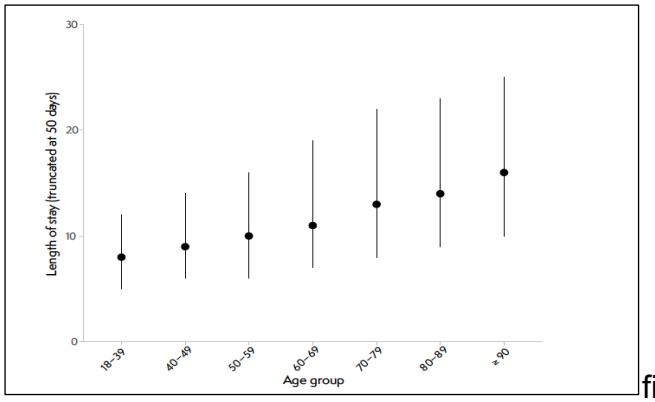


fig 1 length of stay by patient age

Gerontology provision
Patients over 70 years account for 44.5% of emergency laparotomy surgery, have the highest mortality and account for the longest hospital stays. This group of patients is more likely to have complex medical needs and multiple co morbidities. Nationally patients over 70 were more likely to have been reviewed by a consultant anesthetist preoperatively and were more likely to have a consultant anesthetist present during their surgery. The same patient group were more likely to have input from a consultant intensivist. Only 21% of patients over 70 years old nationally and 4% locally were seen by a geriatrician during their admission. Evidence suggests that Gerontology review in patients undergoing emergency laparotomy surgery is associated with reduced length of stay and readmission rates in older patients and improved outcomes. A business case has been developed to appoint a Geriatrician specializing in peri operative medicine with further consideration being given to the development of a team to support a Proactive Care of Older People Undergoing Surgery (POPS) service.

RECOMMENDATION:

The Committee is asked to:

NOTE the assurance provide by the 2018 NELA report and the actions that have been undertaken.

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	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		Long term		Integration		Collaboration	x	Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	No If "yes" please provide copy of the assessment. This will be linked to the report when published.

REPORT TITLE:	**HEART FAILURE SERVICES**								
MEETING:	Quality Safety and Experience Committee						**MEETING DATE:**	**18.02.2019**	
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 report to the committee the results of the recently reported National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report, Failure to Function and the National Heart Failure Audit Report.

REPORT:

BACKGROUND

In November 2018 two national reports were published detailing the care given to patients with heart failure, the NCEPOD report, Failure to Function and the National Heart Failure Audit. Both identified similar themes around the delivery of care and the outcomes for patients receiving care from heart failure specialists compared to non specialist. The UHB contributed to both studies and while only national themes are identified in the NCEPOD report the National Audit identifies local performance around a number of key performance indicators.

The NCEPOD report published in November 2018, sought to identify and explore avoidable and remedial factors in the processes of care for adult patients aged 16 years and older who were admitted to hospital between January 2016 and January 2017 with a primary diagnosis of acute heart failure and who died in hospital.

The National Heart Failure Audit reflects the performance in care across England and Wales between April 2016 and March 2017 around key performance indicators.

ASSESSMENT

During 2016 /17 the care associated with 280 admissions to UHW as a result of heart failure and a further 232 admissions to UHL was recorded in the national audit, The assosciated improvements are attached in **Appendix 1** In addition the UHB contributed to the NCEPOD report completing an organizational questionnaire and case reviews of 10 patients. The NCEPOD recommendation checklist is included as **Appendix 2**

Historically there has been variation between UHW and UHL outcomes noted in the annual National Heart Failure Audit Reports, this is in part due to differences in the patient cohort but also as a result of cardiology provision on the UHL site. Until November 2017 heart failure care was provided by a Gerontologist with a special interest in heart failure when a limited Cardiology presence was introduced. The introduction of a 2 year pilot of an Acute Heart Failure Service will seek to ensure a prudent and equitable approach to heart failure care in UHL.

Mortality
Nationally in hospital mortality was 9.4% in 2016/17, outcomes are generally better for patients admitted to cardiology wards (6.5%) compared with those on general medical wards (10.1%) and for patients receiving care from a specialist (8.0%) compared to those who do not (12.6%). The variable most strongly associated with poor outcome is age over 75 years. The average age of heart failure patients in UHW is 75 years while the average age of heart failure patients in UHL is 78. Local risk adjusted mortality rates are not provided however by examining the crude data it is possible to establish that UHW mortality is 9.57% and UHL mortality is 10.67%.

Place of Care
Nationally only half of patients are cared for on a cardiology ward or received cardiology input despite evidence to suggest that when a cardiology review was undertaken it resulted in optimisation of treatment in over 67% of cases.

Both reports identified the importance of specialist involvement in the provision of best practice care and in the outcomes for patients admitted with heart failure in addition the NCEPOD report highlighted the benefits to patients of specialist palliative care involvement in the care of patients with advanced heart failure.

The proportion of patients being reviewed by a cardiologist nationally is 55.7% while 80.3% were reviewed by either a cardiologist or a specialist. In UHW 51.8% of patient admitted with heart failure were reviewed by a cardiologist and 60.4% were seen by either a cardiologist or a specialist but in UHL the proportion of heart failure patients reviewed by a cardiologist was 2.6% while 28.4% were reviewed by either a cardiologist or a specialist. In late 2017 cardiology provision in the Medical Assessment Unit in UHL was introduced and the responsible consultant also undertakes 40 to 60 cardiology reviews each month although these reviews are not undertaken as part of an existing job plan. As a result of the increased cardiology input it is expected that the 2017/18 audit will demonstrate an increase in cardiology input for patient cared for in UHL. Furthermore the development of an acute heart failure service in UHL will result in increased specialist nurse provision to support earlier diagnosis of heart failure, initiation and titration of disease modifying drugs and earlier interventional treatments and improved follow up.

Medicines Prescribing
The prescribing of key disease modifying medicines was high, nationally 47% of patients seen by a member of the heart failure team were prescribed all three modifying drugs irrespective of where their care was being delivered. Prescribing of these medications exceeded national performance in both UHW and UHL.

Investigations
The NCEPOD report identified that nationally important investigations were omitted in 34% of cases, only a minority of patients had a measurement of their natriuetic peptides (BNP)

measured and echocardiography was undertaken within the appropriate timescale in 44% of newly diagnosed patients and 22% of patients with a history of heart failure.

The audit identified that nationally 89% of patients will have an echocardiogram within 12 months of their admission, however it was noted that rates were higher for patients admitted to a cardiology ward and those with specialist input. In UHW 81.9% of patients received an Echo during the same time scale while 68.7% of patients admitted to UHL received the same investigation. In UHL the Acute Heart Failure Service will support improved decision making around diagnostic tests including a prudent approach to undertaking BNP and echocardiograms.

Palliative Care
The NCEPOD report identified that despite the death of 81.3% of patients included in the report being anticipated, opportunities to deliver palliative care were missed in the majority of cases. Only 12.5% of patients with an established diagnosis of heart failure were receiving care from a palliative care team prior to their final admission to hospital.

In 2016 a heart failure Supportive Care Service was established to improve the experience of patients with advanced heart failure, to prevent avoidable hospital admissions and to support patients to be cared for at home to die in their chosen place. The initial stage of this project included coproduction of a multi specialty and multi professional MDT and monthly parallel clinics to provide early introduction of patients by the Cardiology led heart failure team to supportive care. Bespoke treatment plans are developed to support advanced care planning choices to allow treatment of exacerbations to be managed in the community when preferred place of care or death is home. The supportive care service piloted the use of subcutaneous Furosemide infusion in the community as a Bevan Exemplar as a means of palliating episodes of fluid overload as an alternative to an acute admission. The project has successfully supported 12 patients amounting to 16 treatment episodes which would otherwise have been delivered in hospital. Six of the episodes proved to be end of life care allowing all of these patients to die in their preferred place of death. The project was successful in preventing admissions to hospital in all cases with an overall a saving of 488 bed days. Funding for the supportive care service continues until 2020.

RECOMMENDATION:

The committee is asked to*:*

NOTE the assurance provided by the NCEPOD report Failure to Function and the National Heart Failure Audit and the NCEPOD recommendation checklist.

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	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		Long term	x	Integration		Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	No 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

Appendix 1 **Cardiff and Vale UHB**

National Clinical Audit & Outcome Review Programme

All health boards / trusts participating in national clinical audits and outcome reviews must electronically send a completed front page and Part A version of this form to the mailbox address below within 4 weeks of the publication of reports and, a completed Part B within 3 months to : Mailbox address : wgclinicalaudit@wales.gsi.gov.uk

Audit / Registry Title - National Heart Failure Audit 2016/17

Date of published report – 22 November 2018

HB Clinical Lead / Champion - Dr Z Yousef

Is the HB currently participating in this audit? YES (indicate as appropriate)
if the answer is "Yes" are all relevant services included in the audit? YES (indicate as appropriate)
If your organisation or any relevant services are not participating please indicate why

If you are participating please complete the following table.

% of patients fitting inclusion criteria reported in current audit cycle or registry.	86%
% of patients fitting inclusion criteria with full dataset in this audit cycle or registry.	100%

Has the audit formally identified your organisation or any parts of your organisation as an "Outlier"? NO (indicate as appropriate)

If the answer is YES please describe what actions are being taken to address concerns	

PART A. What are the key national and local findings / recommendations from the last published report which your organisations needs to address (see guidance note below)

National	• **ACEI /ARB on discharge uk 82.8%**
	• **Beta Blocker on discharge 87.1%**
	• **Received discharge planning UK 90.91%**
	• **Referral to HF nurse follow up uk 57%**
	• **Referral to cardiology follow up uk 47%**
	• **Received echo UK 89.2%**
	• **Input from cardiologist UK 55.7%**
	• **Input from specialist UK 80.3%**
Local	• **ACEI /ARB on discharge UHW 94.6% UHL 87.7%**
	• **Beta Blocker on discharge UHW 98.4% UHL 87%**
	• **Received discharge planning UHW 88.9% UHL 67.3%**
	• **Referral to HF nurse follow up 26.1% UHL 16.1%**
	• **Referral to cardiology follow up UHW 53.1% UHL 22.6%**
	• **Received echo UHW 81.9% UHL 68.7%**
	• **Input from cardiologist UHW 51.8% UHL 2.6%**
	• **input from specialist UHW 60.4% UHL 28.4%**

Part A Guidance Note
The recommendations which your organisation needs to address must be listed. On a separate sheet however, you may choose to highlight areas which the audit recognises you are doing particularly well (this information may be useful to other health boards / trusts looking for information to guide their service improvement).

National findings are common problems identified across the audit where healthcare nationally is generally falling below the standard identified by the audit. If your organisation is meeting these standards or performing significantly better than the audit average it should not be necessary to list them (see comment above).

Local findings are where specific weaknesses have been identified within you organisation. This may be an organisation wide issue or relate to individual hospitals or services, but significant variation in the delivery of services across the organisation should be highlighted.

For information a link to NICE guidance on how audit data is mapped to recommendations and quality measures is provided below:
https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance

PART B. Describe the actions already taken or in the process of being developed to address the key findings and recommendations above with timescale and details of named lead.

Action (provide additional detail on separate page(s) when required)	**Timescale** (incl. milestones)	**Clinical Lead**
Evaluation of the Acute Heart Failure Service in UHL to establish benefits to patient group and to inform further service development across UHB	**2021**	**Cardiology**
Appointment to specialist gerontologist post in UHL	**June 2019**	
Evaluation of outcomes Supportive Care Service	**2021**	**Cardiology / Palliative Care**
Evaluation of Bevan Exemplar – subcutaneous Furosemide project	**2020**	**Palliative Care**
Identify funding for Acute Heart Failure service UHL and Supportive Care Service	**2021**	**Cardiology / Palliative Care**

If there are resource implications in the actions detailed above are they included in the health board / trust integrated medium term plans ?
YES / NO (please indicate as appropriate).
If the answer is **No,** how is the matter being addressed ?

Part B Guidance Note

The over-riding principle is that actions being taken must relate directly to the issues highlighted in Part A and, **lead to clear evidence of improvement when services are next re-audited**.

Information from audits and reviews hasn't always been used effectively in the past to improve services, but in future **must directly align with organisation's quality improvement programmes and lead to improved patient care**. Information demonstrating there has been a comprehensive review of report findings which are clearly feeding into local action plans is important

Information from audits and reviews should demonstrate a pattern of year on year improvement

Bear in mind that many important improvements are often linked to relatively simple changes of procedure or process

Information provided should be focussed on addressing the audit / review findings. Organisations must resist the temptation to include information on quality improvement initiatives which have little or no direct relevance to the specific findings and recommendations listed in Part A.

Where findings confirm significant variation of services within an organisation, details of how variation is being addressed and, the learning from the best performing units is being shared should be provided. Clear evidence that report details are feeding into change across the organisation is important.

Where appropriate, organisations should also provide information to demonstrate how they are using the learning from other high performing organisations in Wales or from across the wider audit.

Issues to bear in mind:

- Health boards should take the opportunity to maximise the investment in national audits and utilise findings to direct service improvement.
- Report plans should demonstrate information from audits and reviews is part of on-going local governance
- Reports should feed into on-going MDT working across the organisation
- Information to show reports are driving/guiding change and improvement is important
- information from audits should provide evidence on ongoing year on year improvement

Overall Assessment

How would you assess your organisations progress in relation to this Audit?

Current status	Tick Status	Status Definitions
Red		Cause for concern. No progress towards completion. Needs evidence of action being taken.

Amber		Delayed, although action is being taken to ensure progress.
Green	**x**	Progressing on schedule with clear evidence of progress.

The completed assurance pro-forma should be signed by the health board clinical lead for the audit / review and the Medical Director or their representative.

Health board / trust clinical lead for the audit / review : ……..
Medical Director's Office : …….....

Date ……

NCEPOD recommendation checklist - Failure to function

The overarching purpose of these recommendations is to improve the quality of care provided to people with acute heart failure. Those who should be primarily responsible for leading on the recommendations are listed in parentheses after each recommendation. These are NCEPOD's suggestions and can be extended to others as appropriate.
Column D contains drop-down options. To select an option click on the arrow that appears at the bottom right of the cell.

#	Recommendations	Principal rec?	Has it been met? Yes/No/ Partially/ Planned/ Not applicable	Comments (examples of good practice or deficiencies identified)	Action required	Timescale	Person responsible
1	A guideline for the clinical management of acute heart failure should be available in all hospitals. These guidelines should include standards for: • The location of care - which should be on a specialist unit • Arrangements for heart failure service review within 24 hours • Initial investigations required to diagnose acute heart failure, including a standard protocol for the use of: o BNP/NTproBNP testing o Echocardiography • Immediate treatments (medications guidance for treatment prior to specialist review) Hospitals should audit against these standards annually. (Medical Directors, Directors of Nursing, Clinical Directors) This recommendation supports NICE guideline CG187 This recommendation refers to the specialist heart failure/cardiology team review - see also RECOMMENDATION 2 regarding all acute admissions and consultant review within 14 hours of admission.	Yes	Partially	A proposal to establish an integrated acute heart failure service at UHW has been developed. The proposed model would standardise the care delivered to patient regardless of where in the UHB they recive this care. A 1WTE band 7 nurse has recently been appointed to UHL to support the implementation of an Acute Heart Failure Serice on that sitel. This position is funded for 2 years and the outcomes of this enhanced service will be robustly reviewed and will inform further service development at UHW	Review of enhanced service in UHL	2021	Cardiology MDT
2	All patients admitted with acute heart failure should be reviewed by a consultant within 14 hours of admission, or sooner as the clinical need dictates (e.g. cardiogenic shock or respiratory failure) and discussed with a member of the heart failure multidisciplinary team. For patients with worsening symptoms despite optimal specialist treatment, this discussion should include their palliative care needs. (Consultants)	No	Yes	All patients in UHL will be reviewed by a consultant within 12 hours. Cardiology review is available three days a week and in addition a recently vacated establishment of a geriatrician with a special interest in heart failure. Patients UHW will be reviewed by and acute physician within 14 hours. and 50% are reviewed by cardiology during their admission. IN adition the acute heart failure service planned for UHL will increase specialist heart failure nurse reveiw	Review of enhanced service in UHL	2021	Cardiology MDT

3	All heart failure patients should have access to a heart failure multidisciplinary team. Core membership of this team should include: • A clinician with a sub-speciality interest in heart failure • A specialist heart failure nurse • A healthcare professional with expertise in specialist prescribing for heart failure The primary care team • A specialist in palliative care Other services such as cardiac rehabilitation, physiotherapy, occupational therapy, clinical psychology, elderly care, dietetics and clerical support should be involved as needed. (Commissioners, Medical Directors, Directors of Nursing and Clinical Directors) This recommendation supports the draft NICE guidelines for chronic heart failure management outlining the core membership with the addition of palliative care to the core group.	Yes	Partially	Over 50% of patients in UHW are admitted under cardiology and will be cared for by the MDT. The most recent national audit results demonstrates that in 2016/17 very few patients were cared fro under a cardiology team, however 28.4% of patient were cared for by a heart failure specilaist. Since the end of 2017 a cardiologist was appointed to acute medicine in UHL and is undertaking 40-60 cardiology reviews a month and as a result it is anticipated that the next annual report will demonstrate a significant improvement against this KPI. The development of the Acute Heart Failure service in UHL will increase access to a CArdiology MDT on this site. A supportive care service comprising multi professional MDT including heart failure , general medicine and palliative care is in existance. All patient with a prognosis of 1 -2 years and NYHA stage 3 and 4 are discused once their heart failure treatment is optimised	To review the Acute Heart Failure Service in UHL and the Supportive Care Service	2020	Cardiology MDT / Palliative Care
4	Due to the complexity of medications used by patients with acute heart failure and their common co-morbidities, medications should be reviewed by a pharmacist with specialist expertise in prescribing for heart failure on admission to and discharge from hospital. (Lead Pharmacists)	No	Yes	Heart failure prescribing in both UHW and UHL exceeds national performance. Pharmacy reviews are undertaken routinely on both sites	No action required		
5	Serum natriuretic peptide measurement should be included in the first set of blood tests in all patients with acute breathlessness and who may have new acute heart failure. It is central to the assessment of these patients to guide further investigation. (All Clinicians) This recommendationsupports NICE guideline CG187 rec 1.2.2	Yes	Planned	A proptionate response to BNP should be undertaken and it is anticipated that the UHL enhanced service will demonstrate a prudent and targeted approach to diagnostic tests including accessing results from other health boards etc.	Review of enhanced service in UHL	2021	Cardiology MDT
6	An echocardiogram should be performed for all patients with suspected acute heart failure as early as possible after presentation to hospital, and within a maximum of 48 hours as it is the key to diagnosis, risk stratification and specialist management of acute heart failure. (All Clinicians, Lead Physiologists and Medical Directors) This recommendation supports NICE guideline CG187 rec 1.2.4	Yes	Planned	81.9% of all heart failure admission had an echo with a year of their admissionand 68.7% in UHL. A proportionate response to undertaking diagnostic tests is undertaken taking into conisderation co morbidities and frailty and advanced care planning. The enhanced acute heart failure service being piloted in UHL will support decision making around diagnostics, escalation of care and treatment	Review of enhanced service in UHL	2021	Cardiology MDT

7	Due to the poor sensitivity of individual physiological parameters (in particular heart rate) in identifying severity of illness in acute heart failure, use of a composite physiology score such as the National Early Warning Score is recommended. (All Clinicians, Medical Directors and Directors of Nursing)	No	Yes		No actions required	N/A	
8	For all patients with heart failure, best practice in escalation decision-making includes: • Assessment of the goals and benefits of treatment escalation • Inclusion of the patient (and their family where possible) • Involvement of the cardiology or heart failure consultant • Agreement among members of the multidisciplinary team • Communication of the decision with healthcare professionals across the whole care pathway For patients with advanced heart failure, pre-emptive discussion in the outpatient setting of treatments that would not be beneficial, along with consideration of palliative care needs, can prevent unnecessary admissions and should be encouraged. Escalation decisions should be reviewed at the time of all admissions with acute heart failure. (Heart Failure Teams/Consultant Cardiologists) See also: Treatment and care towards the end of life: good practice in decision making (GMC 2010)	Yes	Partially	The acute heart failure service in UHL will support improved decision making and will support prudent and targeted cardiology involvement. A heart failure suportive care services comprising cadiology, general medicine and palliative care, supports advanced care planning with an aim to minimise repeated emergency admissions and improving quality of life. This service is funded for 2 years and will be evaluated at the end of this period	Review of enhanced servce in UHL and review of supported care service	2020	Cardiology / Palliative Care
9	All treatment escalation decisions that are not initially made by a consultant should be confirmed by a consultant at the earliest opportunity afterwards. The reasons for treatment escalation decisions should be fully documented in the patient's records. (All Clinicians, Consultants)	No	Yes		No Actions required		
10	On discharge from hospital, all acute heart failure patients should receive a summary that includes: • A named healthcare co-ordinator and their contact details • Their diagnosis and the cause of their heart failure • Current medications and description of any monitoring required • Individualised guidance on self-management • Functional abilities and social care needs • Follow up plans • Information on how to access the specialist heart failure team and urgent care (All Clinicians, Heart Failure/Cardiology Leads) This recommendation adds to NICE guideline CG187	No	Yes	71.9% of patients in UHW received discharge planning and 63% of patient in UHL . This is an improving picture and will be monitored annualy through the national heart failure audit	ongoing monitoing of performance	This is revewed on an continuous basis	cardiology MDT

11	After an admission with acute heart failure, all patients should be followed up by a member of the specialist heart failure team within two weeks of discharge from hospital as recommended in NICE guidance (CG187 rec 1.1.4). (Heart Failure Teams/Consultant Cardiologists)	No	No	There is curently no capacity to increase follow up provision by heart failure nurses. Patient are reviewed in clinic within an appropriate timescale. It is anticipated that the Acute Heart Failure service will support prioritisation of follow up.	Review of enhanced service in UHL	2021	Cardiology MDT
12	Patients with a confirmed diagnosis of heart failure benefit from ongoing review. In line with current NICE guidelines (CG108), this should occur at least every six months and more frequently in unstable patients or those with comorbidity. Review should include: • Clinical assessment of cardiac rhythm and fluid status • Assessment of functional and nutritional status • Medication review; including side effects and the need for changes • Measurement of renal function and electrolytes The individual responsible and location of this review should be tailored to meet each individual patient's needs and be guided by the heart failure multidisciplinary team. In advanced heart failure, the responsibility for follow-up may transfer from the heart failure team to the palliative care service. (Heart Failure Teams/Consultant Cardiologists)	No	Yes	All patients with a confirmed diagnosis of heart failure will be reviewed and monitored by the heart failure team.	No Actions Required		
13	Heart failure patients should be offered an exercise-based programme of cardiac rehabilitation that also includes education and psychological support. This is in line with the NICE quality standard (QS9) for chronic heart failure in adults. A record should be kept of the number (and percentage) of suitable heart failure patients who receive cardiac rehabilitation. (Commissioners and Heart Failure Teams/Consultant Cardiologists)	No	No	There is no current provision for cardiac rehabilitation for heart failure patients.			
14	Pathways should be in place for patients with advanced heart failure who deteriorate to access palliative care in the community, in a hospice or in hospital when appropriate. Referral to specialist palliative care services should be based on patient-need and choice and not delayed until deterioration is considered irreversible. A full anticipatory care plan should be agreed with the patient and this should be communicated to and available to all those involved in the acute heart failure pathway. (Palliative Care Leads, Commissioners, Community Providers and Ambulance Services)	No	Yes	A heart failure supportive care service exists to support advanced care planning . Two outpatients clinics are held monthly one in Barry Clinic run jointly by cardiologist and palliative care and a sedond in UHL where the supportive care clinic is run by the palliatuve care with a cardiology clinic being run in parallel to support joint working. The supportive care service is now offering telephone appointments and domiciliary visits.	Service funded until 2020. Substantive funding required	2020	cardiology MDT

15	Hospitals should collect and audit data on the total number of heart failure patients under their care. These data should be submitted to the national heart failure audit. (Medical Directors)	No	Yes	Both UHL and UHW participate in the National Heart Failure Audit with dedicated resource identified for the ongoing collection of this data	No Actions required		

Report Title:	**MANAGEMENT OF ENDOSCOPY SURVEILLANCE PATIENTS**						
Meeting:	Quality, Safety and Experience Committee				**Meeting Date:**	**19/02/19**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Chief Operating Officer						
Report Author (Title):	Deputy Chief Operating Officer						

SITUATION

The purpose of this paper is to provide an update on progress in relation to the management of patients on an endoscopy surveillance waiting list overdue their procedure.

BACKGROUND

The Quality, Safety and Patient Experience Committee received a report at its meeting on 13th February 2018 on the management of patients on an endoscopy surveillance waiting list overdue their procedure. This, along with previous reports, had been submitted against the backdrop of general concerns that patients are waiting too long and governance concerns arising from reported Serious Incidents in Endoscopy. The report to the last Committee outlined a deterioration in the overall endoscopy surveillance position with the volume of patients overdue their procedure increasing but with actions in place to manage this. The Committee requested a further update in February 2019.

ASSESSMENT

The volume and risk profile (a clinically agreed risk scoring methodology based on the planned interval date and the amount of time the patient is delayed beyond the planned date) for surveillance patients has improved since the last committee, as follows:

Endoscopy Surveillance	**Current**	**Last Committee**	**Reduction / increase**	
Risk rating	**Volume Jan 2019**	**Volume Dec 2017**	**Vol**	**%**
300% or more	6	24	-18	-75%
200% - 300%	7	32	-25	-78%
100% - 200%	64	71	-7	-10%
75% - 100%	70	98	-28	-29%
50% to 75%	114	205	-91	-44%
25% to 50%	267	302	-35	-12%
0% to 25%	368	321	+47	+15%
Total > 8 weeks overdue	**896**	**1053**	**-157**	**-15%**

The reduction is greatest for patients in the higher risk bandings, with a 39% reduction in the volume of patients risk stratified as 50% or above.

This reduction has, in the main, been achieved through additional capacity secured through in-year funding to reduce waiting times. This forms part of the wider Health Board plan to improve patient experience and access to endoscopy services, balancing core and additional capacity across clinical priorities and all categories of patients – urgent, routine and surveillance.

The UHB is continuing with additional capacity and anticipates further improvement by the end of March 2019, with the plan to reduce the overall volume of patients overdue their surveillance procedure to circa 400. Additional capacity will continue to be focused on those patients with the highest clinical need.

As previously reported to mitigate the risk of patients waiting beyond their target date for surveillance procedures, the following practice is now fully embedded:

- Risk stratification process in place so that those with the highest clinical need are prioritised. This will not necessarily be those with the longest wait.
- Clinical and clerical validation process is in place.
- Patient letters clearly state that if symptoms change during their waiting period, GP advice should be sought.
- Where symptoms have reportedly changed, GP expedite requests are given priority.

Since the last Committee report in February 2018, two Serious Incidents (SIs) have been reported in relation to patients overdue their surveillance procedure. These SIs have been investigated with the high level actions agreed relating to reducing waits through additional capacity and mitigating the risk of patients waiting beyond their target date through the practice outlined above. It should be noted that the number of SIs as a result of long waiting times in endoscopy is anticipated to increase as the surveillance backlog is reduced.

ASSURANCE is provided by:

- In contrast to the increase reported to the Committee in February 2018, the overall volume of patients overdue their planned surveillance endoscopy has reduced over the last year
- In line with the risk stratification process and prioritisation of patients with the highest clinical need, the reduction seen is greatest for patients in the higher risk bandings
- The UHB is continuing with additional in-year capacity to further reduce the number of patients overdue their endoscopy surveillance
- There are processes in place to mitigate the risk of patients waiting beyond their target date for surveillance endoscopy procedures

RECOMMENDATION

The Committee is asked to:

- **NOTE** the current position and work ongoing in relation to the management of patients overdue their endoscopy surveillance procedure

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	√
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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Ombudsman Public Report
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting 19 February 2019**
Executive Lead : Executive Nurse Director
Author Angela Hughes, Assistant Director of Patient Experience Tel 029 21846108 **angela.hughes5@wales.nhs.uk**
Caring for People, Keeping People Well : avoid harm , Waste and Variation
Financial impact: The Health Board has both a patient safety Quality and experience commitment in line with a financial responsibility for the effective investigation and management of claims.
Quality, Safety, Patient Experience impact : this was an example of the significant impact of a proplonged waiting time on a patients quality of life
Health and Care Standard Number 3.1 Safe and Clinically Effective Care and Standard and 6.3 Listening and Learning from Feedback
CRAF Reference Number Delivering outcomes that matter to people
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by: the completion and evidence of the implementation of the recommendations

The improved and sustained position of the Clinical Board in relation to referral to treatment times

The Quality, Safety and Experience Committee is asked to:

Note the report for information

Situation

On 22 January 2019 the Ombudsman issued a section 16 Public report against Cardiff and Vale University Health Board**.** Under the Public Services Ombudsman (Wales) Act 2005, the Ombudsman can issue one of two types of reports.

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

The second type of report that the Ombudsman can issue is known as a Section 21 report. He can do so if the public body concerned has agreed to implement any recommendations he has made and if he is satisfied that there is no public interest involved.

Background to the report

Mr A complained to the ombudsman that while his mother, Mrs. A, was admitted to hospital following a fall in May **2017**, the Health Board failed to adequately assess and treat her symptoms of slurred speech, lethargy and fits, and incorrectly administered an antidote for a morphine overdose. Mr A also complained that the Health Board failed to deal with his safeguarding concerns appropriately, particularly in relation to bruising to Mrs. A's elbow. He further complained that the Health Board did not deal with his formal complaint reasonably and had failed to provide him with the information he had requested.

The Ombudsman found that the Health Board failed to identify that Mrs. A had acute kidney failure from the time she was admitted. In an attempt to control Mrs. A's back pain, she was prescribed pain relief at inappropriate levels (in the context of her kidney failure) and, even when she began to decline, this was not reviewed. The Ombudsman report suggests that the lack of monitoring of Mrs. A's medication and kidney function resulted in an acute kidney injury, which was probably preventable but was overlooked and, ultimately, precipitated her death. The prescription of the antidote was appropriate to counter the accumulation of opioid pain killers, which could not be filtered from Mrs. A's blood by her damaged kidneys. However, it was prescribed too late, which led to uncertainty about whether it might have had any effect if it had been prescribed sooner.

Key issues and Health Board response

Clinical Care

A failure to recognise the Acute Kidney failure leading from admission which led to the Acute Kidney Injury. Prescription and administration of medication which did not consider the reduced kidney function.

It is fully accepted that we missed an opportunity to recognise the deteriorating kidney function from admission, which led to Acute Kidney Injury. Sadly clinical staff will sometimes miss an opportunity to identify a clinical problem and this failure leads to other concerns' with the pathway of care.

Due to the failure to recognize deteriorating kidney function, analgesia was prescribed in a routine dose rather than as a reduced dose which would be indicated when a patient's kidney function is deteriorating.

The Health Board had not undertaken a review of the clinical care from admission as this was not part of the concerns raised with the Health Board. We have however fully accepted the findings of the Ombudsman's expert as outlined in his report.

Safeguarding

The Ombudsman identified that there had been significant delays in the reporting, processing, investigation and management of Mr A's safeguarding concerns.

The Ombudsman accepted the ultimate outcome of the Safeguarding Investigations, which found that bruising to Mrs. A's arm had been caused by a manual handling accident when Mrs. A was assisted to move up the bed. The report also concluded that there was not any evidence that Mrs. A had suffered a head injury, although the report recognised that the symptoms her family observed might, to them, have appeared to be similar to symptoms of concussion.

The Health Board accepted that when the family on 8 May 2017 raised concerns about a bruise on Mrs. A's elbow there was an allegation of harm. On 19 May an Adult Protection Referral Form ("the First Referral") was completed by the Manager of the Acute Assessment Unit; The First Referral was received by MASH (The Health Board is a member of the Cardiff Multi Agency Safeguarding Hub ("MASH").[1] MASH provides an integrated service intended to improve and facilitate collaborative working between the organisations which have responsibility for safeguarding throughout Cardiff, including the Health Board, Local Authority and the Police. It follows the 'Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse' ("the Adult Protection Policy") on 23 May 2017. The Health Board accepts that the time period between the 8th and 19th May 2017 was too long. A Senior Nurse began a fact-finding investigation following a Strategy Discussion two days later, to try to establish the identity of the member of staff and to ensure that appropriate procedures were followed.

On 12 September 2017, a Strategy Discussion took place, at which it was decided that the evidence did not meet the threshold to progress the First Referral further because there was no evidence to suggest deliberate harm. The bruising had been documented appropriately when it was raised on 8 May 2017 and had been reported by Mrs. A as an accident that had occurred during a manual handling procedure.

Second Referral

On the 14 July 2017, a meeting was held between the Second Consultant, the Senior Nurse, Mr A and Mr A's son, where they raised further concerns in relation to bruising to the arm and concerns that their mother had sustained a head injury. Unfortunately the Senior Nurse present did not recognize this as a new safeguarding issue and assumed this was being processed as part of the original safeguarding referral. It was not until a strategic review of the complaint was undertaken on 15 September 2017, when it was accepted that a second safeguarding referral in relation to the head injury should have been immediately made. Therefore a second referral was made on 15 September 2017 and received by the Multi Agency Safeguarding Hub on 19 September 2017.

On 23 October 2017 Mr A met again with the Health Board this was organised by the concerns team and he was advised that both the First and the Second Safeguarding Referrals were concluded, with no evidence of deliberate harm or of any head injury to Mrs. A.

[1]

The Health Board accepts the Ombudsman view that these delays were unacceptable.

Complaints

The Health Board had failed to process Mr A's complaint in line with its complaints process, Putting Things Right ("PTR"), or keep him updated on progress of the investigation in line with that procedure

On 15 September 2017, the concerns Mr A raised at the meeting in July 2017 were retrospectively logged as a formal complaint under PTR. An internal meeting organized by the concerns team was held on the 15 September 2017 to agree some key actions. At this time it was also agreed to ask the Neurologist to review his assessment of Mrs. A; he noted that slurred speech can be a side effect of both opioid and blood-thinning medications and considered that there was no evidence Mrs. A had suffered any sort of brain injury or disease.

On 23 October 2017 Mr A met again with the Health Board. In attendance at the meeting was the then Director of Nursing for the Medicine Clinical Board, the Acting Head of Concerns and Claims, the lead Nurse from the Emergency Unit, the second consultant and Mrs A's son and grandson. Actions were agreed which included sharing of key documents.

On 9 January 2018, the Health Board formally responded to Mr A's complaint and provided the information requested form the 23 October 2017. The Health Board apologized for the unacceptable prolonged delay in providing a response. It is accepted in full that there was an unreasonable and inexcusable delay in responding to this complaint.

Health Board Actions

In the evidence to the Ombudsman the Health Board demonstrated that some actions had been taken to ensure that key learning was shared across the Medicine Clinical Board

The Health Board evidenced that Mrs. A's case was discussed at the Medical Clinical Boards Quality and Safety Meeting on 13 December 2017.

The management of the concerns process has been reviewed and a data field has been added to our complaints system to ensure agreed actions can be monitored to ensure completion.

The Health Board has been working hard to encourage patients and the public to complain, to improve response times, quality of responses and contact with families. The current performance times for 30 working day responses is following a trajectory of improvement and is currently at 84%

The Health Board has a robust process in place to manage concerns in a proportionate manner in accordance with the regulations. We have in excess of 2000 posters around the Health Board sites advising people about how to raise concerns, we encourage people to phone us, e mail, call into our information centres and talk with a member of our PALS (Patient Advisory Liaison team). We have updated the Internet pages and added a link to a Concerns Form that patients can complete making it easier for patients and families to raise concerns. This helps to ensure a comprehensive response is provided.

All concerns are reviewed by the Executive Nurse Director and the Assistant Director of Patient Experience and graded dependent on the seriousness of the complaint. This indicates the level of investigation required, e.g. a full Root Cause Analysis Investigation, Informal Investigation, which we aim to resolve within 2 to 5 working days, or a formal 30 working days Investigation.

Concerns are shared with the Director's of Nursing within the relevant Clinical Board, following which an Investigating Officer is appointed. It is a requirement that the Investigating Officer to make contact with the Complainant.

Under the Putting Things Right Regulations, all formal concerns have to be acknowledged within 2 working days. Our performance in this area is 98%. The Concerns Team agree the Terms of Reference with the Complainant and provide the Investigating Officer with the specific questions to be investigated as agreed with the person raising the concern. This helps to ensure a comprehensive response is provided. In our ongoing evaluation of the concerns service this initial contact and listening to people has been appreciated. We encourage personal contact with each Complainant to ensure that we acknowledge their correspondence in a more empathetic and personal manner than just formally writing to them.

For those investigations that require further time, the Concerns Team contacts the Complainant, prior to the 30 day target, to explain the reason for the delay and advise that further time is needed.

Within the response, Complainants are offered the opportunity to meet with the Health Board Staff. As part of the regulations, there is an obligation on a Welsh NHS body to consider when it is notified of a concern that alleges harm or may have been caused, whether or not there is a qualifying liability. This is included in the response, along with the advice on how concerns can be forwarded to the Ombudsman.

Ombudsman

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

However on this occasion as an organisation and as a concerns team we failed Mrs. A and her family. For this we remain deeply sorry and we are committed to learning from this review

The Health Board has accepted the report in its entirety.

The Health Board will provide evidence to the Ombudsman that it has complied with the recommendations.

The Health Board had identified, during the course of its own investigation, that Mr A's complaint was not processed correctly, and that communication with him had been poor; and suggested an offer Mr A £750 in recognition of these failings. Following investigation, the Health Board agreed to undertake the following actions:

Within one month of the date of this report:

(a) Provide a full and meaningful apology for all the failings identified in this report.

(b) Offer Mr A £750 as suggested by the Health Board for the complaint handling failure.

(c) Offer Mr A £500 for the failure to progress the two Safeguarding Referrals appropriately and £250 for the loss of Mrs A's medical records.

(d) Offer Mr A further financial redress of £4,000, to reflect the failure to assess, diagnose and treat Mrs A's condition and in recognition of the uncertainty as to whether remedial action might have prevented her death, as well as the distress caused to Mr A and his family in the manner of her death.

Within three months of the date of this report:

(e) Undertake a quality improvement project to consider the e-handover system for sharing information about a patient's condition, medication, and any notable changes or deterioration in their presentation when they are moved in a planned move between wards. Where any shortcomings are identified an action plan should be put in place, to address them.

(f) All staff involved in this case should receive training on reporting and handling of injuries sustained during hospital admission, including receiving and processing of both Safeguarding Referrals and complaints raised under PTR and how each should be progressed. This should include guidance on the value of each of those processes, the importance of full and transparent record keeping, and the consequences of carrying prejudices against patients and their families after any such report or Safeguarding Referral has been made.

(g) All staff involved in complaint handling on this case should be reminded of the role of the Concerns Team, which should ensure that investigations are concluded in a timely manner and that complainants are kept informed, in accordance with PTR.

(h) The Health Board should provide the Ombudsman with evidence that it has adequate arrangements in place for senior medical review on weekends and bank holidays for Geriatric Care.

Within six months of the date of this report:

(i) All doctors involved in this case and any other relevant clinicians should undergo further training, with particular reference to current NICE and professional guidelines, on recognition of sepsis and the risk of AKI, as well as drug dosing and toxicity in elderly patients and those with kidney disease.

(j) All doctors involved in this case should evidence a reasonable level of reflection upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report, including discussion of the matter at their next appraisal. The Health Board's Medical Director should also review the report and consider whether any of the issues raised warrant referral of any relevant clinician to the GMC.

An action plan has been developed to monitor compliance with the recommendations**.**

Attached –Copy of the action plan

Ombudsman Case 201706982 Clinical Board: Medicine

Rec	Action	Health Board Action	Compliance evidence	Responsible Officer	Timescale
44.	**WITHIN ONE MONTH**				
(a)	Provide a full and meaningful apology for all the failings identified in this report.	Apology letter completed	**Copy of letter shared with Ombudsman and Welsh Government**	*Assistant Director Patient Experience*	8 February 2019 **Completed and issued 16/01/19**
(b)	Processed payment of £750 to Mr A as suggested by the Health Board for the complaint handling failures.	Process Payment	**Proof of payment**	*Assistant Director Patient Experience*	8 February 2019 **Payment date 16/01/19**
(c)	Processed payment of £500 to Mr A for the failure to progress the two Safeguarding Referrals appropriately and £250 for the loss of Mrs A's medical records.	Process Payment	**Proof of payment**	*Assistant Director Patient Experience*	8 February 2019 **Payment date 16/01/19**
(d)	Processed payment of further financial redress of £4,000 to Mr A, to reflect the failure to assess, diagnose and treat Mrs A's condition and in recognition of the uncertainty as to whether remedial action might have prevented her death, as well as the distress caused to Mr A and his family in the manner of her death.	Process Payment	**Proof of payment**	*Assistant Director Patient Experience*	8 February 2019 **Payment date 16/01/19**

45.	**WITHIN THREE MONTHS**				
(e)	The Health Board should undertake a quality improvement project to consider e-handover system for sharing information about a patient's condition, medication, a any notable changes or deterioration in their presentation when they are moved in a planned move between wards. Where any shortcomings are identified an action p should be put in place to address them.	Agree the project plan	**Action plan**	*Director of Nursing Medicine Clinical Board*	8 April 19
(f)	All staff involved in this case should receive training on reporting and handling of injuries sustained during hospital admission, including receiving and processing of both Safeguarding Referrals and complaints raised under PTR and how each should be progressed. This should include guidance on the value of each of those processes; the importance of full and transparent record keeping, and the consequences of carrying prejudices against patients and their families after any such report or Safeguarding Referral has been made.	Organise a training session	**Copy of presentation**	*Assistant Director Patient Experience with Lead for Safeguarding*	8 April 19
(g)	All staff involved in complaint handling on this case should be reminded of the role of the Concerns Team, which should ensure that investigations are concluded in a timely manner and that complainants are kept informed, in accordance with PTR.	Included in training session Reminder at the next Clinical Board Quality, Safety and Experience meeting	**Copy of presentation including this action** **Copy of relevant notes from the Clinical Board QSE Meeting**	*Assistant Director Patient Experience*	8 April 19
(h)	The Health Board should provide the Ombudsman with evidence that it has adequate arrangements in place for senior medical review on weekends and bank holidays for Geriatric Care.	Review of arrangements	**Copy of assurance**	*Medicine Clinical Board*	8 April 19

			documents to Ombudsman		
46.	**WITHIN SIX MONTHS**				
(i)	All doctors involved in this case and any other relevant clinicians should undergo further training, with particular reference to current NICE and professional guidelines, on recognition of sepsis and the risk of AKI, as well as drug dosing and toxicity in elderly patients and those with kidney disease.	Identify relevant training	**Evidence of training**	*Named consultants*	8 July 19
(j)	All doctors involved in this case should evidence a reasonable level of reflection upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report, including discussion of the matter at their next appraisal. The Health Board's Medical Director should also review the report and consider whether any of the issues raised warrant referral of any relevant clinician to the GMC.	Review of report by Medical Director Reflective discussion with appraiser	**Outcome of Medical Directors review** Confirmation from appraiser that reflective discussion occurred		8 July 19

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

MINUTES OF THE MEETING HELD ON 12TH DECEMBER 2018

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Alun Morgan	Assistant Director of Therapies and Health Sciences
Sarah Jones	Quality Lead, Pharmacy
Bolette Jones	Head of Media Resources
Robert Bracchi	Consultant, AWTTC
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Rachael Daniel	Health and Safety Adviser
Lisa Griffiths	Quality Manager, Laboratory Medicine

Apologies:

Mike Bourne	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Suzie Cheesman	Patient Safety Facilitator
Kathy Ikin	Directorate Manager, Radiology and Medical Physics/Clinical Engineering
Emma Cooke	Head of Physiotherapy
Maria Jones	Senior Nurse, Outpatients

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 18/408 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

CDTQSE 18/409 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 18/410 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 14th November 2018 were **APPROVED.**

CDTQSE 18/411 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 18/164 Schedule of Patient Stories/ Annual report

Sue Bailey to issue directorates with dates of when they are required to present a patient story and an annual report to this Group.

Action: Sue Bailey

CDTQSE 18/248 Health and Care Standards Response

Sue Bailey to present the Clinical Board Health and Care Standards response to this Group.

Action: Sue Bailey

CDTQSE 18/291 Health and Safety Risk Assessment Academic Building UHL

Rachael Daniel has reviewed the risk assessment and has some concerns that she will discuss with the Estates Team.

Action: Rachael Daniel

It was noted that there have been no further incidents at the Academic Centre.

CDTQSE 18/333 Implications of No Deal Brexit

Further updates have been requested for the implications on services should no deal for Brexit be reached.

Action: Directorates

CDTQSE 18/370 Quality and Safety Sub-Committee Terms of Reference

The terms of reference will be presented to the next Formal Clinical Board Meeting in January.

CDTQSE 18/374 Moveable Bays in Health Records

John Maisey has advised that the moveable bays require a higher level of expertise for repair than can be provided by Clinical Engineering. It was also advised that the moveable bays are not considered as medical devices. Sion O'Keefe will raise the cost implications for repair and the health and safety risks to staff the directorate performance review on Monday.

Action: Sion O'Keefe

CDTQSE 18/374 Ambulance Patients in Radiology CRI

The Radiology department has decided that patients requiring ambulance transport in Radiology will not be booked into Radiology at CRI as it is an unsuitable environment with no facilities for patients awaiting ambulances.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 18/412 Patient Story

Health Pathways Presentation

Hannah Brayford and Patricia Osbourne were welcomed to the meeting to present the Health Pathways Programme. This is an IT web based way of collating primary care/community pathways. A group of GPs and secondary care clinicians are working together to look at how patients should be referred with the aim of reducing waste, variation and harm. A process has been developed to collate all the information to ensure there is consistency across all the pathways. In January 20-30 pathways will go live. These include:
Gastroenterology
ENT
Dermatology
Paeds
Nephrology

The aim is to get over 1000 pathways live by the end of the project.

There is a process for edits to be made to pathways when live. All pathways will be subject to a wider review before go live and individuals can contact Patricia Osbourne to be part of the wider review. As this work is medically focussed it is important that services within this Clinical Board are involved. Alun Morgan will send her a list of key contacts within this Clinical Board.

Action: Alun Morgan

Sue Bailey raised concerns that this could lead to an increase in demand for diagnostics. Hannah Brayford advised that these are pathways that are already in existence.

Sue Bailey also enquired if the pathways will have turnaround times requirements/ expectations on performance e.g. timelines that need to be met at specific points in the pathway. Hannah Brayford responded that this is not the case, the elements of the pathway will fit in with existing RTT times.

In terms of accessing the information, individuals can log on to a link via PC or mobile. Hannah Brayford will send Helen Jenkins the details for circulation. Sue Bailey thanked Hannah Brayford and Patricia Osborne for attending noting that the Clinical Board is keen to engage and be involved in this work.

Sierra Leone Visit – Child Cancer Care Link

Sue Bailey welcomed Scott Gable to the meeting. In October Scott Gable visited a hospital in the Republic of Sierra Leone. In recent years the country has experienced civil war. In 2015 it was hit with an Ebola outbreak with approximately 11,000 deaths and in 2017 devastating landslides hit the country.

There is a new government in the country which has set out to reduce cancer rates and close links have been developed with Velindre. Scott Gable was approached by Dr Meriel Jenney to visit a hospital in Sierra Leone. Dr Jenney and colleagues at Wellbody has worked with clinical Teams in Sierra Leone to set up a chemotherapy treatment centre. The hospital they visited has a capacity of 250 beds. Diagnosis is purely clinical with no x-ray department. There is no supply chain so whilst a laboratory could be set up there was no supply chain for reagents. During the visit, the clinical team at Sierra Leone were fully engaged and supportive of changes. They were taught procedures and techniques in taking samples of tissue to test for lymphoma, as needles and syringes were readily available. The scientists in the hospital were proficient in IT and mobile phone technology was introduced so that images could be sent to consultants across the world for diagnosis. As the country is not subject to the heavy regulation that healthcare is subject to within the UK, the team visiting the hospital were able to source reagents and drugs that are suitable to meet requirements for diagnosis and treatment. Since Scott Gable's return from the visit, multiple images have come across from Sierra Leone which suggests that the changes put in place during the visit are being driven forward.

Scott Gable noted the following in terms of learning from the visit:

High level support helps drive change.

Solutions to challenges have to have engagement from the team delivering them to be successful.

Solutions have to be sustainable.

Try small tests of change and learn from the outcomes.

By thinking 'outside the box', things can be used safely in other ways if assessed properly.

Small changes can drive massive change.

CDTQSE 18/413 Feedback from UHB QSE Committee 17th October 2018

The minutes of the meeting are not yet available.

CDTQSE 18/414 Health and Care Standards

Sion O'Keefe reported that the next phase will commence again in 2019. More robust evidence and shared learning is required this year and there needs to be links to business continuity.

CDTQSE 18/415 Risk Register

Work is needed to the Clinical Board and directorate risk registers. Alun Morgan will telephone Sian Rowlands to enquire if there is any update on when the new template will be implemented.

Action: Alun Morgan

CDTQSE 18/416 Exception Reports

There is a delay in enrolling samples in Specimen Reception due to staffing issues. Part of a solution is to encourage areas to use ETR. Alun Morgan raised this at the Winter Resilience Group and printers have been provided to Heulwen Ward.

An MHRA inspection is being held in the blood transfusion laboratory tomorrow. There is slippage on their action plan following the last inspection which will likely be challenged.

Haematology interfaces are not yet live as the intention is to delay until January to avoid go live over the festive period,

The HTA re-inspection was held on 22nd November 2018. Overall this was a successful visit. Final work is to be completed around audits, to provide assurance that audits are robust and the actions address the root cause. This needs to be completed by the end of January 2019. On behalf of the Clinical Board Alun Morgan commended the leadership Sue Bailey has shown over the last year and he also thanked the Cellular Pathology department and Lisa Griffiths for all their hard work and efforts.

It was noted that the Quality Assurance Pharmacy post at SMPU is vacant.

Discussions have been held of utilising a function on the QPulse system to define when maintenance of equipment is due. This will help to avoid missing the servicing/maintenance dates for equipment.

All directorates should have an inventory of their equipment which identifies the maintenance needs and servicing contracts that are in place. Any equipment risks should then be emailed to Tony Powell for him to place on the equipment risk register. This may identify economies of scale. It was agreed that all directorates will undertake this work and present an update to this Group in February.

Action: Directorates

Sion O'Keefe reported that a workplace inspection of the bereavement office in the concourse highlighted patient experience risks, IG risks with a recommendation that larger accommodation is required. Whilst this has been with the UHB Wayfinding Group for a number of years, Sion O'Keefe is not assured that the space is included within the redesign plans of the concourse. Sion O'Keefe will write up the issues into an SBAR document.

Action: Sion O'Keefe

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 18/417 Initiatives to promote Health and Wellbeing

Risk Assessment for Allergen Coding of Menus

A risk assessment was completed following concerns raised around ensuring that allergy information is accurately recorded on the menus provided to patients. An issue was raised where ingredients have been changed and the allergy information was not updated.

The risk assessment recommends that:

The master allergen coding sheet is updated by named personnel only and is audited and cross checked against all available information.

There should be a consistent and accurate admission procedure which confirms any known allergies leading to documentation and communication via the nutrition and hydration bed plan. A memo on the importance of completion of the bed plan will be sent via the nursing network to nursing and therapies staff.

There will be ongoing provision of opportunities for ward staff to be educated and trained in how to manage patients with specific food allergies.

The All Wales Catering IT solution will allow real time updates to products. Visible allergen information will be held at the bedside.

The newly appointed All Wales Procurement Dietitian is to ensure that an urgent review of the All Wales website is undertaken urgently.

It was noted that this risk assessment has been escalated within the Health Board.

Influenza Campaign 2018-19

The Clinical Board is pleased to report that it has reached 60.7% uptake of frontline staff who have received the flu vaccination. This Clinical Board is the first clinical to reach the WG target. Staff who have not yet received the flu jab are encouraged to be vaccinated.

CDTQSE 18/418 Falls Prevention

The UHB Falls Group submitted a paper to the UHB Board and it was noted that the UHB is pleased with the progress being made around the falls framework. An outcome has not yet been received on whether the business case to enhance the CRTs has been accepted as part of transformational funding.

Simulation training is in place for falls on wards however uptake has not been high and Oli Williams is therefore liaising with senior nurses. Sue Bailey enquired whether the training could be modified for the outpatient setting.

SAFE CARE

CDT QSE 18/419 Concerns and Compliments Report

From 1st April 2018 to 30th November 2018 the Clinical Board reported 42 formal concerns. This compares to 44 in the same period as last year.

In November 2018, 3 formal concerns were received. This compares to 2 received in November 2018.

Since 1st April 2018, the Clinical Board is reporting 16 breaches in response times. There was 1 breach in November relating to Laboratory Medicine directorate.

The Clinical Board received 1 AM concerns in November. Since 1st April 2018 the Clinical Board has received 6 AM concerns.

From 1st April 2018 to 30th November 2018, the Clinical Board has received 65 compliments. This compares to 61 received in the same period last year. 9 compliments were received in November 2018.

The key theme for formal concerns received is communication between staff and patients. 19 of the 42 concerns received fall within this category. The breakdown by sub-category is as follows:

- 6 (32%) related to attitude of staff.
- 6 (32%) related to difficulties in arranging/cancelling appointments.
- 7 (36%) related to lack of communication/communication issues.

CDTQSE 18/420 Ombudsman Reports

Nothing to report.

CDTQSE 18/421 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 18/422 Patient Safety Incidents

SI Report

The Clinical Board is reporting 4 SIs:

In72302 The closure form has been submitted to Welsh Government.

In69239 An RCA has been completed and the closure form submitted to Welsh Government.

In72037 This incident has now been closed by Welsh Government.

In79310 This incident relates to a delay in advising a patient that tissue was still being held relating to a pregnancy loss. An RCA and action plan has been completed.

CDTQSE 18/423 New SI's

An incident is being investigated relating to a patient on a Mental Health Ward who choked on food and subsequently died. Issues are being investigated around the adequacy of the swallowing assessment to determine if this had an effect on the incident.

A patient arrived for a CT check and CT Neck and Head and it was later decided that the CT head and neck was not necessary however the CT head and neck had already been undertaken. Sue Bailey advised that as this was justified at the time, this is not classed as an SI.

CDTQSE 18/424 RCA/Improvement Plans

Nothing to report.

CDTQSE 18/425 WG Closure Forms – Sign Off

In72302

During a planned audit of historical block and slide holdings, evidence was found that two slides from a forensic case from 2016 had been used by Cardiff University for a scheduled purpose (teaching) for which consent was not given. The case was reported to the HTA. The HTA have reviewed the case and are satisfied with the findings of the RCA and that corrective and preventative actions had been taken and have closed the incident.

A comprehensive closure form was submitted for Welsh Government. The root cause was that there was no procedure to manage material for teaching and education and no procedure for PACE material. A vast amount of work has been undertaken to ensure these procedures, training and competency assessments are in place to ensure there is no reoccurrence.

CDTQSE 18/426 Regulation 28 Reports

Nothing to report.

CDTQSE 18/427 Patient Safety Alerts

PSN 046 Management of life threatening bleeds from the arteriovenous fistulae and grafts

This is applicable to Radiologists who undertake fistulagrams. Rebecca Vaughan-Roberts to contact the patient safety team to identify who is leading the organisation on this alert.

Action: Rebecca Vaughan-Roberts

CDTQSE 18/428 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 18/429 Medical Device Risks/Equipment and Diagnostic Systems

Only 2 items have been received for the equipment risk register. These have been sent to Capital Management. Tony Powell noted that there is funding available for medical equipment and directorates need to submit their equipment risks to him to be considered for the funding.

Sue Bailey reported that the Rees temperature monitoring system in the blood transfusion laboratory is linked to Cellular Pathology and there is an issue that the alarm is being activated within Cellular Pathology every time the fridge is opened in the blood transfusion laboratory. Costs have been received for separating the nodes.

Tony Powell raised concerns that other Clinical Boards are auctioning off medical equipment or arranging its disposal themselves rather than following the UHB policy of approaching Clinical Engineering. This is putting the UHB at risk and Fiona Jenkins will be writing out to Clinical Boards to remind them of the need to follow the policy. Sue Bailey will also ask Matt Temby to raise at the Clinical Board Director of Operations forum.

Action: Sue Bailey

It was noted that Scott Gable will be attending the Medical Equipment Group as a representative from Laboratory Medicine.

CDTQSE 18/430 IP&C/Decontamination Issues

Cleaning schedules in Radiology are being reviewed to raise them to theatre standard.

Work is progressing on a Standard Operating Procedure for RDAs.

Work is ongoing around ANTT training within Phlebotomy.

The UHB is currently undertaking a large piece of work around endoscopes and ensuring that all illumines are cleaned. Rebecca Vaughan-Roberts and Oliver Griebel have audited all the endoscopes within Radiology for assurance.

It was noted that the drying cabinet in Radiology is up and running.

CDTQSE 18/431 Key Patient Safety Risks

Safeguarding

The UHB Safeguarding Meeting was held last week. A presentation was delivered on FGM and the work undertaken with the police. An open access specialist clinic has been set up in SARC which has been well received.

Today is the last day of the 16 days of action for ending domestic abuse against women. This has been linked in to the #orange scheme. Events will continue to be rolled out throughout the year. Alun Morgan has written to Clinical Boards to try to increase the number of men who are willing to come forward as ambassadors with the aim of having one ambassador in each of the Clinical Boards.

Level 2 domestic violence training is due to be rolled out for all patient facing staff in the New Year. This is a full day's training and will have major implications on releasing staff to attend the training.

MCA Act

Nothing to report.

CDTQSE 18/432 Health and Safety Issues

Rachael Daniel reported that the UHB Operational H&S Group was held today. The obligatory response to violence in healthcare was discussed. This replaces the current memorandum of understanding of prosecuting individuals who are violent to staff. This has been launched by Vaughan Gethin AM. She noted that this Health Board has been recognised as forward thinking in terms of case management. The Case Management team will be presenting at Clinical Board Health and Safety groups to provide more information.

Rachael Daniel also reported that the SW Police Sergeant will be based at UHL for 3 days a week.

The Fire safety Annual report was received. Issues around fire audits and assessments were raised and will be discussed further at the Clinical Board Health and Safety Group.

An incident was raised within Radiology where a contractor climbed a ladder propped against a door which he thought was a storage cupboard but was actually for main thoroughfare. Jonathan Davies of the Health and Safety Team will attend Clinical Board Health and Safety meetings to advise directorates on issues they need to consider when bringing in contractors.

CDTQSE 18/433 Regulatory Compliance and Accreditation

The MHRA are inspecting the Blood Transfusion Laboratory tomorrow.

UKAS surveillance visits are being held in Biochemistry this month and inspecting Cellular Pathology in February.

CDTQSE 18/434 Policies, Procedures and Guidance

The following policies are under review and out for consultation:

CCTV Policy
Environmental Policy

Latex policy

Comments to be submitted to the authors by 9th January 2019.

EFFECTIVE CARE

CDTQSE 18/435 Clinical Audit

Nothing to report.

CDTQSE 18/436 Research and Development

Nothing to report.

CDTQSE 18/437 Service Improvement Initiatives

The CSI team are moving forward to transformation and a new Head of Transformation will be appointed. The aim is to create a community of practice which will have a portfolio of work and will share learning.

A Project Managers workshop is being held by the Project Management Office which is looking at setting up a network for structured projects.

CDTQSE 18/438 NICE Guidance

Nothing to report.

CDTQSE 18/439 Information Governance

Sion O'Keefe and Sue Bailey have been discussing whether it is more appropriate for information governance issues to be discussed at the Regulatory Compliance Group rather than QSE. It was **AGREED** that the detail around information governance issues will be discussed at the Regulatory Compliance Group and any issues that require escalation will be presented to this meeting.

A list of fax machines in use within the Clinical Board has been compiled. A mechanism is needed for 2020 when the use of fax machines will become obsolete within Health Boards.

CDTQSE 18/440 Data Quality

An approach has been implemented where patients receive a text informing them of their appointments and they can see their appointment letter online. Directorates were reminded to ensure that they are holding the correct contact details for patients.

DIGNIFIED CARE

CDTQSE 18/441 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

It was noted that the CHC has undertaken a number of unannounced visits over the last few weeks.

CDTQSE 18/442 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

CDTQSE 18/443 Initiatives Specifically Related to the Promotion of Dignity

Rebecca Vaughan-Roberts is attending a bariatric patient pathway meeting tomorrow. She will feedback at the next meeting.

Action: Rebecca Vaughan-Roberts

CDTQSE 18/444 Equality and Diversity

A transgender training session is being held tomorrow and this is fully subscribed.

TIMELY CARE

CDTQSE 18/445 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 18/446 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

The Clinical Board waiting time projections for December are positive.

INDIVIDUAL CARE

CDTQSE 18/447 National User Experience Framework

The Clinical Board Report for November 2018 was **RECEIVED.** 96% of patients and visitors rated their overall experience as 7 out of ten or above and this is reflected in the positive comments written within the report.

Patients are raising concerns with parking as they are finding it is becoming increasingly more difficult to park. Alun Morgan raised his concerns on the number of students he has seen parking in the multi-storey car park.

STAFF AND RESOURCES

CDTQSE 18/448 Staff Awards and Recognition

The deadline for nominations for the UHB Staff Recognition Awards is 14th December.

Dates for the 2019 Clinical Board Staff Recognition Scheme have been circulated.

CDTQSE 18/449 Monitoring of Mandatory Training and PADRs

Fire training compliance is 67% and needs to be improved. Sue Bailey offered to present face to face training sessions to departments if needed.

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

The following minutes were **RECEIVED:**

Biochemistry Quality and Safety Group Minutes 6th November 2018
Clinical Board R&D Group Minutes 13th November 2018

ANY OTHER BUSINESS

Nothing further to report.

DATE AND TIME OF NEXT MEETING

9th January 2019 at 2pm in Room 4.4. 4th Floor, Ty Dewi Sant, UHW

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING
13th September 2018
Seminar Room, Hafan y Coed, Llandough Hospital

Present: Jayne Tottle, Director of Nursing Mental Health (Chair)
Will Adams, Professional Practice Development Nurse
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Owen Baglow, Clinical Lead for Quality, Safety & Governance
Philip Ball, Senior Nurse Manager Vale Locality CMHTs
Matthew Brayford, Integrated Manager Pendine CMHT
Lisa Crump, ANP Adult In-patient
Adeline Cutinha, Consultant Psychiatrist, Gabalfa CMHT
Alison Edmunds, Concerns Co-ordinator
Catherine Evans, Patient Safety Facilitator
Gwilym Griffiths, CPN Links CMHT
John Hyde, Mental Health Lecturer, Cardiff University
Jayne Jennings, Ward Manager Willow Ward
Neil Jones, Addictions Psychiatrist/Interim Clinical Director Adult MH
Robert Kidd, Consultant Psychologist
Helen O'Sullivan, Senior Nurse Manager Community Adult
Kelly Panniers, ANP Adult In-patient
Jody Rawlings, Ward Manager Beech Ward
Tara Robinson, Senior Nurse Manager Rehab & Recovery
Darren Shore, Team Lead North CRHTT
Jayne Strong, ANP Rehab & Recovery
Andrea Sullivan, Concerns Co-ordinator
Mark Warren, Interim Lead Nurse Adult Mental Health

Apologies: Jayne Bell, Lead Nurse Adult Mental Health
Des Collins, Ward Manager Pine Ward
Mark Doherty, Lead Nurse MHSOP/Neuro
Carol Evans, Assistant Director Patient Safety & Quality
Ruth Evans, Lead CPN Links CMHT
Martin Harper, Integrated Manager Links CMHT
Mike Lewis, SIMA Co-Ordinator
Mary Morgan, Senior Nurse Manager Adult In-patient
Bala Oruganti, Consultant Psychiatrist
Annie Procter, Director Mental Health
Ian Wile, Director of Operations MH
Lowri Wyn, Ward Manager Cedar Ward

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

Chair welcomed all to the meeting and introductions were made.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

No Actions.

PART 3 : CLOSURES

3.1 AD

AD had been known to Mental Health Services since October 2014. AD had a diagnosis of schizophrenia and a history of alcohol dependence. AD had several admissions to hospital within Mental Health Services.

2016 – AD was consuming excessive fluids. AD had Polydipsia (excessive thirst) and required constant supervision and monitoring which would include restricted fluid intake. In 2017 AD was admitted to Cedar ward, Hafan y Coed under Section 2 of the Mental Health Act 1983 for her own health and safety. This admission was precipitated following concerns raised by staff at the supported accommodation regarding AD's over eating and drinking. AD had been excessively drinking water whenever possible, which resulted in the staff at the supported accommodation having to lock off communal taps. Care plans from the supported housing were shared with the ward staff in relation to her fluid restriction regime. AD was placed on 15 minute intermittent observations in order to monitor her. Food and fluid charts were commenced to monitor her dietary intake, as well as her physical observations including her weight and BM's (blood glucose monitoring) to monitor her diabetes. A referral to dietetics was also completed on admission in relation to her over eating and drinking.

A few weeks after admission, AD was noted to have a raised blood pressure and was monitored every 20 minutes as advised by the Medical Emergency Assessment Unit (MEAU) and noted that her blood pressure had lowered slightly. Staff attended AD's room to call her for her medication and found her unresponsive. Resuscitation was commenced and the emergency pinpoint system was activated for assistance from staff within Hafan y Coed. An emergency cardiac arrest call was also put out. The Resuscitation Team from the general hospital site arrived on ward within 5 minutes of the call being put out. They then took over the resuscitation of AD but sadly were unsuccessful.

Notable practice

It was acknowledged that AD had chronic physical health issues which included diabetes, anaemia and hyponatraemia. These health issues were being exacerbated by her excessive fluid intake due to polydipsia which is excessive thirst. The latter was being addressed in her care placement and these concerns were communicated to the ward who continued efforts to control the amount of fluid AD was taking.

- On admission AD had a physical examination, ECG and routine bloods performed which included full blood count, liver function, random glucose, thyroid function, urea and electrolyte, lipid profile and bone profile. All of these results were normal at this time.

- On admission AD was referred to the Dietician due to concerns about over eating and drinking. AD was seen the following day and was commenced on a food and fluid chart to monitor her dietary intake.

- AD was referred to Speech and Language Therapy for a swallow assessment due to ongoing concerns about her eating habits, particularly risk of choking. The swallow assessment indicated no impairment, no intervention was required and nursing staff were advised to continue offering AD a normal diet and prompt her not to overfill her mouth and to eat slowly when eating.

- There were no concerns raised about the resuscitation attempt from the resuscitation team's audit, the correct Basic Life Support (BLS) process was followed. The nursing staff had commenced CPR (Cardiopulmonary Resuscitation) and used a pocket mask to give rescue breaths. However the Resuscitation Team did note that no oxygen was being piped through the pocket mask on their arrival at the scene, however the Resuscitation Team did administer oxygen upon their arrival within 5 minutes. Resuscitation guidelines recommend that oxygen is attached to the mask as soon as it becomes available. It was noted that staff were using the pocket mask to provide rescue breaths alongside the chest compressions. The Band 6 (Deputy Ward Manager) and Band 7 (Ward Manager) nurses all attend ILS (Intermediate Life Support) on a yearly basis.

The Director of Nursing encourages nurses to attend the ALERT (Acute Life Threatening Events, Recognition and Treatment) Course. This course provides skills to identify a deteriorating patient and provide interventions at an early stage and will provide a bespoke course for Mental Health.

Lessons Learned:

The NEWS chart used to record AD's physical observations was not completed fully on the afternoon of her passing. It had recordings of her blood pressure but nursing staff had not recorded any other vital signs that day.

Staff to update their NEWS training.

Inquest on 17/10/18.

TO CLOSE.

3.2 LR

LR went off the ward to utilise unescorted leave in the grounds. At this time LR had up to 4 hours unescorted leave and had typically been using this in brief periods in the grounds returning frequently throughout the day. On this particular morning, LR used one brief period of leave around 7:25 am and returned safely. LR then decided to use another period at 7:50am; LR appeared settled and reasonable to proceed, however, she failed to return within her designated 4 hour period. By lunch time concerns were raised as this behaviour was out of character. Staff undertook a full search of the unit, ward and the main hospital and grounds. There were no sightings. Contact was also made with her husband who had not seen her. LR had left her mobile phone in her bedroom. Due to the level of concern regarding her wellbeing, contact was made with the Police to report her missing. The Police commenced their search procedures, they gained access to hospital CCTV via the security team and retrieved footage of LR departing the main entrance, taking a coat off and putting it behind a nearby bin and then walking towards the hospital exit with two plastic bags. The Police put LR's missing status on facebook, with a photo of LR, to request help or reports of sightings. As this process was carried out the ward based nursing team maintained contact with LR's husband to provide reassurance and support.

The next day LR was discovered in a pub in Canton. An off duty staff member had seen LR and reported this to the Police. LR was safely returned to the ward. LR had maintained her safety throughout, convincing a local hostel to provide her with a bed. She had enough money for food and had also had her hair done.

In reviewing the clinical notes it does not appear that the Police had made any requests with the nursing team to proceed with putting her photo and case onto facebook

Lessons Learned:

It was noted that the police gave no details of LR's mental health illness on facebook; they just said LR was missing. The Police will use all means at their disposal to find a missing person, therefore,

patients should be made aware that if they do not return from Leave the Police may put the fact that they are missing on social media.

TO CLOSE.

3.3 LW

In April 2018, the Community Mental Health Team (CMHT) received a telephone call from a cousin of LW to advise that neither the family, nor his housing team had seen LW for a few months. LW had not been seen by the CMHT since he was closed to the service in September 2017. The cousin was advised to contact the Police to report LW as a missing person and request a welfare check be carried out.

South Wales Police confirmed that, following the family's request for a welfare check, LW had been found deceased at his property. It is believed by the Police that he had been deceased for some time. Trauma to neck from a sharp instrument.

LW was known to mental health services since 2005 when he was given a diagnosis of Delusional disorder (paranoid thoughts, grandiose ideas). He refused medication from 2015 but was previously treated with Quetiapine 600mgs.

LW was not been seen by the CMHT since September 2017 when he was closed to the service due to non-engagement. There are reports of concerns around behaviour from police and housing services since that time. All of these reports were reviewed by social work staff at CMHT (including attempts to contact family and discussions with his G.P.) and no concerns identified relating to his mental health so no further action taken. His last actual contact with CMHT was August 2017 when a social worker visited him at his property with housing officers due to concerns raised. At this stage, the social worker felt LW would benefit from mental health support but LW was adamant he did not want support so a new referral was not opened.

Background:

In 2014:

A medical appointment was offered to LW as the Assertive Outreach team had concerns that he was unwell. LW believed people were coming into his room moving things and that they had made 12 holes in his headboard which were releasing poisonous gas; he had used tape to seal parts of the boiler in his room where he felt the fumes were coming from; he was sleeping with a hammer under his pillow. He felt a lot of people were following him and watching him. LW was given a diagnosis of paranoid personality disorder and medication was prescribed.

LW was admitted to hospital on Section 2 of the Mental Health Act after being arrested for criminal damage to his son-in-law's car. It was recorded that the criminal behaviour was part of a delusional ideation that his son-in-law was a drug baron and there were cameras in his flat put there by social workers and cameras in Tesco watching him.

LW's engagement with the CMHT was sporadic - engaging for a time, on times self-presenting as well as refusing to engage with any professional for varying reasons. His medication compliance varied.

In 2015:

LW was charged with harassing a girl who worked in a pub in town. A mental health professional saw LW in the police cell, there was no evidence of Serious Mental Illness but they felt that LW's risks were escalating. LW received a 23 week sentence suspended for 24 months for the harassment, a restraining order forbidding him to approach the girl and was banned from the pub. He also received a Treatment Order which stated he must attend appointments at the CMHT.

In 2016:

Medical professional advised LW would require a depot medication due to history of non-compliance and lack of insight, they recommended a trial of Aripiprazole. LW refused to consume the medication. Continued reports came from his family of his deterioration. LW stopped attending his CMHT appointments so the medical professional recommended he was in breach of his Treatment Order. LW was sent to prison for two months. The Prison in-reach team reviewed him and LW stated he was not unwell and would not take medication nor engage with mental health services.

In 2017:

Housing team reported psychotic behaviours by LW. LW told the police that he felt that people in the community were watching him and judging him. The CMHT offered support to LW but he refused flatly. LW's GP had no concerns. LW was last seen by the CMHT in September 2017; he was closed to the service for non engagement.

Sadly, April 2018 LW was found deceased at his property.

Issues:

Lack of LW's insight into need for help and his anti-social behaviour put up barriers when trying to engage him.

It was felt LW did not meet the criteria for the Assertive Outreach Team service and the opinion was that LW did not have a serious mental illness but more of a presentation that fits with an antisocial personality disorder, he engaged when he wanted something and it was felt that LW was no different on or off medication.

Lessons Learned:

Formulation – healthcare professionals know the risks but don't always bring it together. Must have formulation and a consistent approach.

Staff can identify suicidal risks but not skilled to ask questions on psychosis.

Action: Will Adams is training staff regarding psychotic episodes.
Robert Kidd recommends staff to ask what the patient is worried about to address paranoia

Good Practice

- The CMHT had good communication with partner agencies and the family.
- Worked with partner agencies in a timely manner when concerns were raised.
- Probation was informed of deterioration and concerns

Inquest Hearing

LW was last seen in early January by his niece. Police found LW on the bathroom floor with stab wounds to the neck. The likely cause of death was "sharp force injury to the neck" the Coroner recorded a conclusion of suicide.

TO CLOSE.

3.4 JR

Mrs X complained about the care that her daughter had received from Cardiff & Vale UHB. Mrs X liaised with Cardiff & Vale UHB Mental Health Concerns team. All responses to concerns include the paragraph *"If you are not satisfied with the outcome of the investigation you may refer your concerns for consideration of further investigation to the Public Services Ombudsman for Wales (PSOW)"* Mrs X referred her concerns to the PSOW.

Complaint:

a) Complained that her daughter should have been admitted to hospital for in-patient treatment, not discharged home for treatment.

b) The Care Plan for her daughter after discharge was inadequate and there had been a delay in providing the support her daughter required.

JR has a diagnosis of Borderline Personality Disorder, which includes symptoms of emotional dysregulation and self-harming, including attempts at suicide.

a) Should have been admitted to hospital, not discharged home for treatment.

Following an unsuccessful attempt at suicide, an assessment was carried out which concluded that hospital admission would be counter-productive, resulting in increased risk-taking behaviour. It was recommended the JR be treated at home with support from the Crisis Resolution Home Treatment Team (CRHTT) and psychological support from the Crisis Recovery Unit (CRU) as a day patient.

The Ombudsman Professional Advisor said that, in view of the outcome of the mental state assessment and the need for JR's active involvement in the recovery process, it had been appropriate to discharge JR home with community support and access to CRU. This is consistent with good practice for caring for patients with emotional and behavioural problems because it actively supports recovery with the least restrictive delivery of care. Restrictive physical environments and over-dependence on services is not considered to be therapeutic. The Advisor said he saw no evidence to support admission to hospital and the approach taken by the clinicians was consistent with the provisions in the Mental Health (Wales) Measure 2010.

b) The Care Plan after discharge was inadequate and there had been a delay in providing support

The investigation found that, whilst the support JR received had been consistent with Welsh Government guidance, decisions relating to care should have been better explained. The investigation also found that there had been a delay in the Health Board providing JR with the care and support she required. JR was offered Emotional Regulation Group (ERG) to support her recovery. However, unfortunately, as she missed one ERG intake, because she had to wait for a Psychologist appointment, JR had to wait a year for the next ERG session. Whilst it is understood that there were no sessions running in the intervening period, the Health Board should have considered what alternatives were available to meet JR's needs and aid her recovery.
The failure to provide any similar support during that period was not reasonable.

Recommendations from the Ombudsman:

a) It was recommended that the Health Board apologise for the failings identified.

b) It was also recommended that the Health Board pays Mrs X £250 in recognition of the time and trouble in taking her complaint to the PSOW and pays JR £500 in recognition of the delays in implementing her care plan.

c) It was recommended that the Health Board undertakes a full review of Ms A's care plan to ensure that all identified support is being provided and, where that is not possible, a suitable alternative has been identified and offered.

Issues:

JR's Care Plan has been reviewed and is up to date.

The PSOW recommended that the CRU's Operational Policy be reviewed. The Operational Policy is being reviewed.

TO CLOSE.

3.5 GOOD PRACTICE:

GW

Jayne Strong reported on a patient that had recovered remarkably well.

GW is a patient under the care of the Community Forensic Team who has been supported by the Focussed Outreach Recovery Team (FORT) over the last 13 months with his transition from 24 hour supported accommodation to his own independent flat. GW had spent 10 years in 24 supported environments. He self manages his medication and has good insight into his illness and believes he is in an "amazing place" mentally. GW is now able to manage his daily living needs independently; he undertakes volunteering at Oxfam shop and is hoping to gain a permanent paid position there in the future. He also does volunteering work at Hafal gardening project.

FORT used "The Recovery Star" tool with GW (which can be found easily on the internet and downloaded) to identify areas he would like to focus on. This has enabled GW and the FORT team to see the progression to independent living he has made. GW says he has "great hope for the future" and that he has "come out of his shell". FORT is planning discharge from the service.

Park Road Houses, Whitchurch

Catherine Evans reported that she had recently carried out an inspection of Park Road Houses, Whitchurch with a Senior Nurse. The patients and staff at Park Road Houses spoke highly of Tara Robinson, Senior Nurse Manager.

4.0 DATE OF NEXT MEETING

15th November 2018 at 9.30am in the Seminar Room, Hafan y Coed.

MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE
17th October 2018
SEMINAR ROOM, LLANDOUGH HOSPITAL

Present: Annie Procter, Clinical Board Director, Mental Health (Chair)
Will Adams, Professional Practice Development Nurse
Gail Evans, ANP MHSOP Day Services
Mark Jones, Directorate Manager Adult Mental Health
Robert Kidd, Consultant Psychologist
Bala Oruganti, Consultant Psychiatrist/Audit Lead
Mark Warren, Interim Lead Nurse, Adult MH
Ian Wile, Head of Operations & Delivery Mental Health
Dave Williams, Criminal Justice Liaison Nurse
Norman Young, Consultant Complex Needs

Apologies: Owen Baglow, Quality, Safety & Governance Lead
Jayne Bell, Lead Nurse Adult Mental Health
Arpita Chakrabarti, Assistant Clinical Director MHSOP & Neuro
Mark Doherty, Lead Nurse MHSOP/Neuro
Carol Evans, Assistant Director of Patient Safety & Quality
Catherine Evans, Patient Safety Facilitator
Katie Fergus, Interim Clinical Director Adult MH
Claire Humphries, Safeguarding Nurse Advisor
Mick McGeoch, Clinical Audit Co-ordinator
Jayne Tottle, Director of Nursing Mental Health
Joanne Wilson, Directorate Manager MHSOP

In attendance: Lynda Jenkins, Nursing Informatics Officer

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting.

1.2 Apologies for Absence

Apologies for absence were noted.

Presentation: Nursing E Documents – Lynda Jenkins

An All Wales project has commenced to standardise and digitise documents used by general nursing in Health Boards across Wales. Initially the focus is on Adult In-patient areas in secondary care.

Lynda Jenkins explained that she recently commenced a seconded role to manage the first Phase of the transition from paper to electronic nursing documents.

All Wales Specialist Groups have made recommendations to the Nurse Directors for a standardised risk assessment for the following:

Continence, Falls, Manual Handling, Skin, Nutrition, Pain.

A standardised Adult In-Patient Assessment on Admission document is being introduced across Wales.

Once the documents are agreed by the Nurse Executive, a Welsh Health Circular will be issued by the CNO office directing the use of the documents.

A pilot will commence in Medicines Clinical Board and General Surgery in April 2019. It was acknowledged that Mental Health Clinical Board have been using the PARIS computerised recording system for many years and representatives from the Mental Health team are advising on the way forward.

Two years ago, technical solutions from North Wales and Swansea were considered. It was agreed at the time that a single solution using the best of both was required, and that NHS Wales would build this. Now, the Swansea tool seems the favoured option as this will allow the project to progress quicker.

Ian Wile asked if there was any connection with the Welsh Community Care Information System (WCCIS) that has been developed for community and mental health. Lynda advised that David Hopkins, who is leading on the WCCIS work, is advising on the way forward, and the documents produced for secondary care are reflecting what has been produced for the WCCIS.

There is no communications plan as yet. Currently looking at what paper documents are being used, i.e. drug charts.

A future visit to a Trust in England is planned to see how they are using their digital systems.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on 20th June 2018 were accepted as an accurate record.

1.4 ACTION LOG/MATTERS ARISING

The Committee received the Action Log and noted the actions that had been completed; these would be removed from the Log:

Clozapine

Recommendation for mechanisms so that GP's have a "red flag" on patient's electronic records indicating they are CMHT prescribed Clozapine.

Annie reported that after discussions, it was decided the "red flag" system on patient's electronic records would probably not work. Neil Jones had completed an audit regarding letters to GPs from secondary care (CMHTs) alerting the GPs to the fact that Clozapine is being prescribed by secondary care. Neil was taking this forward with Primary Care.

Policies

Jayne Tottle and Annie Procter to nominate a multi-disciplinary group to organise the updating of policies. The group would include Medics, Occupational Therapy, Pharmacy and Psychology. It was noted that there is no system to identify when policies are due for review.

Annie would ask Jayne to send an e mail requesting expressions of interest.

Action Annie Procter/Jayne Tottle

1.5 TERMS OF REFERENCE

The Terms of Reference had been circulated for consideration. No comments received, date of next review is October 2019.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 UHB Quality, Safety and Experience Committee

The Chair noted the Minutes of the UHB Quality, Safety and Experience Committee meeting dated 12th June and 18th September 2018.

2.2 Health and Care Standards

An update will be given at the next MHCB Q&SE meeting in December 2018.

2.3 Regulatory compliance and external accreditation - No report.

2.4 Risk Register

On-going.

2.5 Directorate QSE Groups

The **ADULT DIRECTORATE QUALITY & SAFETY** Minutes dated 12th July and 20th September 2018 were noted.

The **MHSOP/NEUROPSYCHIATRY QUALITY & SAFETY –** Minutes dated 4th June and 10th September 2018 were noted.

The PSYCHOLOGY & COUNSELLING QUALITY & SAFETY – Minutes dated 15th August 2018 were noted.

PHARMACY - No report

MENTAL HEALTH ACT - Nothing to report.

INFECTION, PREVENTION & CONTROL (IPC) – No report

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

3.1 Initiatives to promote health and wellbeing

Smoking Cessation

The fire risk in Hafan y Coed had increased since the no smoking policy due to patients smoking in their rooms. It was acknowledged that Ward Managers were finding the smoking policy very problematic to manage. Gail Evans pointed out that it was difficult to make patients with brain injuries on the Neuropsychiatry ward understand that they could not smoke. Ian Wile will meet with the Ward Managers to discuss the problems whilst supporting public heath strategy.

Ian Wile said that the Welsh Government plan to extend smoke-free areas to outdoor public spaces.

SAFE CARE

4.1 New SIs

Chair acknowledged that many Serious Incidents are complex and it is very challenging to complete investigations within the 60 working day target set by Welsh Government**.** Monthly targets are in place for each Clinical Board and these are performance managed through the Executive Performance reviews. Chair requested that SI's be completed promptly.

4.2 Patient Safety Notice

ISN2018/003 – Medication Chart

The Internal Safety Notice had been circulated to all clinical areas. It was noted that medication charts introduced in 2016 should now be in routine use, and 2012 versions be removed from all clinical areas.

PSN045 – Resources to support safer modification of food and fluid

The Patient Safety Notice had been circulated and noted.

ISN2018/006 – Laryngoscopes on Resuscitation Trolley

The Internal Safety Notice had been circulated to all clinical areas, which highlighted laryngoscopes on a resuscitation trolley were inoperable due to no working batteries. Will Adams confirmed that an audit had been carried out and that trolleys were being checked daily. Trolley audits would be managed at Directorate level.

4.3 Key Patient Safety Risks:
Care Treatment Plans (CTP) & WARRN (Wales Applied Risk Research Network)

Ian Wile said that he had drafted a response to the National Delivery Unit All Wales Review of CTPs in Adult Mental Health Services to the Mental Health Capacity Legislation Committee. Cardiff & Vale Mental Health Services were typical of the All Wales position in that CTPs were generally completed but the quality and application of those plans were generally poor.

An Action Plan had been prepared and Ian asked for volunteers to set up a small group to take this forward. Robert Kidd and Will Adams volunteered.

A risk assessment process was evident in 98% of the case note samples. However, only 2% of cases recorded the assessment using the Wales Applied Risk Research Network (WARRN) assessment and formulation approach. The Mental Health Clinical Board will re-deliver the WARRN training programme and audit compliance.

Will Adams queried whether Form 4 was to be continued (as at a Sentinels meeting it had been suggested stopping Form 4 and just use WARRN and adding a sheet for historical risk); no decision has been reached. To report back to the MHCB Quality & Safety Committee in February 2019.

EFFECTIVE CARE

5.1 MHCB Clinical Audit Plan

Interventions for smoking, BMI, high blood pressure physical health check – not necessarily being missed but not being captured in case notes. Data can be impossible to find for filling in audit data. BMI is recorded but as no height recorded, how accurate? Suggestion to contact PARIS to see if they can put it on. Checklist for "have you done this" but where evidenced? Annie said there is a need to refine and progress. Bala will discuss this with Adult Directorate.

Norman Young said that he would have the fist year's data for First Episode Psychosis in December 2018.

5.2 Implementation of key NICE Guidance

Norman Young informed the Committee that "Preventing Suicide in Community and Custodial Settings NICE guideline [NG105] was published in September 2018.

https://www.nice.org.uk/guidance/ng105

5.3 Research and Development

Norman Young informed the Committee that UHB Research & Development office are now taking charge of the money received from Welsh Government and distributing it to Clinical Boards based on funded projects. Mental Health Clinical Board needs a detailed plan on how to move forward, which will be considered at the next Research &Development meeting.

CRIS (Clinical Research Information System), is a computer information system used to search clinical records using key words for eligible patients. The NCMH and the Clinical Board are collaborating on a pilot over the next two years. Annie will ask Allan Wardhaugh for advice.

DIGNIFIED CARE

6.2 Diverse Cymru BME MH Workplace Good Practice Certification Scheme and Hearing Loss

Annie Procter said that that Ian Wile is looking at the Diverse Cymru BME MH Workplace Good Practice Certification Scheme, and hearing loss actions.

TIMELY CARE

7.2 Crisis Service Discharge Template

Bala Oruganti reported that there is a persistent back log of discharge summaries to GP's following discharge of patients from inpatient settings (Bala said he is focussing on Cedar Ward – the Crisis Assessment Ward). Bala said there had been significant changes in the Junior Doctor work force, which meant reduced number of hours of junior doctor input into the ward. Bala appreciated senior management's support within the existing limitations but due to the junior doctor's high workload, sometimes there would be a backlog of 10 discharge summaries per week.

Bala had met with GPs and Practice Managers to understand what essential information they needed. Most of them said they would need information about diagnosis, medication and follow up arrangements.

Bala had circulated a draft Discharge Summary Template, which contained essential information, to the MHCB Quality & Safety Committee. Bala said that the Trainees said they find the new template very helpful.

The MHCB Quality & Safety Committee approved the template for piloting in Crisis services. Bala will do a prospective Audit and bring back to the MHCB Quality & Safety Committee in February 2019.

INDIVIDUAL CARE

8.1 Feedback from Surveys

Service User Feedback

Mark Warren said he had recently me with Linda Newton and Jacqui Campbell of CAVAMH, who had been commissioned to assist in the distribution and completion of service user and carer questionnaires. Jacqui is planning to visit in-patient wards and the community in November to assist patients and carers with completing the questionnaires.

8.2 Compliments

Compliments received for:

Daffodil Ward – Hoists were exceptionally clean.

Dr Liam Gilgar, Gabalfa CMHT - Thank you letter from a service user.

Substance Misuse Team, UHW (Darren Robinson & Vicky Wiles) - Thank you e mail from a Senior Nurse in Medicine Clinical Board.

LPOP – Thank you from Medicine Clinical Board for assistance with a patient.

Complaints are on-going.

STAFF AND RESOURCES

9.2 Staffing Levels

No report.

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

Policies and Procedures

The Group were asked to receive and ratify the following:

10.0 Missing Persons Procedure – Mental Health Clinical Board Inpatient Facility or a Missing Community Patient (UHB111)

The Missing Persons Procedure had been circulated and to the MHCB QS&E members for review.
THE PROCEDURE WAS APPROVED

10. Guideline for Section 17 Leave of Absence Mental Health Act 1983

The Protocol had been circulated to the MHCB QS&E members for review.

As there was no-one present that could comment on this Guideline, it is to be re-presented at the next MHCB QS&E meeting.

DATE OF NEXT MEETING

Thursday, 13th December 2018 at 9.30am in The Seminar Room, Hafan y Coed.

(next Clinical Board Q&S Lessons Learned Meeting is on 15th November 2018 in the Seminar Room, Hafan y Coed)

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

Present: Jayne Tottle, Director of Nursing Mental Health (Chair)
Owen Baglow, Clinical Lead for Quality, Safety & Governance
Philip Ball, Senior Nurse Manager Vale Locality CMHTs
Josh Bell, HCSW Hazel Ward & Open University Student
Matthew Brayford, Integrated Manager Pendine CMHT
Anne-Marie Bollen, Mental Health Lecturer, Cardiff University
Emily Boobyer, Primary Care Mental Health Nurse
Des Collins, Ward Manager Pine Ward
Ruth Evans, Lead CPN Links CMHT
Steve Ford, Lead CPN Pentwyn CMHT
Liam Gilgar, ST4 Gabalfa CMHT
Gwilym Griffiths, CMHN Links CMHT
Martin Harper, Integrated Manager Links CMHT
Robert Kidd, Consultant Psychologist
Tracey Lewis, CMHN, Vale Vale Locality CMHT
Helen O'Sullivan, Senior Nurse Manager Community Adult
Mark Warren, Interim Lead Nurse Adult Mental Health
Justin Williams, Team Lead South CRHTT
Harriet Woods, CMHN Links CMHT

Apologies: Will Adams, Professional Practice Development Nurse
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Natalie Coombs, Deputy Senior Nurse Manager CMHTs
Lisa Crump, ANP Adult In-patient
Mark Doherty, Lead Nurse MHSOP/Neuro
Alison Edmunds, Concerns Co-ordinator
Carol Evans, Assistant Director Patient Safety & Quality
Catherine Evans, Patient Safety Facilitator
Mary Morgan, Senior Nurse Manager Adult In-patient
Kelly Panniers, ANP Adult In-patient
Annie Procter, Director Mental Health
Natalie Robertson, Principal Physiotherapist in Mental Health
Andrea Sullivan, Concerns Co-ordinator
Lowri Wyn, Ward Manager Cedar Ward

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

Chair welcomed all to the meeting and introductions were made. Chair explained that this meeting follows governance, patient experience and lessons learned and is a very important meeting. Patient names are used confidentially within the meeting but are anonymous in the notes. This meeting reviews the care given to individuals whilst good practice is noted.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

No Actions.

PART 3 : CLOSURES

3.1 MW

MW was a 45 year old man who had numerous involvements with Addictions Services for over 10 years. MW was admitted to hospital on 2 occasions in 2014 for assessment of his mental state as he had been voicing suicidal ideas. During both admissions there was no evidence to support the presence of a severe mood disorder or a psychotic illness.

There were a number of involvements with Addictions Services over many years, the main involvement being that of substitute prescribing. There was a period of disengagement with services in 2017. MW re-referred to EDAS (Entry into Drug and Alcohol Services) at the end 2017 for the purpose of substitute prescribing. MW re-engaged with Community Addictions Unit (CAU) in January 2018 and commenced substitute prescribing in February 2018. There were a number of admissions to UHW in 2018 with probable accidental overdoses which appears to be precipitated by excessive alcohol and illicit substance misuse.

In June 2018, MW failed to attend for methadone doses for three consecutive days. His Key Worker made several attempts to make contact with him but all were unsuccessful. Due to concerns and recent accidental overdoses, South Wales Police were contacted and a welfare check requested.

No information was received back from South Wales Police so the Police were called again and informed – "I did the right thing to be concerned and he won't be coming back for medication". GP surgery contacted and it was confirmed that MW had sadly passed away.

Inquest outcome: 1a multi drug toxicity.
Conclusions: drug related

Lessons Learned:

1) Insufficient documentation from Crisis Services following a referral by the CMHT. There was no CPA 1A or risk assessment.

   Action:
   The lack of presence of this documentation would not have affected the outcomes for MW, however documentation was insufficient. The staff involved have been spoken to and documentation will be completed more robustly in future.

2) The reply from South Wales Police "did the right thing to be concerned and he won't be coming back for medication".

   Action:
   This will be taken to Police Liaison meeting for discussion.

TO CLOSE.

3.2 LJ

LJ was taken to the Links Community Mental Health Team (CMHT) by the police for an emergency assessment following concerns raised by friends about threats to hang himself. His threats to commit suicide had been made over an internet chat room. Following the assessment, LJ was escorted home by the police with a safety plan in place. The plan included telephone contact to the GP who agreed to prescribe medication and a follow up appointment was arranged with the GP for the following week. LJ was also advised to contact EDAS (Entry into Drug and Alcohol Services). There was no evidence of a mental health illness.

LJ called the Links CMHT a week later to say how appreciative he had been for their intervention and that he was taking his medication and following the advice offered.

A couple of months later a Section 136 assessment took place by the South Crisis Resolution Home Treatment Team (SCRHTT) after LJ was found at a train station with his head on the track. LJ was advised to see his GP and the GP was contacted by SCRHTT. LJ was again also advised to contact EDAS for alcohol dependency. LJ did not display any evidence of acute mental illness.

A couple of weeks later another Section 136 assessment took place following his threats to commit suicide over the internet in a chat room; LJ had been drinking alcohol. Emergency services had been contacted, by users/admin of the chat room. Following the assessment LJ was again advised to see his GP and contact EDAS. LJ lived alone and had recently split from his partner (personal and business). Increased stress appeared to be the driver for suicide attempts.

A couple of weeks later LJ was admitted to hospital following an overdose. On assessment he said he regretted the overdose and reported to be feeling better, and said he had plans to start a new job. LJ was discharged and agreed to seek support from EDAS. This was LJ's last contact with mental health services.

A few months later, very sadly LJ committed suicide LJ killed himself at his home address; it was reported to have been streamed live on a website.

Issues identified:

No follow-up referral to CMHT or PMHSS (Primary Mental Health Support Services) was offered.

LJ's attempts to end his life were attributed to alcohol and impulsivity and consideration for the potential of a dual diagnosis was not documented.

The assessments assessed the risk at the point of assessment but did not appear to take into consideration previous attempts and their frequency. No connection made to previous attempts.

Lessons Learned:

This case was discussed at the CRHTT Quality & Safety meeting. The possibility of a summary letter being sent to the patient after assessment, containing detailed recommendations, will be addressed. (There was a query whether this is a MH Act requirement for Section 136 – Phillip Ball would look into this. NB it is not a requirement).

Notable practice:

The decision to assess at CMHT at the point of contact demonstrates good working practice/ good working relationship with police and saved further distress to LJ.

Noted that LJ has previously worked for the armed forces and information was provided for the veterans service.

Miscellaneous:

Owen Baglow will contact Coroner's office to enquire if any witnesses are being called to the inquest. Jayne Tottle said she would support staff if they needed to attend.

Will invite Claire-Louise Thomas, Mental Health Officer, Public Protection Department, South Wales Police to Lessons Learned when relevant.

It was noted that the LJ killed himself 3 months after the last contact with mental health services; it is unknown what his state was at that time.

TO CLOSE.

3.3 CE

Historically, CE had a number of periods of low mood in the past.

An urgent referral was made by CE's GP due to concerns regarding deterioration in mental health. CE was seen the same day for an assessment by the Gabalfa Community Mental Health Team (CMHT). The conclusion of the assessment was that the CE's presentation was not indicative of a major affective disorder. At the time of the assessment the main issue appeared to be with relationship issues. The patient admitted to having suicidal thoughts but denied any actual plans. Coping strategies were discussed with the patient and CE reported that he was accessing counselling via his employment in a few days time. CE's GP was updated on the conclusion of the assessment and the patient was discharged back to the care of his GP.

A few days later another urgent referral was made by the GP as CE experienced a suicidal ideation. Following the assessment by the Crisis Team, it was concluded that there was no indication for hospital admission or input from the Crisis Resolution Home Treatment Team. However, a referral to Primary Mental Health Support Services (PMHSS) to engage in talking therapies was agreed with CE as being appropriate and his GP was updated on the outcome of the assessment. Information on Cardiff MIND was provided, and a Call help line provided.

Sadly, about a month later CE died. Cause of death: 1a compression of neck consistent with hanging. Conclusion: suicide.

Issues:

The referral to PMHSS was closed without feedback to the Crisis Team or CMHT.

Action:
Review of process for closure of PMHSS referrals. The Lead for PMHSS has discussed the closure of referrals with the team, and all staff are aware of the correct procedures and documentation required when closing a referral.

Miscellaneous

The Clinical Lead Nurse for Links CMHT informed the meeting that if there is a risk they invite the patient back for an appointment a week later to see if the risk is the same. This is not mandatory but is really good practice.

It was reported that the Mental Health Services for Older People (MHSOP) run a training programme for staff on suicide prevention.

TO CLOSE.

3.4 GP

GP was a 52 year old man who had a history of contact with Pendine Links Community Mental Health Team (CMHT) from 2007. His primary problem was one of longstanding anxiety symptoms, experiencing panic attacks and avoidance of going out. He regularly did not attend appointments arranged for him at the CMHT. GP was treated for low mood on various anti-depressants over the years.

In July 2018, very sadly, GP was found dead by the police at his home address. Cause of death was hanging. Conclusion: Suicide.

Background:

GP was also allocated a peer support worker to help enable him to leave the home. However after several attempts by the peer support worker this input was discontinued. GP was offered regular appointments at his home address. In October 2017, he was medically reviewed and no changes to his medication were made. It is documented that a further Out Patient Appointment would be offered in 4 to 6 weeks time. However this does not appear to have materialised. GP remained open to the CMHT but from October 2017 there was no further contact.

Issues:

It appears that this Out Patient Appointment was never booked for GP for the following reasons:

1) The SHO seeing GP documented his letters himself. However, the SHO left Pendine CMHT shortly afterwards. If the medical secretary had documented the letter then she would have automatically booked in a follow up appointment.

2) The Admin Lead regularly went through a list of patients awaiting Out Patient Appointments, however, at that time the CMHT was very short staffed and the Lead was having to run both admin and cover reception so therefore did not get chance to go through the list.

3) The medical secretaries print off a list of patients awaiting Out Patient Appointments every two weeks; they then check this list to ensure everyone has been booked in. On this occasion, the medical secretary checked the list and saw that GP was awaiting an appointment and went to book him an appointment. At this point however she was called away to do something else, on returning to her desk she believed she had booked in an appointment for GP, when in reality she had not.

GP remained open to the CMHT but there was no contact with him from October 2017.

GP was supposed to be offered an Out Patient Appointment at Pendine CMHT to take place approximately 4 to 6 weeks from October 2017. This did not occur. It is impossible to say whether or not if he had had this appointment; it would have led to a different outcome.

Pendine CMHT was short of admin staff and was down one medical secretary at the time.

The medical secretary was having to cover for five doctors. The lead admin was performing the role of both administrator and receptionist.

The Locum changed and GP's case was not handed over.

The CMHT's Integrated Manager changed.

Lessons Learned:

Review procedure for booking medical Out Patient Appointments.

Action:
The Integrated Manager is now looking at patient and case notes and a system has been put in place to ensure all patients are reviewed.

Dr Liam Gilgar, ST4, will send a reminder to junior doctors to ensure they hand over to another team on leaving a post.

Jayne Tottle will discuss with MHCB Quality & Safety, and Clinical Directors re locums.

Notable practice:

GP was medically reviewed at his home address due to his fear of leaving the house.

Responses from the CMHT were prompt – for example, from point of assessment he received a medical review just 5 days after.

A Peer Support Worker met with GP on several occasions and tried to engage him to leave the house.

GP generally saw the same members of staff which was good consistency of care.

TO CLOSE.

3.5 GOOD PRACTICE:

MD

MD was a 34 year old gentleman. He was well known to mental health services with a long standing diagnosis of Borderline Personality Disorder, pseudo hallucinations and polysubstance misuse.
MD often presented to health services in crisis following deliberate self harm and/or threats or attempts to end his life (often while intoxicated).
On MD's last meeting with his key worker, it was reported that attendance for dispensing had been good, and that his mental health was stable. MD had only missed two days collection in four weeks, he reported no heroin use and he felt the Methadone was holding him. He did admit to using crack but explained this had reduced to once a fortnight.
MD's deliberate self-harm and intentional overdose had significantly reduced.
MD's Care and Treatment Plan had been updated by his care co-ordinator and reflected his progress. His most recent Risk Assessment was updated where it was felt MD remained at significant risk of deliberate self-harm but no risk of deliberate suicide.

Very sadly, MD was admitted to critical care in a semi-conscious state presenting with symptoms of an unknown infection and possible accidental overdose. MD did not respond to treatment and succumbed to multiple organ failure. Cause of Death 1a aspiration pneumonia. 1b self-poisoning
Conclusion: drug related

Good Practice:

There is clear communication between the multi-agency support he was receiving. Information sharing between the involved team was notable.

MD's team made every effort to improve attendance and compliance with treatment. MD was offered regular outpatient appointments for review.

Case notes and feedback from MD's key worker suggested that MD had a therapeutic relationship with those involved in his care. Where possible support from the same staff remained in place as MD found it difficult to trust.

MD met with his key worker on a monthly basis and was offered appointments with his care coordinator fortnightly.

Documentation of care is clear throughout PARIS. Regular, timely appointments offered.

MD had regular discussions about risk when utilising substances, especially when his use was reducing.

4.0 DATE OF NEXT MEETING

17th January 2019 at 9.30am in the Seminar Room, Hafan y Coed.

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

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE held at 1.30 pm, 10th July, 2018 in PCIC Meeting Room 1, CRI

Present

Gareth Hayes (GH) (**Chair**)	Clinical Director Clinical Governance
Kay Jeynes (KJ) (Vice Chair)	Director of Nursing PCIC
Anna Mogie (AM)	Lead Nurse, North and West Cardiff
Ceinwen Frost (CF)	Lead Nurse Vale Locality
Danielle Hewings (DH)	Operational Manager, GP Out of Hours
Helen O'Sullivan (HO'S)	Quality and Safety Manager
Karen May (KM)	Head of Medicines Management
Maria Dyban (MD)	Community Director
Nicola Evans (NE)	Head of Workforce and OD
Nicky Hughes (NH)	Lead Nurse S&E Locality
Sarah Griffiths (SG)	Head of Primary Care
Rachel Armitage (RA) (Minutes)	PCIC Quality and Safety Officer

By invitation

Lisa Leamon	RGN, Adult and Paediatric Stoma Care, Senior Coloplast Care Nurse, Cardiff and Vale University Health Board – for Patient Story

Apologies

Lynne Topham (LT)	Locality Manager, North and West Cardiff
Anna Kuczynska (AK)	Acting Clinical Board Director
Helen Earland (HE)	Senior Nurse PC
Denise Shanahan (DS)	Nurse Consultant
Lisa Dunsford (LD)	Director of Operations
Chris Darling (CDg)	Assistant Head of Operations
Matthew McCarthy (MM)	Patient Safety Facilitator

Preliminaries		**Action**
07/18/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Chair.	
07/18/002	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	

The agenda was re-ordered.		
07/18/003 (Agenda item 6)	**PATIENT STORY – STOMA REVIEWS** Lisa Leamon, RGN, Adult and Paediatric Stoma Care, Senior Coloplast Care Nurse, was welcomed to the meeting. She presented three cases which demonstrated the quality of life improvements, cost savings and reduction in the need for health care appointments brought about by of stoma care initiative carried out for patients in their GP surgery instigated by the Pharmacy prescribing team. The following points were discussed: • For the last 7 years there has been a stoma care pathway in place to ensure 3, 6 and 12 month follow-up reviews take place; prior to this there was no formal follow up of patients post discharge. This project has been successful as patients prefer to attend their GP surgery for follow-up; this had enabled longstanding stoma patients to have a one-off review for stoma care • Benefits to patients and their QOL • Prescription changes were actioned immediately and brought about quick improvements • The prevalence of parastomal hernias affecting the efficiency of the stoma products originally prescribed was identified in a number of patients • The reliance of the project on pace-setter funding • The inability of some Practices to accommodate a stoma clinic; work is under way to develop shared arrangements.	
07/18/004 (Agenda item 3)	**DECLARATIONS OF INTEREST** GH asked for any declarations of interest – none noted.	
07/18/ 005 (Agenda item 4)	**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**
07/18/006 (Agenda item 5)	**PCIC CLINICAL BOARD QUALITY AND SAFETY GROUP ACTION LOG** The Clinical Board (CB) Quality and Safety group action log was reviewed. Members noted the content. The following points were discussed:	

	Update on service model and staffing for CHAP: The appointment of GPs to the CHAP and HM Prison services remains challenging. Recruitment is under way for joint appointments, following which service and workforce mapping will be undertaken to build in future resilience. A separate review of homeless services is also under way. **01/18/008 Risk Register S&E 06.01.17 HMP Mental Health Provision:** Mark Warren, Senior Nurse Manager, Mental Health has presented a staffing paper to the Mental Health Clinical Board requesting increased Primary/secondary care staffing; outcome is awaited, LD to follow up. Update to be provided at the next meeting. **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 September QSE meeting. **05/18/007 Quality and Safety Dashboard – Interface Incidents:** Datix entry now up to date. Themes and hotspots are being identified and used to inform improvement work in the areas concerned; results will be fed back to GPs. Learning has been shared with the UHB Medical Director and at the LMC quarterly meetings. **05/18/007 Quality and Safety Dashboard – GP Sustainability:** Current indicators were identified as not providing an accurate reflection of practice sustainability. A Task and Finish Group has been established to examine data already being collected and how that can be fed into the dashboard. **05/18/008 Risk Register – GP OOH IT issues:** Currently on hold; a quote had been received to meet some of the necessary specifications. This is resting with LD awaiting authorisation by the UHB Board. **05/18/013 Health and Care Standards Submission** – a meeting has been held with the Concerns Team to review and clarify processes; it is important for the Clinical Board to be assured that any investigation and response has been sufficiently robust but it will not be an intermediary between the complainant and the GP. Action completed.	
07/18/ 007	**QUALITY DASHBOARD** KJ summarised the dashboard. The following points were highlighted.	

	Current SIs: one SI remains open and out of timescale owing to Police involvement. It was suggested that a line be added to the Dashboard to enable identification of new SIs and a cumulative total.	**RA**
	Vacancy Rates: NE highlighted that turnover remains at >10% which creates a higher vacancy factor and financial concern. Sickness data for May was 5.28%; long term sickness data is under review. Statutory and mandatory training rate for May was 75.06%; fire training and dementia training require particular emphasis. The mandatory training portfolio is under review by the Executive Director of Workforce and Organisational Development.	
	Interface Incidents: congratulations were afforded to the Quality and Safety team for improving performance on this indicator.	
	Information Governance: the open incident has now been closed.	
	Pressure Ulcers: KJ remains in ongoing dialogue with the UHB corporate Patient Safety Team regarding the reporting of pressure ulcers as serious incidents.	
	Medication errors: this number was noted as unusually high for PCIC but it was confirmed that there were no particular themes.	
	***C. diff*:** It was noted that RCA had identified that current C. diff cases are not related to local Primary Care prescribing. KJ will meet with the IPC team to discuss forward actions to support this work.	**KJ**
	MSSA: The RCA template requires to be modified to provide more helpful information. KJ to discuss with Fiona Walker, Locality Lead Pharmacist.	**KJ**
	Cold Chain Breaches: These have been reviewed for data integrity and to ensure that appropriate actions are taken. No areas of concern noted	
	District Nurse (DN) average escalation levels: Escalation guidance for staff remains under review, update required for September 2018.	
	GP sustainability: see comments above under Action Log review.	

07/18/ 008	**RISK REGISTER (RR)** **QS&E 000214 OOH** Work is under way with Andrew Nelson, Head of Information and Performance, to realign shift fill and introduce multidisciplinary working to improve capacity and demand management. Recruitment is ongoing; a paramedic practitioner and Paediatric Practitioner have been recruited; the impact will be formally evaluated. It was highlighted that the service should be referred to as "Urgent Primary Care OOH" to emphasise that this is not always a GP service. **QS&E 000113 Independent Sector** Continues to be tolerated. Long term sickness has eased recently. **QS&E 160714 Patient Flow** KJ noted a reduction in pressure across the whole system. AM highlighted that a domiciliary care agency is currently ceasing to trade; work is ongoing to find alternative care provision. Patient flow will be affected as the Local Authority uses this agency to support many packages of care. **PCIC 110914 Complex Packages of Care** KJ confirmed that a complex care provider is also reporting that it is fragile; nurse assessors have visited all the affected families and discussed contingencies and there is ongoing dialogue with the provider. **PCIC 160614 Primary Care Estates Development** SG confirmed that key developments have been distributed across the Primary Care support team due to a pending vacancy. Work has commenced in Pontprennau. **PCIC 0814 Local Development Plan** To be allocated to CD as risk owner **PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainabilty** To be allocated to LD as risk owner. Two posts have been recruited into the sustainability team. Work is under way to develop GP fellowship and mentorship schemes. The QOF is changing so performance measures will be amended accordingly. **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** Staff focus groups are under way; 5 vacancies remain. **S&E 06.01.17 HMP Mental Health Provision** Remains an issue. LD is liaising with Ian Wile, Director of Operations, Mental Health. **N&E 10.01.17 Cardiff CRT Medication Administration Procedure** AM has met with Local Authority colleagues; work is under way to move towards home carers providing medications. **VL 29.07.17 Change of phone lines** Risk rating to be reduced and ownership transferred back to the Vale Locality. **CHC 11.08.17 CHC Commissioning group** KJ confirmed that she continues to work with Procurement colleagues regarding care home commissioning. **PC141117 GP OOH IT issues** Discussed above. Work on hold pending finance. It was noted that the risk owner should be amended. **Further discussion:** • NH shared escalation reports relating to HMP Cardiff as follows: – Homelessness nurses have reported seeing a change of cohort in Tresilian House and no longer feel safe. Advice being sought from Carl Ball, UHB Personal Safety Adviser – Increased use of “Spice” by men in HMP Cardiff leading to daily and sometimes multiple resuscitations of users. Improvement work is under way with HMP Cardiff – Staffing levels for pharmacy, nursing and GPs; NH has revised skill mixes to support the team – Timings of night-time medications; work is ongoing with HMP Cardiff. – Risk Rating reviewed by DON and Asst HOD, risk rating adjusted all risks to be managed within the Locality apart from the SPICE risk which will be added to thePCIC risk register	

	• AM highlighted Park View issue, noting that the Assistant Locality Manager, North and West has written a paper for consideration by LD regarding the impact on services. KJ advised that the paper was submitted for consideration of the Q&S impacts, as the majority of issues have been perceived to be environmental and H&S in nature.	
07/18/ 009	**ANNUAL SELF-ASSESSMENT – HEALTH AND CARE STANDARDS** KJ summarised the report, highlighting that the UHB corporate Medicines Management Group had indicated that PCIC will undertake an audit of District Nursing and domiciliary prescribing and administration. KJ agreed to formally respond to the paper.	**KJ**
07/18/ 010	**NATIONAL CLINICAL AUDIT AND OUTCOME REVIEW PROGRAMME** MD highlighted that recent audits had been carried out in CKD, COPD and Type 1 DM. While it had not been possible to extract local data it had been identified that conditions were not being correctly coded by GPs, which led to ineffective treatment. It had also been shown that there is a lot of variation between surgeries and clusters. MD agreed to feedback the findings to clusters.	**MD**
07/18/ 011	**OMBUDSMAN REPORT – DENTAL – MS H** This item was presented for information, noting that the Ombudsman's recommendations had been accepted by the Practice. It was noticed that this Dentist had also been subject to a Reference Panel. The QSE Committee **noted** the report.	
07/18/ 012	**CONCERNS THEMES PERFORMANCE SUMMARY** KJ shared the PCIC summary. It was suggested that themes analysed by Locality is be helpful, information shared with the relevant business units. KJ reminded everyone of the requirement to respond to concerns in the agree timescales. Performance needs to be improved, it is currently very variable, it is noted that AM and Primary Care concerns are often complex in nature and require longer to review to progress and agree a response.	
07/18/ 013	**INFORMATION GOVERNANCE** The QSE Committee **noted** the Information Governance Group minutes. KJ highlighted the impact of the GDPR in	

	particular in relation to District Nursing practice; it was agreed that assurance was required from the Lead and senior nurses that the service was complying with the required change. KJ agreed to discuss this with CDg.	**KJ**
07/18/ 014	**BUSINESS UNITS QS&E MINUTES** KJ agreed to feedback to individual business units on matters recorded in their minutes.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
07/18/ 015	**VIOLENCE SURVEILLANCE REPORT: EASTERN BASIC COMMAND UNIT (JANUARY – MARCH 2018 DATA). POLICE, AMBULANCE AND EMERGENCY DEPARTMENT RECORDED VIOLENCE** The QSE Committee **noted** the report.	
SAFE CARE		**Action**
07/18/ 016	**INTERNAL SAFETY NOTICE - INTERNATIONAL DYSPHAGIA DIET STANDARDISATION INITIATIVE (IDDSI) TEXTURE DESCRIPTORS** The QSE Committee **noted** the report.	
07/18/ 017	**PRESSURE ULCERS – RCA/SI REPORTING** NH highlighted that PUs and VA1s were not being reported from the MASH through to the Locality lead nurses as agreed; she will discuss this with Linda Hughes-Jones, Head of Safeguarding. KJ advised that MM had now visited all the DN team and shared the revised guidance for PU reporting via Datix and the requirements for staff to consider all Grade 3, 4 and unstageable damage as SI's. RA is able to review the Datix report and together with Pt safety will monitor and oversee the SI reporting.	**NH**
07/18/ 018	**TRACHEOSTOMY GUIDELINES** The QSE Committee **noted** the report. KJ highlighted that compliance will need to be audited in the Localities by the lead nurses.	**LLN**
07/18/ 019	**POINT OF CARE TESTING** KJ highlighted that quality assurance feedback is awaited from Seetal Sall, Point of Care Manager. KJ agreed to follow up with Seetal Sall.	**KJ**
07/18/ 020	**MEDICAL EQUIPMENT ISSUES**	

	No medical equipment issues had been identified.	
07/18/ 021	**PCIC EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE AND BUSINESS CONTINUITY: ACTION NOTES OF THE MEETING HELD ON 18TH APRIL 2018** The QSE Committee **noted** the action notes. KJ highlighted that the Major Incident desktop exercise event planned for 20th July will be cancelled owing to there being insufficient numbers of attendees. Another event will be arranged for October; at least 5 members of each Business Unit at band 7 level and above will be required to attend. Work is ongoing to ensure robust contingency plans for each Business Unit.	
EFFECTIVE CARE		**Action**
07/18/ 022	**INFECTION CONTROL** KJ confirmed that a significant amount of work has been undertaken in relation to ANTT, with positive feedback having been received from those who have completed the training and been assessed as competent. AM suggested that it would be useful to review infection rates once all training had been completed. KJ confirmed that she would be presenting at the IPCG on 12th July and highlighted the plan to reduce antimicrobial prescribing by a further 5%. PCIC Clinical Board current plans will be maintained. It was noted that a UTI prevention booklet is almost ready to be signed off. NH highlighted that Hywel Dda is running a new continence programme and a female incontinence pathway is being developed within the UHB.	
DIGNIFIED CARE		**Actions**
TIMELY CARE		**Action**
07/18/ 023	**SAFEGUARDING** **23.1 Safeguarding update** **23.2 Supporting Safeguarding in the Third Sector**. **23.3 Recommendations following Child Practice Review shared in relation to a Dental issue** **23.5 Safeguarding Steering Group Minutes 31st May, 2018**	

	These documents were presented for information; The QSE Committee **noted** the contents.	
INDIVIDUAL CARE		**Action**
07/18/ 024	**Dementia Action Plan** The Action Plan will be brought to the next meeting.	**DS**
STAFF AND RESOURCES		**Action**
07/18/025	**WORKFORCE UPDATE – RECRUITMENT UPDATE/STUDENT STREAMLINING** KJ highlighted that there will be a change in the way that novices will be recruited from March 2019. Students receiving a bursary in Wales will be tied into the NHS in Wales for 3 years but will require no interview for appointment to posts once qualifying; they will be provided with options of where to work, to be facilitated by the Health Boards and Universities. In addition the Health Boards will need to hold vacancies from March 2019 in order to support this strategy. PCIC will accommodate 8 students – 6 DNs and 2 in HMP.	
SUB-GROUP REPORTS		**Action**
07/18/026	**26.1 GP OOH Business Unit** It was noted that there was 83% compliance with mandatory training and that 10 compliments had been received. **26.2 Vale Locality** No additional issues to report. **26.3 Cardiff South and East Locality** NH confirmed that the Chief Operating Officer had been invited to meet with the Governor of HMP, the DN service remains very fragile and that work was under way on the model of support for GPs and the wider team. **26.4 Cardiff North and West Locality** AM confirmed that one care home is in escalating concern. **26.5 Pharmacy and Medicines Management** KM confirmed that the incentive scheme was focused on antimicrobial prescribing to support infection prevention. **26.6 Palliative care** KJ confirmed that there are ongoing issues for the hospice in engaging the support of Health Board staff, particularly relating to Mental Health. In addition there are ongoing challenges in accessing Speech and Language Therapy and Dietetic services. There are also	

	issues with one provider relating to the cost of beds, which may result in a reduction of beds available.	
PART 2:	**Items to be recorded as Received and Noted for Information by the Committee**	**Action**
07/18/ 027	**CMO UPDATES** CEM/CMO/2018/3 Valproate Contraindicated In Women Of Childbearing Potential Unless There Is A Pregnancy Prevention Programme CEM/CMO/2018/4 Influenza Season 2017-18 – Cessation of use of antivirals now recommended CEM/CPhA/2018/008 Drug Alert Class 3 (Action within 5 days): Fdc Pharma, Latanoprost/Timolol 50 micrograms/Ml +5mg/Ml eye drops, solution, PI 35638/0004 CMO Update 92: June 2018 **MHRA MEDICAL DEVICE AND MEDICINES ALERTS** MDA/2018/010 All T34 ambulatory syringe pumps –risk of unintended pump shutdown and delay to treatment MDA/2018/012 BD Vacutainer EDTA and BD Vacutainer Lithium Heparin Tubes – risk of incorrect results for lead testing or other assays using ASV methodology MDA/2018/016 Home use and Point of Care blood glucose monitoring system: Accu-Chek Aviva, Accu-Chek Performa and Accu-Chek Inform II test strips – risk of strip error messages and false high and low blood glucose results MDA/2018/019 (Wales) JM103 and JM105 Jaundice Meters – risk of misinterpretation of measurement in hyperbilirubinaemia cases **WELSH HEALTH CIRCULARS** WHC 2018/014 All Wales Communication Standards Between Primary and Secondary care WHC 2018/020 AMR Improvement Goals and HCAI Reduction Expectations by March 2019: Primary and 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 (English and Welsh versions) **WELSH GOVERNMENT ADVISORY** • Preventive dental advice, care and treatment for children from 0-3 years and appendices (English and Welsh versions) • EU Mercury Regulations **NICE GUIDANCE** NG84 Sore throat (acute): antimicrobial prescribing Otitis meda (acute): antimicrobial prescribing NG 87 Attention deficit hyperactivity disorder: diagnosis and management NG92: Stop smoking interventions and services Peripheral arterial disease: diagnosis and management (updated February 2018) https://www.nice.org.uk/guidance/cg147 MTG36 Peristeen transanal irrigation system for managing bowel dysfunction **PATIENT SAFETY NOTICES** • Electronic High/Low Chairs **INTERNAL SAFETY NOTICE AND GUIDANCE** **UPDATES FROM OTHER GROUPS** • NHS Wales Safeguarding Network Minutes 23 November 2017 • NHS Wales Safeguarding Network Minutes 6 February 2018 • NHS Wales Safeguarding Network Minutes 3 May 2018 • Safeguarding Spring Newsletter • Public Health Wales Infections Surveillance Report June 2018	
	ANY OTHER BUSINESS	
07/18/028	RA presented a Patient Experience briefing. It was noted that CHIST in N&W Locality results will be available to report and that the DoSH will be sending out a survey imminently. Also the All Wales levels of care Quality Audit is taking place in S&E and will report into the WG work.	
DATE OF NEXT MEETING		
Tuesday, 11th September, 2018, 1.30 pm – 3.30 pm, PCIC meeting room, 1 CRI		

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

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE held at 1.30 pm, 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 Trecheostomy 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.	**LD**

	PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainabilty Clinical Directors' sessions have been put in place and the GP Fellowship Scheme is almost complete. LD to review and update the risk.	**LD**
	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.	**LD/KJ**
	PC141117 GP OOH IT issues Discussed above. LD to review and update the risk.	**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.	

	Interface themes and lessons learnt 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** Pharmacy Quality and Safety Indicators from Annual Returns 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. Feedback on Pandemic Flu Testing 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. Brexit and medicines supply chain - Preparations for leaving the European Union 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	**KM/KJ/ CDg**

	stockpile or extend the duration of prescription treatment periods. Short Acting Beta-Agonists (SABA) Community Pharmacy Audit Provided for information, noting the high numbers 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** General Ophthalmic Services – NHS Sight Test Fee, NHS Optical Voucher Values, Payments for Continuing Education and Training and Pre-Registration Supervisors Grant This item was **noted** for information. Quality and Safety in Optometry 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. Update on The General Data Protection Regulations and Notifications relating to the Performers List, Ophthalmic	

	List and Supplementary List for Optometrists 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** Continence Service – Paper Light Trial 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. Information Governance Group minutes 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** • Pharmacists and Nurses as Prescribers across a cross-section of primary care providers: what is effective supervision? • Medicines management support for recently discharged patients in the Cardiff West Cluster: a co-ordinated, needs-assessed, approach (Bevan Commission) • Peezy Pilot study	

	• NATROX wound healing study 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** Richard Wolf TEM Tube Set, single-use item, sterile 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** Audit of HIV partner notification and National HCAI & AMR Collaborative October 2017 – April 2018: Preliminary Quality Improvement (QI) Projects Overview The QSE Committee **noted** the updates, which had been provided for information.	

09/18/030	**PATIENT EXPERIENCE** OOH Survey responses and North and West Locality summary (email) 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 OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE held at 1.30 pm, 13th November, 2018 in PCIC Meeting Room 1, CRI

Present

Kay Jeynes (KJ) (Vice Chair)	Director of Nursing PCIC
Anna Mogie (AM)	Lead Nurse, North and West Cardiff
Carol Preece	Senior Nurse S&E Locality (representing Nicola Hughes)
Denise Shanahan (DS)	Nurse Consultant
Karen May (KM)	Head of Medicines Management
Maria Dyban (MD)	Community Director
Nicola Marvelley (NM)	Assistant Head Of Workforce (representing Nicola Evans)
Sarah Congreve	Assistant Vale Locality Manager (representing Ceinwen Frost)
Sarah Griffiths (SG)	Head of Primary Care
Rachel Armitage (RA) (Minutes)	PCIC Quality and Safety Officer

By invitation

Judy Brown	Safeguarding Nurse Advisor

Apologies

Anna Kuczynska (AK)	Acting Clinical Board Director
Ceinwen Frost (CF)	Lead Nurse Vale Locality
Gareth Hayes (GH) (**Chair**)	Clinical Director Clinical Governance
Helen Earland (HE)	Senior Nurse PC
Helen O'Sullivan (HO'S)	Quality and Safety Manager
Lisa Dunsford (LD)	Director of Operations
Matthew McCarthy (MM)	Patient Safety Facilitator
Nicky Hughes (NH)	Lead Nurse S&E Locality

Preliminaries		**Action**
11/18/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Vice Chair.	
11/18/002	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
The agenda was re-ordered.		
11/18/003 (Agenda item 5)	**SAFEGUARDING UPDATE** Judy Brown provided an update on the new Standard Operational Procedure and highlighted the following: • Independent Domestic Violence Advocate – based at UHW and working across all hospital sites as well as	

	providing training on domestic abuse and sexual violence; also supporting victims across all age ranges and providing safety plans • Modern slavery and human trafficking – development is under way of Level 3 training to cover adults and children combined in one day • County Lines • Mandatory reporting of female genital mutilation • PREVENT training • Domestic abuse • Child exploitation • Parental mental health and the impact on children • Safeguarding adults at risk • The need for PARIS records to include the names of all people living in the home of a service user • New pressure ulcer reporting arrangements. There was discussion that it would be more robust to maintain the safeguarding reporting procedure and omit the Serious Incident (SIs) reporting part of the process, in line with the Ombudsman's recommendations and the Coroner's Rule 28; however, it had been decided at Welsh Government (WG) level that SI reporting should continue and that Safeguarding reporting should be discontinued • Update on the numbers of current Adult and Child Practice Reviews and domestic homicide reviews under way and due to be published, highlighting the valuable learning gained from these • It was confirmed that there had been a pilot of Health Visitor supervision in groups of 4 – 6 people to enable shared learning; this had proved successful and will be rolled out across relevant areas across the Health Board • Work was under way to introduce a "Drive" approach to domestic abuse in Cardiff, focusing on disrupting perpetrator behaviour as well as supporting victims • Colleagues were requested to telephone the Safeguarding team with notifications rather than relying on PARIS for information exchange, noting that there was not capacity to review PARIS on a daily basis leading to a risk that information would not be acted upon in a timely way. It was formally recognised that the PCIC team provides excellent casenotes to inform the MASH discussions. Likewise it was recognised that Health staff also carry out effective research. Formal thanks were given for the robust process for dealing with community acquired pressure sores. KJ confirmed that PCIC had requested to be part of the pilot for managing pressure ulcers and was awaiting the required pro forma from the Asst Exec Nurse Director to commence in December 2018. There was discussion on the Vale IT systems, noting that they were not yet sufficiently secure to allow the sharing of personal identifiable information between Health and Social Service	

	colleagues, which had led to data breaches. It was noted that there had been a positive uptake of Safeguarding amongst GP providers, and that Safeguarding features four times a year at CPET sessions. KJ welcomed the confirmation of the value of the PCIC approach to safeguarding, noting that the Clinical Board had a clear focus on this responsibility, but recognising that there would always be more to do and the need to keep abreast of strategies and initiatives. *(Judy Brown left the meeting.)*	
11/18/004 (Agenda item 3)	**DECLARATIONS OF INTEREST** KJ asked for any declarations of interest – none noted.	
11/18/005 (Agenda item 4)	**MINUTES OF THE PREVIOUS MEETING HELD ON 11TH SEPTEMBER, 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**
11/18/006	**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. A plan is expected to be in place by the end of December 2018. Update to be requested. **03/18/007 Risk Register – call recording at CRI:** To check that call recording is in place; if so this item to be removed from the Action Log. *Post meeting note: testing completed in triage room and under way in consulting rooms. Action will be completed before next QSE meeting.* **03/18/007 Out of Hours Service Delivery:** Action plan under weekly review by LD and Loretta Reilly. Report to be brought back to January QSE meeting. **05/18/008 Risk Register – GP OOH IT issues:** To check that new system is in place; if so this item to be removed from the Action Log. *Post meeting note: OOH has received notification that the work is on hold until after Christmas 2018. This has been escalated.* **09/18/009 Risk Register – review and update risks:** Update to be provided by LD.	**RA** **LD/LR** **LD**

	09/18/011 Pharmacy Updates – Feedback on Pandemic Flu Testing: action directed by WG. Remove from action log. 0**9/18/020 Poor Discharge Follow-up Process:** KJ to discuss with Executive Director of Nursing week commencing 19th November.	
11/18/007	**PATIENT STORY** This item was deferred to the next meeting of the QSE.	
11/18/008	**QUALITY DASHBOARD** KJ summarised the dashboard. The following points were highlighted. **Current SIs:** a revised process is under development to support reporting to MASH and via VA1 forms as described above within the Safeguarding discussions with a pilot commencing in December 2018.. The new incident relating to a prisoner with TB is being supported by Public Health Wales in conjunction with the Ministry of Justice; key testing and regular meetings are under way. ***C. diff/*** **MSSA/*E. coli*:** It was noted that the UHB remains the second lowest prescriber of antimicrobials in Wales. The 24% reduction in E.coli has been commended at an All Wales level. The QSE Group **noted** the Quality Dashboard and the agreed indicators.	
11/18/009	**RISK REGISTER (RR)** **QS&E 000214 OOH** Current position to continue. **QS&E 000113 Independent Sector** Risk profile discussed; continues to be tolerated and no change to be made to rating. **QS&E 020714 CHAP** Further update on action plan required noting the increase in patient caseload. **QS&E 160714 Patient Flow** Review of Cardiff Community Resource Teams is under way including Cardiff Local Authority and Health stakeholders. A plan is in place to reduce the number of cancellations. It was noted that the community assessment beds have been closed in one home with a smaller number of beds secured in an alternate home. The District Nursing Service is currently experiencing significant pressures; the Roath team has been temporarily stood down and caseload dispersed to other teams. Updated risk assessment required. Early positive feedback has been received on a pilot project involving the Vale Community Resource Service (CRS) working with the Medical Emergency Admissions Unit in University Hospital, Llandough; this has also enabled an	**NH** **CP**

	improvement in Vale CRS performance. **PCIC 110914 Complex Packages of Care** KJ confirmed that a revised risk assessment has been developed and escalated to LD for sharing with the Executive team. It was noted that capacity is insufficient to support patients with complex care needs in their own homes, plans are in place to work through a number of actions to sustain existing packages of care. **PCIC 160614 Primary Care Estates Development and PCIC 0814 Local Development Plan** Update required from LD. **PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainability** One GP Practice has returned its contract to the UHB and it will be retendering; there will be no effect on the risk score. A Practice merger in the Vale of Glamorgan has been successful while a merger in Cardiff has not progressed. This remains a risk in relation to single-practitioner status and plans to retire within 12 months. "MyGP" requires evaluation. **PCIC 10.03.16 Pressure Ulcer (PU) Prevalence** KJ will update in accordance with the Dashboard discussion above. **PCIC18.05.16 Domiciliary Care Provision** It was noted that an additional domiciliary care provider in the Vale of Glamorgan is unstable. An All Wales planning group has been established to develop contingency arrangements. **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** A transformation bid has been submitted on behalf of PCIC and the Mental Health Clinical Boards. **S&E 10.07.18 HMP Spice Incidents** Continuing high incidence of code reds and blues. **N&E 10.01.17 Cardiff CRT Medication Administration Procedure** No further progress. **CHC 11.08.17 CHC Commissioning group** KJ confirmed that she has escalated the lack of formal processes for contracting and commissioning to both LD and the Executive consultation review. **PC141117 GP OOH IT issues** Discussed above. LD to review and update the risk. <u>Risks escalations to note</u>	**LD** **SG** **LD**

	Community Pharmacy National Enhanced Service accreditation. KM highlighted that a new model of training has been developed to cover generic skills using avatars for both training and assessment methodology. Consequently professionals have been finding assessments impossible to pass and the re-take interval of one month creates a risk that by March half of pharmacies will be unable to provide enhanced services; this in turn will have a negative impact on GP sustainability. This has been escalated. KJ agreed to share this with the Executive Director of Nursing and the Assistant Director of Nursing at the next meeting. *Retrospective Assessments* - It was recommended that this issue requires a revised risk assessment. The QSE Group **noted** the Risk Register.	**KJ** **CP**
11/18/010	**AUDIT** <u>PCIC Audit Plan 2017/2018/2019</u> KJ confirmed that the 2017/18 PCIC audit plan has been reviewed to ensure that all relevant work is captured and to check the viability of the audit plan; likewise MD has reviewed the national audit plans. The following points were noted: • There was little data for the CKD work and that it is necessary to encourage GPs to code for this • Access to GMS remains a priority for the team • Audits built into the Pharmacy incentive scheme are ongoing, while Community Pharmacy needs to conduct one audit a year – add to the audit plan • The timescale for LES audit of NOAC/wound compliance is currently ongoing and reporting is expected in the middle of 2019 • GP OOH will be asked for outcomes to be presented at the QSE meeting in January 2019 • District Nursing audit is completed. It was agreed that all other audits should be completed and report into the PCIC QSE. The plan will be updated and rescheduled for 2019. <u>Quality Audit undertaken within District Nursing Services</u> CP summarised the audit of staff experience, leadership, records and patient outcomes. It was highlighted that there had been a good response to the audit. The key learning was that baseline observations were not done. Over all the results were good and will be fed into workforce planning. <u>Primary Care WAO Report and management response</u> KJ summarised the main audit findings and associated action plan, confirming that the concerns about the impact of the Local Development Plan (LDP) had been regularly escalated for the last 2 years and commissioned work was taking place in the UHB to understand the issues in relation to population growth. It was highlighted that citizen stakeholder input would	**KJ/RA** **RA** **KJ/RA**

	be helpful. It was confirmed that a trading framework has been developed to support transitional resources aligned to the patient pathway. The recommendations arising from the audit require a significant increase in funding which is not expected to be provided. It was noted that the Wales Audit Office will in due course repeat the audit and will expect evidence of a shift in investment and an updated position. SG highlighted the significant challenge for the UHB presented by the lack of recognition of the impact of the LDP. The QSE Group **noted** the report.	
11/18/011	**DATIX** <u>Patient Safety report on incidents</u> it was noted that there is a good culture of reporting and that no significant issues have been identified; it was also noted that there has been significant progress around the 7-day target, although the 30-day process target continues to require improvement. <u>Interface audit response</u> KJ confirmed that the internal audit report has not yet been signed off pending resolution of some controversial points contained within it in relation to the understanding of the process outside of the clinical board and the responsibilities of commissioners overseeing contracted services. The QSE Group **noted** the updates.	
11/18/012	**PHARMACY UPDATES** KM confirmed that the national prescribing indicators to June 2018 have been released and sent to the Chief Executive; the report is produced quarterly and shows performance at UHB level. The UHB has been reported as either best or second best in all indicators except Tramadol and opioids; consequently the Pharmacy team is focusing on pain management for 2017/18. KM summarised the domains for which data is collected, noting that these will inform improvement work by the identification of Practices with less robust processes. It was highlighted that data is now available for community pharmacy which has not previously been reported. It was noted that the Cascade process had been discussed at the Primary Care QSE meeting; SG has tasked the Primary Care Support Officer to identify a plan for identifying independent contractors who need further support in accessing the generic database. The QSE Group **noted** the report.	
11/18/013	**PRIMARY CARE GENERAL MEDICAL SERVICES AND DENTAL GOVERNANCE HIW PRACTICE INSPECTION UPDATE REPORT – NOVEMBER 2018** The report was presented for noting prior to submission to the	

	UHB QSE Committee. No new GMS inspections have taken place but there have been two non-compliance letters sent to Dental Practices following recent HIW inspections, immediate action has been taken and assurance provided. Updates are awaited. The RAG ratings will be reviewed. The QSE Group **noted** the report.	**KJ/RA**
11/18/014	**BUSINESS CONTINUITY** <u>Exercise PrinCIpal Challenge feedback and next steps</u> KJ thanked colleagues for their contributions to the recent business continuity table-top exercise which had been very positively received by the Contingency Planning team. It was confirmed that ongoing testing of plans at Business Unit level has been scheduled for the early part of 2019. It was identified that Bronze Control awareness training would be beneficial to many colleagues. RA to discuss with Huw Williams. The QSE Group **noted** the report. <u>PHW Briefing infectious cases, MERS-CoV & Ebola & CBRN reminder following Salisbury/Amesbury</u> and <u>PCIC Emergency Preparedness, Resilience and Response & Business Continuity: Action notes of the meeting held on 24th October, 2018</u> These items were presented for information.	**RA**
11/18/015	**CONCERNS** <u>Concerns themes performance summary by Business Unit</u> The QSE Group **noted** the report. Kj highlighted to those present the need for improvement against the target response times specifically in relation to Independent sector concerns. <u>Managing Staff Concerns</u> This item was presented for information.	
11/18/016	**OMBUDSMAN'S REPORT – MR A AND GP** KJ confirmed that all recommendations contained within the Ombudsman's reports had been accepted and actioned by the Practice concerned and that deafness awareness training had been provided at CPET, while a link to online deafness awareness training has been sent to all GPs. The QSE Group **noted** the report.	
11/18/017	**INQUEST REPORT – FJ** KJ summarised the report noting that there had been detailed	

	multi-agency and multidisciplinary discussions regarding whether the death could have been prevented. The combined Root Cause Analysis report had been sent to the parents. It had been identified that there were insufficient WAST vehicles in the UHB catchment area available at that time following categorisation of the call which meant a delay in response to the practice. There were other factors that have been address in the report, an action plan is to be developed and supplied to the Coroner for the Inquest in early 2019. The QSE Group **noted** the report.	
11/18/018	**INFECTED BLOOD INQUIRY – RETENTION OF MEDICAL RECORDS** The QSE Group **noted** the requirement for all departments to support in the provision of medical notes and associated supporting work relating to the infected blood inquiry.	
11/18/019	**CLINICAL BOARD QUALITY, SAFETY AND PATIENT EXPERIENCE GROUP – TERMS OF REFERENCE AND OPERATING ARRANGEMENTS** KJ confirmed that the Terms of Reference have been updated and requested comments from colleagues. The QSE Group **approved** the ToRs **subject to** the addition of a member representing the Palliative Care service.	
11/18/020	**BUSINESS UNIT QSE MINUTES** KJ confirmed that she has reviewed the Business Unit minutes and responded to teams as appropriate. S&E Locality are in the process of reviewing all of the QS&E processes within the Locality in line with the clinical board processes.	
11/18/021	**INFORMATION GOVERNANCE** The QSE Group **noted** the Information Governance Group minutes.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
11/18/022	**RESEARCH AND DEVELOPMENT (R&D)** • Establishment of a Joint Research Service • Non-commercial Performance Report • Bevan exemplar: Use of AliveCor smart ECG monitors in the development of the new IP pharmacist role to improve the early detection of atrial fibrillation KJ summarised the current position on the above studies, noting that the Bevan Commission research will commence in North Cardiff. KJ highlighted the need to increase the level of R&D activity within PCIC to ensure retention of significant funding; also that	

	Guru Naik, PCIC R&D Lead, will attend the next CPET meeting to promote R&D. The QSE Group **noted** the update.	
SAFE CARE		**Action**
11/18/023	**TRACHEOSTOMY GUIDELINES UPDATES** AM and CP updated on the current position. AM, NH, CF to provide further update at next meeting. The QSE Group **noted** the report.	**AM/NH/ CF**
11/18/024	**ANNUAL AUDIT REPORT - ANTICOAGULATION MONITORING BY THE ACUTE RESPONSE TEAM (ART) 2017** KJ confirmed that the audit had been undertaken to ensure compliance with NICE guidelines, noting in particular the average number of days' interval between patients being identified as therapeutic and their discharge to GP. Report to be forwarded to the Medical Director's office. The QSE Group **noted** the report.	**RA**
11/18/025	**POINT OF CARE TESTING** KJ confirmed that the priority areas for point of care testing in the primary care arena are glucose monitoring and INR. A review of AQ processes in place to support Independent contractors is ongoing and part of national discussions. Clinical Board CBD is feeding into the All Wales discussions and will update KJ on a position specifically in relation to the use of Glucometres in Primary care. The QSE Group **noted** the report.	
11/18/026	**MEDICAL EQUIPMENT ISSUES** *None reported since last meeting.* KJ confirmed that a medical equipment representative has been nominated.	
EFFECTIVE CARE		**Action**
11/18/027	**INFECTION CONTROL** • HCAI monthly update and reduction expectation dashboards • Public Health Wales short briefing: Start of Respiratory Syncytial Virus (RSV) season in Wales. The QSE Group **noted** the updates, which had been provided for information.	

11/18/028	**OPTOMETRY WALES: PRIORITISATION OF PATIENTS REFERRED INTO SECONDARY CARE HOSPITAL EYE DEPARTMENTS** The QSE Group **noted** the update, which had been provided for information.	
DIGNIFIED CARE		**Actions**
11/18/029	**SENSORY LOSS** Sensory Impairment Audit and WHC (2018) 030 Sensory Loss Communication Needs (Accessible Information Standard) The QSE Group **noted** the updates, which had been provided for information.	
11/18/030	**DEMENTIA** Dementia Action Plan DS outlined the plan, highlighting that some of the actions relate to items on which WG asks for reports. It was noted that there is a mixed picture of provision and management. Colleagues were requested to comment on the format and on what content would ensure that the plan is meaningful and would support dementia becoming part of core business. The following points were discussed: • The need to include the appointment of dementia link workers • The need to retain dementia as a standing item on the QSE agenda WHC (2018) 030 Sensory Loss Communication Needs (Accessible Information Standard) The QSE Group **noted** the update, which had been provided for information. It was highlighted that it would be necessary to read the books before recommending them to ensure that the recommendation was appropriate.	**RA**
TIMELY CARE		**Action**
11/18/031	**SAFEGUARDING** • Child Practice Review updates • RISE poster These items were presented for information. The QSE Group **noted** the contents.	
INDIVIDUAL CARE		**Action**
11/18/032	**DISTRICT NURSING/PODIATRY SHARED CARE PATIENTS** AM shared the newly developed Podiatry and District Nurse Patient Shared Care Process. KJ welcomed this as a valuable	

	piece of work and recommended that it should be shared at all QSE groups to ensure that it is embedded across the Clinical Board.	
11/18/033	**AUS-TOMS** Item deferred to next meeting.	
STAFF AND RESOURCES		**Action**
11/18/034	**WORKFORCE UPDATE** The QSE Committee **noted** the updates which had been discussed under item 8, PCIC Quality Dashboard.	
SUB-GROUP REPORTS		**Action**
11/18/035	35.1 GP OOH Business Unit No additional issues to report. 35.2 Vale Locality • Note was made of the improvement in waiting times for the continence and wound healing services. • Court of Protection issues and associated risks were highlighted. 35.3 Cardiff South and East Locality • CP highlighted that there is currently no hot water supply in the Department of Sexual Health (DoSH), CRI Outpatients, Sexual Assault Referral Centre or the CRI X-Ray departments. This was noted as a serious infection prevention and control risk and it was recommended that if hot water could not be provided services should be suspended. • CP is providing dedicated support to DoSH to assist with workforce and capacity issues • PReP waiting list remains a significant challenge; actions have been put in place to improve the waiting list and increase the uptake rate • HIV database has now gone live 35.4 Cardiff North and West Locality AM reported that a residential home provider has informed the UHB of its intention to de-register; it will be necessary to find alternative provision for 17 people before 13th December, 2018. 35.5 Pharmacy and Medicines Management No additional issues to report. 35.6 Palliative care No additional issues to report. 35.7 Primary Care No additional issues to report. 35.8 Clinical Governance Group No additional issues to report.	

PART 2:	ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE
11/18/036	**CMO UPDATES** CEM/CPhA/2018/14 — Drug Alert Class 4: Daiichi Sankyo UK Ltd, Olmetec 20 mg film-coated tablets CEM/CPhA/2018/15b — Update: Epipen and Epipen Junior (Adrenaline Auto-injector devices) – supply disruption CEM/CPhA/16b — Epanutin (Phenytoin) 30 mg/5 ml Oral Suspension – supply disruption CEM/CMO/2018/5(R) — Protecting those aged over 65 from flu (Revision) **MHRA MEDICAL DEVICE AND MEDICINES ALERTS** • Baxter: Temporary importation of unlicensed VIAFLEX 0.9% Sodium Chloride 1L from the USA to address manufacturing disruption in UK • McKinley T34™ Ambulatory syringe pump - Co badged communication between the Medicines and Healthcare products Regulatory Agency (MHRA) in conjunction with the Association of Palliative Medicine (APM) • Important Update to Field Safety Notice issued 07 March 2018 Ref: FSN2018-001_Updated UK **WELSH HEALTH CIRCULARS** WHC (2018) 029 — Guidance on the Ionising Radiation (Medical Exposure) Regulations 2017 for employers and health professionals who carry out medical radiological procedures WHC (2018) 034 — BCG Vaccine Supply and Ordering in Wales WHC (2018) 036 — Flu Vaccination for Residential Care and Nursing Home staff in 2018-19 **WELSH GOVERNMENT ADVISORY** *None received since last meeting.* **NICE GUIDANCE** *None received since last meeting.* **PATIENT SAFETY NOTICES** *None received since last meeting.* **INTERNAL SAFETY NOTICE AND GUIDANCE** • Guidelines For Identifying Wound Infection & Appropriate Use Of Topical Antimicrobial Wound Dressings (AWD) • ISN: 2018/006 - Laryngoscopes and suction issues **SI CLOSURE FORMS** **UPDATES FROM OTHER GROUPS**

	• NHS Wales Safeguarding Network Minutes, 19th July, 2018. • Agenda and minutes from the UHB Nutrition and Catering Steering Group June 2018 • Safeguarding Team Newsletter Autumn 2018.
DATE OF NEXT MEETING	
Tuesday, 22nd January, 2019, 1.30 pm – 3.30 pm PCIC meeting room 1 CRI	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 09th August 2018
Venue: Critical Care Resource Room

In Attendance:

Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board (Chair)
Maria Roberts (MR) Patient Safety Manager, Patient Safety Team
Fiona Kear ((FK) Assistant Service Manager, Haematology, Immunology & Medical Genetics
Beverley Oughton (BO), Senior Nurse, Critical Care
Mary Harness (MH), Senior Nurse, Haematology
Sarah Matthews (SM), Senior Nurse, Transplant & Nephrology
Claire Main (CM), Lead Nurse, N&T
Lisa Higginson (LH), Senior Nurse, N&T
Ceri Phillips (CP), Lead Nurse, Cardiothoracic
Maurice Wentworth (MW), ALAS
Sarah Lloyd (SL), Directorate Manager, Neurosciences and ALAS
Lorraine Donovan (LD), Senior Nurse, Neurosciences and ALAS
Hattie Cox, (HC), Graduate Management Trainee, Neurosciences
Bethan Ingram (BI), Advanced Nurse Practitioner, Haematology
Siobhan Smith (SS), Pharmacist, Haematology
Keith Wilson (KW), Consultant, Haematology
Alex Murray (AM), Clinical Lead, Medical Genetics
Steve Gage (SG), Pharmacist, Pharmacy
Martyn Read (MR), Consultant, ICU
Holly Williams (HW) Patient Quality and Safety Facilitator (S/Services) and note taker

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome & Introductions Those in attendance introduced themselves.	
1.2	Apologies for absence Hywel Roberts, Paula Goode, Suzie Cheesman, Orla Morgan, Colin Gibson, Nav Masani, Nicola Foreman and Vince Saunders.	
1.3	To review the Minutes of the previous meeting 20th July 2018 The minutes were agreed as an accurate record. Matters Arising Item 1.3 Haematology Risk: confirmation of floor plan option being in discussion. Surveillance of patients awaiting Cardiac Surgery: pending un update from Richard Wheeler. Item 1.4	**CP**

	Neurosciences Presentation: Pending circulation from Emma Jones. Item 2.1 B5 Nephrology SI: The Resuscitation Committee has met and outcomes are pending in reference to the IO's query Inquest: Family not in attendance therefore this inquest went ahead informally and is now closed. Item 3.2 Critical Care Secretarial Support: no update following e-mail raising the issue being sent by MR. Posture Mobility Centre: access to hot water issue is now resolved. Thoracic Surgery Public Consultation: CF informed attendees of this consultation opportunity and advised that C&V employees will be asked to declare their employment when providing information. Staff were encouraged to complete. Item 4.1 Medication Charts: SC not present to update therefore comments taken from previous meetings' minutes - *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.*	**RB/EJ** **HR** **SC**
1.4	<u>Patient Story – ALAS – cancelled as the patient wants to attend.</u>	
PART 2: SAFE CARE		
2.1	<u>Open Inquests</u> **INQ/UHW/3373:** Dialysis Patient discharged during the winter period. To move the incident under Surgery. **INQ/IN44394:** NEWS protocol not adhered to. Inquest has been postponed to close of November, 2018. Witnesses have been confirmed. **INQ/UHW/3195:** Burr Hole procedure. An update is to be followed up further. **INQ/IN65611:** Overdose on B5. Family has raised questions. Report is due to Coroner in September, 2018, and the Inquest is scheduled for October, 2018. **INQ/UHW/3194:** Rib fracture and pneumonia. Inquest scheduled for September 2018. An update is to be followed up – presently overseen by the Claims Department. <u>Closure Forms</u> **IN68586:** It has been reported that there is an increased incidence of Pneumocystis jirovecii pneumonia (PcP) among patients who have had renal transplants and have been inpatients on T5/Cardiff Transplant Unit (CTU) since January 2018. It was agreed that T5 ward will move to A2 ward in order for the refurbishment to take place. This is scheduled to take place in the early Autumn of 2018. ***Action:*** There has been interest received from ITV following notable practice – 8 transplants completed within a 30 hour period. CM to liaise with the Comms Department to manage the arrangements in light ofT5 move to A2. **IN47040:** It has been reported that a patient has died on ward B5, UHW and MSSA	**MR** **MR** **MR** **CM**

	Bacteraemia is listed on part 2 of his death certificate. A learning point was identified that a plan for monitoring bloods must be very clear in the records. **IN33464: See also IN26753 below.** The Coroner raised concern regarding induction programmes and procedures relating to chest drain insertion. This still needs to be clarified by the Directorate. **IN26753:** A patient required insertion of a left intercostal drain because of a post cardia surgery pleural effusion following aortic valve replacement on 10th May, 2016. The drain was inserted by a middle-grade doctor who inadvertently punctured the patient's left heart ventricle. Procedures for local induction were put in place, with competency assessments discussed. Need further information from Directorate	**NG** **NG**
2.2	Patient Safety Alerts MDA/2018/025R: (Cardio) Novaline haemodialysis bloodlines have been replaced. Risk assessments were undertaken prior to replacements being received to ensure safe practices during the interim period. MR advised that such Safety Alerts should come from the Procurement Department, but at present this does not seem to be a standardised means of communication. CM to send MR e-mail exchange information to track how this alert was received. Research – suspect package received in N&T research Department – this was discussed during the meeting and colleagues are advised to be alert as packages may still be in the system and yet to be delivered/located. Notable reactive practice identified.	**CM**
2.3	Healthcare Associated Infections HCAI Report & HCAI by Ward: These reports were presented by CF to the attendees, with current reports against targets discussed. Decontamination Group: Mark Inker, Clinical Board representative within the Group is to be invited to share information, with a particular focus being on equipment decontamination.	**MW**
2.4	Pressure Damage Data detailing the number of incidents reported within the Clinical Board between 1st April, 2018 to 26th July, 2018 was reviewed. The prevalence and level of harm associated were discussed, in addition to the pathway required to suitably attend to these reports and close (particularly G3-4). The All Wales Tool, version 2014 is to be used to support reporting.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee Not discussed.	
3.2	Exception reports and escalation of key QSE issues from Directorate QSE Groups Not discussed	
3.3	Datix Report The Clinical Board's overdue incidents at Submitted and In Progress stages were	

	reviewed. This number had significantly reduced and those in attendance were thanked for their work in enabling this reporting improvement. Further attention is required however, with many overdue incidents sitting within the no-harm and minor levels.	**Dirs**
3.4	<u>External Quality Assurance Glucose and Ketona</u> Neuro to present a position at next meeting.	**LD**
3.5	<u>Sign off of Ambulatory Chemotherapy Documents</u> A presentation/discussion led by BI that reflected on the key documents circulated prior to the meeting. BI advised the attendees of the rationale for patients using the mobile infusion pumps and the support in place to educate them and also staff. The pump has been successfully used in other areas of the UK, USA and also reaching into Europe. The clinical engineering team have been involved to ensure that high standards have been met and to ensure accuracy for patients. All relevant staff will be trained in the use of this mobile chemotherapy pump to support with educating patients. The team involved have developed a user-friendly information leaflet and workbook for patients and staff. There is a checklist available to ensure patients are advised whilst on the Ward of how to use the pump safely and effectively, with a troubleshooting facility available in the event of requiring this at home. There is also guidance provided in the event of spillages. The mobile infusion pump can be programmed and there is also a backpack to support with ease of transportation. ***Actions:*** BI to confirm with Julia Harper (Corporate Governance) to ensure that the template used to present this procedure is the correct version/format. BI will review the prevalence of spillages recorded and feedback. **The procedure was signed off during the meeting**	**BI**
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u> Neurosciences: Advised that provision of urology services in Rookwood has ceased. LD felt this should be included on the risk register due to the potential harm to patients this will cause. An SBAR is pending in relation to this matter and will be provided to CF for further consideration.	**SL**
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	<u>Received and noted for information:</u> National Report – Rookwood and SpS CB July 2018 Cardiff your NHS Wales experience – Specialist Clinical Board Traceability July 2018-08-07 Checklist (Adult pre-op) Jehovah's Witness Discussed by the attendees.	

PART 6: DATE OF NEXT MEETING		
6.1	Friday 31st August 2018, 8am, in the Critical Care Resource room, UHW.	

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

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 31st August 2018
Venue: Critical Care Resource Room

MINUTES

In Attendance:
Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board (Chair)
Navroz Masani (NM), Clinical Board Director
Hywel Roberts (HR), Consultant, Critical Care and Medical Lead for QSE
Suzie Cheesman (SC) Patient Safety Manager, Patient Safety Team
Fiona Kear ((FK) Assistant Service Manager, Haematology, Immunology & Medical Genetics
Beverley Oughton (BO), Senior Nurse, Critical Care
Sian Williams (SW), Senior Nurse, Cardiothoracics
Helen Scanlan (HS), Service Manager, Neurosciences
Gareth Jenkins (GJ), Service Manager, Haematology, Immunology and Medical Genetics
Vince Saunders (VS), IP&C
Sarah Matthews (SM), Senior Nurse, Nephrology & Transplant
Claire Main (CM), Lead Nurse, N&T
Maurice Wentworth (MW), ALAS
Steve Gage (SG), CB Lead Pharmacist Martyn Read (MR), Consultant, ICU
Holly Williams (HW) Patient Quality and Safety Facilitator

Present: Gemma Williams (GW), Personal Assistant, QSE Facilitator

PART 1: PRELIMINARIES		**Lead**
1.1	Welcome & Introductions	
1.2	Apologies for absence Received from Catherine Wood, Colin Gibson, Gemma Ellis, Orla Morgan, Maria Roberts, Paula Goode, Ceri Phillips, Jennifer Proctor, Anne-Marie Morgan and Mary Harness.	
1.3	To review the Minutes of the previous meeting 9th August 2018 The minutes were agreed as an accurate record. Matters Arising Item 1.3/1.3 Surveillance of patients awaiting Cardiac Surgery - SW noted that the letter to patients is being finalised. CP and Richard Wheeler will be meeting next week to discuss. CP/SW to feed back to the group. Item 1.3/1.4 Neuro presentation – GW confirmed that the presentation given by Emma Jones has been circulated to the group. Item 1.3/3.2 Critical Care secretarial support – It was confirmed that the band 4 PA post has gone out to advert. Item 1.3/4.1 Medication Charts – SC noted that previously on Oracle you could make a non-stock order for the incorrect chart but that this has now been stopped. HR	**CP/SW**

	confirmed that there is now a new chart again that is different from the 2016 chart. Not yet in use but feedback has been positive. SG raised concern regarding the cost of the new charts as they are more of a booklet. However, it was noted that fewer would be used so it should balance out. Concern was also raised regarding the possibility of staff missing out pages due to the size of the document.	
	<u>Item 2.1 Open Inquests</u> INQ/UHW/3373 – Dialysis patient discharged during the winter period. Incident to be moved under Surgery. CM to check.	**CM**
	INQ/IN44394 – NEWS protocol not adhered to. Inquest has been postponed until November 2018. Witnesses have been confirmed.	
	INQ/UHW/3195 – Burr Hole procedure. An update is to be followed up further.	**MRR**
	INQ/UHW/3194 – Rib fracture and pneumonia. Inquest scheduled for September 2018. An update is to be followed up. Presently overseen by the Claims department.	**MRR**
	<u>Closure Forms</u>	
	IN68586 – increased incidence of Pneumocystis jirovecii pneumonia (PcP) among renal transplant patents inpatients on T5/Cardiff transplant Unit (CTU) since January 2018. It was agreed that T5 ward will move to A2 ward in order for the refurbishment to take place.	
	IN33464 – see also IN26753 – the coroner raised concern regarding induction programmes and procedures relating to chest drain insertion – this still needs to be clarified by the Directorate.	**NG/CP**
	IN26753 – drain was inserted by middle grade doctor who inadvertently punctured the patients left heart ventricle. Procedures for local induction were put in place with competency assessments discussed. Need further information from Directorate.	**NG/CP**
	Item 2.2 Patient Safety Alerts – MDA/2018/025R (Cardio) Novaline haemodialysis bloodlines have been replaced. CM confirmed that she had emailed MRR regarding how the alert was received.	
	Item 2.3 Healthcare Associated infections – Mark Inker, Clinical Board representative within the group is to be invited to share information, with a particular focus being on equipment decontamination. MW will speak to CG next week.	**MW**
	Item 3.3 Datix Report on agenda.	
	Item 3.4 External Quality Assurance Glucose and Ketona - Lorraine Donovan not available to attend this meeting. GW to ask her to present at the next meeting.	**GW**
	Item 3.5 Sign off Ambulatory Chemotherapy Documents – CF requested Bethan Ingram links in with Julia Harper regarding the format of the documents. This has now been addressed and the documents are now on the website.	
	Item 4.1 Any urgent Business - Neurosciences and the stopping of Urology Services in Rookwood – it was noted that the waiting list is growing. Concern regarding this issue was raised this week and this has been sent to Surgery. Tina Bayliss in Surgery to pick up.	

1.4	Patient Story – N&T CM referred to the new Renal Social Worker role which has been identified as a key role within the services. Previously the role was employed through Cardiff Local Authority which limited the number of patients they could see. A job description was developed for the role employed by the Directorate themselves so that they had remit to look after all patients in our area. Currently trying to identify and map out what services are available through the community. Developing much better links with charitable organisations and can work collaboratively together. Patients have access to multiple advocates. Many of the patients need modifications to their house so trying to educate people in each of the services as to what it means to have dialysis at home. Also developing understanding of renal disease. CM referred to an individual patient story regarding a long standing transplant patient. The patient comes back to the service annually for their check-ups. On the last occasion she mentioned that she was having trouble getting chronic pain relief for her arthritis and that she couldn't move around as well. The patient was put in contact with the social worker. The social worker tried to call her a number of times but with no luck so she went to CM for advice. A convenient time was agreed for the patient to talk to the social worker and it came to light that the patient didn't want her daughter to be aware of what was going on. There was also an issue that the GP wouldn't prescribe the medication she needed for pain relief because of the amount that had already been given. The patient said that she didn't want to come back in as it would annoy her daughter. A plan was made for the patient to come in on the back of another appointment. It came to light that the daughter had been stealing the patient's pain relief. The patient had also been threatened by her daughter so the issue was raised with the safeguarding team, who advised also contacting the domestic abuse team. Currently the social worker role is key to understanding what has been happening at home. Issue isn't as yet resolved. Advocacy meetings have been set up with patient and GP. It was noted that it was a good example of how the role can help patients. NM suggested that it could be worth looking at other areas with regards to the social worker role and that it could be discussed in SSCBMT. NM and Core Team to discuss.	**NM**
PART 2: SAFE CARE		
2.1	Open Inquests CF referred to 2 of the Open Inquests. INQ/IN44394 initials JO - SC noted that there was now a new date for October. MRR will be attending. Report is in. MRR will be doing the closure form today. UHW/INQ3455 initials ASL - HR confirmed that he had emailed the report again. He is not expecting to go to the Inquest. INQ/IN65611 initials JP - Overdose on B5 – this date has changed again now. Pre meeting with Coroner and the Health Board on the 1st October. Inquest to be held on the 5th November 2018. INQ/IN71483 Patient died from line – SC noted that this can come off. Police have now concluded. HMC Statements CF noted that there have been issues regarding coroner statements in that the	

	Clinical Board/Directorates only find out from the Coroner what staff have been asked for statements/what information has been requested. CF noted that it has been requested that Patient Safety or the Clinical Board be copied into the requests but this hasn't as yet been happening. Directorates to inform Consultants. <u>Open Serious Incidents</u> In46388 initials AP - Patient underwent a neurosurgical procedure and the perforator failed to disengage. John Martin carried out the RCA. Patient has been raising concerns as it has been taking so long. The report has gone to John Martin for the last iteration and will then be sent to the patient. In73577 initials EF - New SI from last month – patient had an X- ray in October which showed a suspicious shadow. Radiology suggested patient is re X-rayed but the patient wasn't. Difficulty identifying the Investigating Officer but this has now been identified. In56779 initials GT - Unexpected death in Neurosurgery related to acute MI – HR has met with the neurosurgical SpR. HR will write the report and close it. In61929 initials DD - Patient who had a delay in neurosurgery and lost sight as result of delay. Colin Gibson is writing up the report but he is currently on leave. HW has contacted him for an update when he returns on the 3rd September. <u>Closure Forms</u> CF noted that there were 4 forms all related to pressure damage. They will go for signing today. The closure forms will be circulated after the meeting.	**Dirs** **GW**
2.2	<u>Patient Safety Alerts</u> Welsh Health Circular WHC 2018 037 Issue Date 29 August 2018 – "Flu Vaccinations and Planning flu clinics in 2018-19 for people aged 65 years and over". MH is the lead for Flu planning/vaccinating. Awaiting MH to arrive at the meeting. The WHC relates to the 3 different types of flu vaccine this year for different age groups; for those aged 65 and over, for those aged 18-64 at risk, healthcare workers and social care workers under 65 years should be offered the quadrivalent influenza vaccine (QIV). 18-64 vaccination for all staff. Would have to access the over 65 for those patients. SG will follow this up.	**SG**
2.3	<u>Healthcare Associated Infections</u> <u>HCAI Report</u> VS updated the group in cases within the month for July 2018: C. difficile - 5 cases for month UHW B1; UHW ITU Cardiac; UHW CTU; UHW B4 Haem; RH W4 MRSA – 0 cases MSSA – 6 cases UHW B5; UHW TCT x2; UHW ITU x2; UHW Haem Day Centre E. coli – 2 cases UHW B4 Neuro; UHW B4 Haem P. aeruginosa – 3 cases UHW CTU; UHW B4 Haem; UHW ITU Klebsiella spp - 3 cases: UHW B4 Haem; UHW ITU; UHW ITU Cardiac It was noted that zero cases of MRSA was very good as it has been around 3 months with no cases. <u>Clinical Board HCAI Group</u>	

	The HCAI group has now been refocused – the group focuses on reviewing RCAs and pulling out the themes. Work around ANTT. <u>HCAI Newsletter</u> HCAI Newsletter for the Clinical Board. The group agreed to change the wording in relation to Commode cleaning – agreed to change "once a week" to "once a day". Issues with commode cleaning on a couple of our wards – all areas need to be signing for cleaning. Some areas are picking this up with individuals who have signed for a clean commode when it is dirty. HW requested that the posters are displayed in the staff room areas. Newsletter will be quarterly. <u>Facebook Page</u> HW noted that the Clinical Board has now had approval for a Clinical Board Facebook page. <u>Hand Hygiene</u> CF noted that the last scores were 91% for the Clinical Board in July. The first four months of the year have shown that the Board has only been over the 95% target once. Some Directorates haven't been over the 95% for >12 months. Improvements needed around this. Critical Care has been an issue and VS has been doing dome work around this, he will be carrying out real time hand hygiene audits and advice. <u>ID Badges audit</u> All staff bar 2 had their ID badges on during the meeting. Reminder of the responsibility to wear their ID badge at all times when in work. <u>Hand Hygiene and Bare Below Elbow</u> The second letter from Navroz Masani, Clinical Board Director, is still to go out as awaiting response from Executives regarding measures suggested. CF noted that the Clinical Board are still not getting the names of recidivists. CF reiterated that Directorates need to inform the Clinical Board of any people who are not complying.	**Dirs** **Dirs**
2.4	<u>Pressure Damage Tool</u> CF informed the group that the Clinical Board was trying to standardise pressure damage and RCAs. HW referred to the pressure damage flow chart sent out ahead of the meeting. Useful for people to have more awareness regarding the process and where to send the information, in terms of RCA and incident form.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u> Not discussed.	
3.2	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> None raised.	
3.3	<u>MCA Audit Results</u> HR referred to the SBAR circulated "Specialist Services Mental Capacity Act Audit 2018: Summary". It was noted that results were not submitted for Neurosurgery and Neurology	**RB/SL**

	when they will have biggest numbers. Neurosciences to check (RB/SL). Compliance with MCA varies – somewhere between 42-85% compliance. Need to ensure in future that different audits are not carried out at the same time as confusion regarding documentation audit and MCA audit. To clarify HR noted that the audits were used to find out how compliant each area was with MCA and how well we are assessing capacity. Will try to standardise number of patients audited by Directorate in future for consistency. HR will speak to Julia Barrell regarding a clearer tool to use and possibly run the audit again. MCA training shows that 75% of nursing staff have been trained and only 13% of medical staff. It was noted that Julia Barrell has trained a large number of Consultants in CC but that this may not have been linked in with LED. HW will follow this up with LED. DMs to run reports for Consultants and their mandatory training compliance to review figures.	**HR** **HW** **DMs**
3.4	Datix Update HW advised that the number of overdue incidents is coming down so thanked Directorates for their support with this. The majority of overdue incidents are no harm and minor stages so should be able to close fairly quickly. However until we check them we can't guarantee that they are no harm or minor – please can everyone check. 27 incidents still open and active from 2017. CF noted that this was a huge improvement.	**Dirs**
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business Transfers from T5 CM noted that N&T were half way through the transfer. On track to move suite 19 by middle of September Hartmanns Solution SG noted that the Clinical Board needs to make a decision regarding alternatives for Hartmanns Solution. Pharmacists to work with Directorates. SG referred to the issue that a number of DALs are not completed when the patient is discharged so the medication referral doesn't get to the GP. Decontamination TOE Probes SW referred to decontamination of TOE probes noting that the machine is not available and hasn't been available for two weeks in Theatres. The smaller machine is being used but there is a back log. Not clear when this will be resolved; VS will pick this up. It's been escalated to Nick Gidman, Directorate Manager in Cardiac as well. In the meantime Tristel wipes are being used as agreed with IP&C. Staff Wellbeing HW noted that there are some staff wellbeing sessions being led by a lady from Noah's Ark. She is happy to open the session up to the Health Board for staff to	**VS**

	attend. HW handed out some hard copies of a poster detailing the dates of these sessions. HW will also send the poster out electronically to the group to be displayed in staff rooms.	**HW**
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information: Clinical Negligence Newsletter June 2018 – for information Sarah Watts (Solicitor) will be coming to a future meeting to discuss how to manage claims. The next QSE meeting will be Sepsis focused. 13th September 2018 is World Sepsis Day. Closure letter to centre (pancreas CUSUM report) - for noting. Closed by NHS BT. Few issues raised regarding outcome of recent increase in renal transplants. There will be an M&M review of all the patients and this will then be discussed in this meeting. CM to discuss with Mike Stevens.	**CM**
PART 6: DATE OF NEXT MEETING		
6.1	Thursday 20th September 2018, 8am, in the Critical Care Resource Room, UHW. The meeting will be focused on Sepsis.	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 20th September 2018
Venue: Critical Care Resource Room

SEPSIS FOCUSED

MINUTES

In Attendance:
Hywel Roberts (HR), Chair, Consultant, Critical Care and Medical Lead for QSE
Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board (Chair)
Suzie Cheesman (SC) Patient Safety Manager, Patient Safety Team
Sian Williams (SW), Senior Nurse, Cardiothoracics
Helen Scanlan (HS), Service Manager, Neurosciences
Vince Saunders (VS), IP&C
Sarah Matthews (SM), Senior Nurse, Transplant & Nephrology
Steve Gage (SG), Pharmacist, Pharmacy
Martyn Read (MR), Consultant, ICU
Holly Williams (HW) Patient Quality and Safety Facilitator
Rachel Barry, Lead Nurse, Neurosciences
Mathew Price, Service Manager, Neurosciences
Jonathan Kell, Consultant, Haematology
Anne-Marie Morgan, Directorate Manager, Haematology, Immunology and Medical Genetics
May Harness, Senior Nurse, Haematology
Gareth Jenkins, Service Manage, Haematology, Immunology and Medical Genetics
Kevin Nicholls, Service Manager, Cardiothoracics
Colin Gibson, REU/ALAS
Ceri Phillips, Lead Nurse, Cardiothoracics
Orla Morgan, Lead Nurse, Critical Care
Beverley Oughton, Senior Nurse, Critical Care

Present:
Gemma Williams (GW), Personal Assistant, QSE Facilitator
Gayle Sheppard (GS), ASM, Cardiothoracics
Jonathan Wood (JW), Physiotherapist
Emily Casseen (EC), N&T
Emma Swales (ES), Ward Manager, N&T
Faye Blackborow (FB), Haematology
Sian Jeffries (SJ), Senior Staff Nurse, Critical Care

PART 1: PRELIMINARIES		**Lead**
1.1	Welcome & Introductions	
1.2	Apologies for absence Received from Ravindra Nannapaneni, Jennifer Proctor, Fiona Kear, Alex Murray and Claire Main.	
1.3	To review the Minutes of the previous meeting 31st August 2018 The minutes were agreed as an accurate record. Matters Arising Updates not in previous minutes	

	• HW fed back on Lanyards – it isn't possible to change the position of the badges. MR to speak to Ian to look at the double lanyards. • Learning Developments – HW advised staff to speak to Rebecca Corbin re any mandatory training issues i.e. if the matrix hasn't been updated. HW happy to follow up any queries. • HW has emailed out regarding the HCAI newsletter and Datix reports - hopefully all had sight of this. <u>Matters Arising from Minutes:</u> • Surveillance of Patients on the waiting list for Cardiac Surgery – CP/SW to feed back. • Open Inquests – Dialysis patient discharged during the winter period – incident to be moved under Surgery. CM to feed back. Matters Arising not completed. Time restrictions meant that the meeting had to move onto the presentations.	**MR** **CP/SW** **CM**
1.4	<u>Patient Story – Jonathan Wood</u> Jonathan introduced himself as a Clinical Specialist Physio who works in ALAS. Jonathan referred to a recent patient who had sepsis which had dramatic effect on his life. Gentleman nil past mouth. Fully independently mobile. Developed flu like symptoms and was put on antibiotics but still continued to deteriorate. Diagnosed with meningococcal meningitis. The patient pulled through and was transferred to Morriston. The patient had to have 4 amputations due to septicaemia and extensive skin graphs due to the amount of damage. Acute rehabilitation in Morriston and asked to come to Rookwood. In patient in ALAC for 9 months and discharged end of July last year. The patient covered many different specialties and services; Plastics Surgeons, Rookwood Medical Team, Clinical Specialist Nurses, Occupational Therapy Posture Mobility and Intensive Physio. Electric wheelchair on loan before he got his own. Summary of his journey and timescales. Strengthening upper limbs. Skin started to break down when using the limbs spent 9 months in total trying to manage this. Discharged with a lot of support. Psychological, community occupational therapy support, ongoing social worker input. Significant goals. Now walking. Can drink independently. Returned to live at home. Looking to get back into work. Holistic MDT approach for such high level function.	
PART 2: SAFE CARE		
2.1	<u>Paul Morgan, Sepsis</u> PM introduced himself as the Sepsis lead for the organisation and gave a presentation on "Sepsis management in Cardiff and Vale UHB" It was noted that World Sepsis Day was on the 13th September. Stands in concourse. PM discussed the following; - What is sepsis - Sepsis definitions - Inpatient sepsis screening and sepsis six and action toolkit - Sepsis star - Health Pathways Project - DESEOTiW study - Acute kidney Injury - Sepsis outcomes - UHW sepsis mortality is currently under 16%.	

	All patients with sepsis are now given a "Recovery After Sepsis" Handbook, which points patients in the direction of support. GW to circulate the presentation to the group.	**GW**
2.2	Sian Jeffries, AKI SJ provided a brief summary of the work. Outreach team responds to AKI alert by raising awareness to the ward staff that the patient has AKI symptoms. The work carried out has meant less patients going to Critical Care and less going on to develop chronic disease. SJ will look at more of the data they have and bring it back to a future meeting. The data demonstrates the improvements of using the AKI bundle.	
2.3	Open Serious Incidents (SIs) SC noted that there were 15 Open SIs currently. Closure Forms 1 Closure form is with Carole Evans for sign off this month. Lengthy to go through so will discuss at the next meeting. Working on another 3 to get to target. Open Inquests Inquests not many updates.	
2.4	Patient Safety Alerts None to note.	
2.5	Healthcare Associated Infections • HCAI Report VS noted higher rates of C.Difficile. 5 cases in August and September had had 4 cases already. Also increase of MSSA - 6 cases in August and September has 5 already. P.aeruginosa on the increase - 4 cases in August and 2 for September. Should only have 9 cases for the Health Board in total so this is concerning. Need an extra-ordinary meeting to discuss these cases. VS will look to set up a meeting.	**VS**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee None.	
3.2	Exception reports and escalation of key QSE issues from Directorate QSE groups Saline - Imported SG noted that the UHB has had to import Saline which has a different appearance – to be aware. Electronic Wristbands SC noted that electronic wristbands will be coming soon. All areas need USB leads and cartridges for the wristbands.	
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business Medication Checks on Discharge CF informed the group of an incident where a patient was discharged with the wrong medication. The patient luckily didn't come to harm. CF requested that Directorates raise the importance of checking medication by nurses on the ward before the patient is discharged and the importance of getting the patient to check the medication with them.	
PART 5: ITEMS TO BE RECORDED AS RECEVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information: None.	
PART 6: DATE OF NEXT MEETING		
6.1	Friday 12th October 2018, 8am, in the Critical Care Resource room, UHW.	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 12th October 2018
Venue: Critical Care Resource Room

MINUTES

In Attendance:

Carys Fox (CF), Chair, Director of Nursing, Specialist Services Clinical Board
Hywel Roberts (HR), Consultant, Critical Care and Medical Lead for QSE
Nav Masani (NM), Consultant Cardiologist, Clinical Board Director
Suzie Cheesman (SC) Patient Safety Manager, Patient Safety Team
Colin Gibson, REU/ALAS
Mark Inker, Project Manager, ALAC
Orla Morgan, Lead Nurse, Critical Care
Lisa Higginson, Senior Nurse N&T
Claire Main (CM), Lead Nurse N&T
Rob Bradley, Pharmacist N&T
Rafael Chavez (RC), Consultant, N&T
Sian Williams (SW), Senior Nurse, Cardiothoracics
Martyn Read (MR), Consultant, Critical Care
Craig Spencer (CS), Consultant, Critical Care
Ceri Phillips (CP), Lead Nurse, Cardiothoracic
Rachel Barry, Lead Nurse, Neurosciences
Holly Williams (HW) Patient Quality and Safety Facilitator
Jennifer Proctor, Lead Nurse, Haematology
Helen Scanlan (HS), Interim Directorate Manager, N&T
Gareth Jenkins, Service Manage, Haematology, Immunology and Medical Genetics
Vince Saunders (VS), IP&C
Lisa Simm, Service Manager, Neurosciences
Hattie Cox, Graduate Manager Trainee, Neurosciences
Rachel Jones, Speech and Language Therapist, Speech and Language Therapy

PART 1: PRELIMINARIES		Lead
1.1	Welcome & Introductions	
1.2	Apologies for absence Received from Gemma Williams, Steve Gage, Mary Harness, Matthew Price	
1.3	To review the Minutes of the previous meeting 20th September 2018 The minutes were agreed as an accurate record. Matters Arising Lanyards • CF advised that Ian Sidney, Stock Controller in CC, has identified lanyards that are available to order. She will circulate the order form/information for Directorates to action accordingly. Surveillance of Patients on the waiting list for Cardiac Surgery – CP/SW to feed back. • CP advised that the Cardiff and Vale waiting list was being monitored, with Cardiac Out-Patients being provided with a card to document and report any changes in their wellbeing. This card is to be finalised and then implemented. Open Inquests	**CF** **CP**

	• CM – no feedback for the Clinical Board. Extraordinary Meeting • VS – See Section 2.5 Healthcare Associated Infections Medication Checks on Discharge • **From Previous Meeting's minutes:** CF informed the group of an incident where a patient was discharged with the wrong medication. Fortunately, the patient didn't come to harm. CF requested that Directorates raise the importance of checking medication by nurses on the ward before the patient is discharged and the importance of getting the patient to check the medication with them.	**CM**
PART 2: SAFE CARE		
2.1	Mark Inker, Decontamination Issues affecting our Clinical Board Mark introduced himself as Project Manager for ALAC and representative of the Health Board's Decontamination Group. Background documentation was included in the agenda circulation. Mark advised attendees to review the IP&C intranet page for useful guidance regarding standards of practice. CF also provided an example of an external EU incident highlighting the importance of decontamination for patient safety. Cardiac colleagues provided feedback regarding improvements they have made to their practices and this was noted within recent audit results achieved – a notable improvement. Review of each Directorates practices and no issues arose. A discussion regarding the availability of equipment to support with decontamination process, and the effectiveness/efficiency of these took place. Disposable equipment options were also considered, including those already in place e.g. disposable bronchoscopes in CC.	
2.2	Update on renal patients and report outcomes M&M RC provided a brief summary regarding this agenda item. Following a review of patient cases, he confirmed that no exceptional circumstances could be identified and during monthly M&M Meetings, such cases would be closely overseen. There was an acknowledgement that there would be pressures associated on the Consultants when multiple procedures are undertaken. M&M Meetings A discussion took place about how patients qualify for discussion at these meetings, and for assurance, NM requested that each Directorate e-mail their protocol for mortality screening to CF, HW and the PA Specialist Services addresses.	**DMT**
2.3	Open Serious Incidents (SIs) 19 Serious Incidents open. • **Neurosurgery incident:** the RCA has been provided to the patient/family and is presently going through the re-dress process. An SI Closure Meeting for this incident is scheduled for 24th October, 2018. • N&T X-ray incident: the IO is reviewing the clinical records and statements received. • Neurosurgery ECG incident: the RCA is being reviewed by CF. Closure Forms	

	2 Closure Forms completed for September, 2018. The Clinical Board anticipates at least 4 Closure Forms for October 2018. Of the Open SI incidents, a number of these are pressure damage related. <u>Open Inquests</u> One patient inquest discussed with this scheduled to take place on 5th November 2018. CM is in contact with the patient's family. The Improvement Plan will require involvement on a wider Health Board level.	
2.4	<u>Patient Safety Alerts – attached to the agenda</u> • All Fresenius syringe pump users • Public Health Link – Epipen and Epipen Junior – Supply Disruption Those in attendance confirmed the circulation of these.	
2.5	<u>Healthcare Associated Infections</u> • <u>HCAI Report – included in the agenda circulation</u> VS advised that the reported cases of C.Difficile, MSSA and E.Coli was high during September 2018 (5: 6: 6 cases respectively). At the time of the meeting, three new cases of MSSA has been reported, against a requirement of not more than one case each month. An Extraordinary Meeting was held on 25th September 2018 to discuss the prevalence and the RCAs supporting their analysis. Unfortunately there was poor Medic representation and also not all RCAs were available/completed to support the meeting as fully as planned. Further meeting to be arranged • <u>Ward Rounds</u> VS and HR shared that their recent Ward Round in CC had been successful and provided VS and colleagues the opportunity to identify and discuss key moments of hand hygiene which may otherwise be missed, and also troubleshoot when required. Ongoing Ward Rounds have been recommended however there was an acknowledgement of the capacity the IP&C Team have to support. VS recognised this to be a priority however. • <u>Hand Hygiene</u> VS advised that OM, VS, EL and HW met to discuss the development of an SOP to identify key moments of Hand Hygiene. This is being finalised and is available to the Clinical Board for modification/circulation. OM advised that many of the wall-mounted gel devices are often empty and not re-filled as swiftly as required. To be picked up at HCAI meeting with Facilities rep • <u>PVCs</u> There was a discussion around the influence of PVCs inserted in the Community and how these are identified and managed following admission. Poor PVC care can be a risk factor to developing an infection. PVC auditing (including information reviews) has identified that maintenance of inserted PVCs and also the completion and documentation of VIP scoring is lacking in many cases. Intentional Rounding – NM advised that a robust process would support the oversight of PVC insertion, VIP scoring, documentation and suitable removal. CP and HW to liaise to progress this further.	**VS** **OM/VS** **OM** **CP/HW**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u>	

	None	
3.2	Rachel Jones, Role of SLT in Critical Care Presentation  SLT in Critical Care Patient Story Versior	
3.3	MTeD Continuity – Rob Bradley N&T Pharmacist There are occasions when IT systems failure mean that completion of electronic discharge documentation is not possible. This could delay patient discharge and adversely impact patient flow. Each Directorate is to ensure they have a supply of paper TTH forms for use. If these are required, please make contact with Pharmacy who can supply/locate these for use.	
3.4	Exception reports and escalation of key QSE issues from Directorate QSE groups Never Event Attendees were advised that a Never Event incident has occurred in the Critical Care Directorate. An IO has been appointed following the Never Event Incident Meeting, and statements have been required from those who can support the investigation process. Final Q&SE Meeting for Martyn Read MR advised that this would be his final Q&SE Meeting. HR thanked him for his support and dedication and welcomed CS moving forward. Suite 19 – an update CM advised that T5 has been restored but they have encountered issues with the shower facilities and also water intake. A meeting is to be arranged for a walk-around to assess the issues further. Electronic Wristbands SC advised that the implementation of the electronic wristbands was ongoing, however in some areas within the Health Board, the absence of USB cables and cartridges and also installation of the Wristbands link on designated computer desktops are being managed. Waiting list death – Cardiac Surgery An M&M meeting was held on 8th October, 2018 to discuss this incident. The cause of death is yet to be confirmed and the post mortem is pending.	**HW**
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business None	
PART 5: ITEMS TO BE RECORDED AS RECEVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information – circulated as part of the agenda • Cardiff Health Board SPE Tables Your NHS Experience • Traceability non-compliance for September 2018 • Welsh Health Circular – Sensory Loss Communication Needs	
PART 6: DATE OF NEXT MEETING		
6.1	Thursday 1st November, 2018, 8am, in the Critical Care Resource Room, UHW.	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Thursday 1st November, 2018
Venue: Critical Care Resource Room

MINUTES

In Attendance:

Carys Fox (CF), Chair, Director of Nursing, Specialist Services Clinical Board
Colin Gibson, Clinical Engineer, Rehabilitation Engineering, REU/ALAS
Vince Saunders (VS), IP&C Lead
Mary Harness (MH), Senior Nurse, Haematology
Bev Oughton (BO), Senior Nurse, Critical Care
Gareth Jenkins, Service Manage, Haematology, Immunology and Medical Genetics
Orla Morgan, Lead Nurse, Critical Care
Holly Williams (HW) Patient Quality and Safety Facilitator
Rafael Chavez (RC), Consultant, N&T
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Rachel Barry, Lead Nurse, Neurosciences
Jayne Marchant (JM), Sister, Critical Care
Helen Scanlan (HS), Interim Directorate Manager, N&T
Claire Main (CM), Lead Nurse N&T
Sian Williams (SW), Senior Nurse, Cardiothoracic
Lisa Higginson (LH), Senior Nurse N&T
Yvonne Hyde (YH), CNS, Infection, Prevention and Control

Not present but referenced:

Ceri Phillips (CP), Lead Nurse, Cardiothoracic
Ruth Stone (RS), Staff Nurse/Practice Educator, Neurosurgery
Kirsty Britton (KB) Senior Staff Nurse/Practice Educator, Nephrology and Transplant
Nav Masani (NM), Consultant Cardiologist, Clinical Board Director

PART 1: PRELIMINARIES		**Lead**
1.1	Welcome & Introductions	
1.2	Apologies for absence Received from Gemma Williams, Steve Gage, Matthew Price, Suzie Cheesman, Hywel Roberts, Craig Spencer, Jennifer Proctor, Maria Roberts, Anne Marie Morgan, Keith Wilson, Ravindra Nannapaneni, Ceri Phillips	
1.3	To review the Minutes of the previous meeting 12th October, 2018 The minutes were agreed as an accurate record. Matters Arising Lanyards • CF will circulate the order form/information for Directorates to action/order accordingly. Surveillance of Patients on the waiting list for Cardiac Surgery	**CF**

	• No update due to no Cardiothoracic representation at the meeting (at this time). Update from 20th September 2018 however: ✓ *CP advised that the Cardiff and Vale waiting list was being monitored, with Cardiac Out-Patients being provided with a card to document and report any changes in their wellbeing. This card is to be finalised and then implemented.* <u>M&M Meetings</u> ✓ Reponses received from Haematology and Critical Care. Please can the remaining Directorates confirm their criteria for selection for discussion at M&M <u>Suite 19</u> ✓ A meeting will be arranged to support a walk through the suite. ✓ There was a discussion regarding the quality of work completed on T5, and how this may compare to other Specialist Services areas such as B4 Neurosurgery. The doors have been delivered but not yet affixed.	**N&T, Neurosciences & Cardiothoracic**
1.4	<u>Patient Story:</u> Presented by JM, Critical Care.	
PART 2: SAFE CARE		
2.1	<u>ANTT update</u> **Neurosciences:** nursing improvements reported, with all Wards exceeding 80% compliance. RS, practice educator is reviewing this focus further and a meeting with LD has been arrange to discuss. Medic involvement is the next focus regarding training. **ALAC:** all nurses are compliant **Cardiothoracic:** C5 have 7 nurses left to complete training. All others are 100% compliant. Medical staff is unclear but likely to be a significantly lower compliance rate. **Critical Care:** CITU reports a 75% compliance and GITU have identified that the assessment process is a difficulty for new staff. Medical and trainees will also report a significantly lower compliance rate. This will be an agenda item for the HCAI meeting in November, 2018. **Nephrology and Transplant:** KB is supporting with this focus. The nursing staff are reporting 100% compliance. The homebased team is to be assessed however. The medical staff will report a significantly lower compliance rate. Patient-focused dialysis training is ANTT compliance. They are re-assessed every 6-months. **Haematology:** all staff are practically assessed. Completing ANTT training online is difficult and remains and ongoing process. Junior medical staff do not use any devices until they are assessed. Staff and Consultants are assessed annually. OM queried whether NM would be able to circulate communication regarding ANTT training compliance and its importance. There was also a consideration regarding the Practice Educators' capacity to deliver this.	
2.2	<u>Open Serious Incidents (SIs) & Closure Forms</u> These were briefly reviewed with 18 presently open. The Clinical Board is progressing with the closure of incidents, with one confirmed for October, 2018. <u>Open Inquests</u> One patient inquest discussed with this scheduled to take place on 5th November 2018. CM is in contact with the patient's family. An Improvement Plan Meeting was scheduled for 31st October, 2018. The Improvement Plan will need to attend to more impactful improvements at a Health	

	Board level.	
2.3	Patient Safety Alerts Medicines Safety Briefing & Infected Blood Inquiry Retention of Medical Records. *Not discussed during the meeting but embedded in the agenda for review.*	
2.4	M&M Reviews See section 1.3	**N&T, Neurosciences & Cardiothoracic**
2.5	Healthcare Associated Infections B5 MRSA reported: VS advised that this HCAI was likely to have developed from a cannula as the skin surrounding this was red and inflamed. The cannula was placed and removed in Royal Gwent prior to admission to UHW. Blood cultures were correctly taken on admission which isolated MRSA. The group agreed that this should not be assigned to B5 but within the All Wales surveillance rules it will. CF will discuss with Eleri Davies B4 MRSA reported: VS advised this was instead MSSA reportable. VS confirmed the next HCAI meeting is due to take place on 13th November, 2018, with mandatory attendance expected (medical representation) – extraordinary meeting. The increasing numbers of HCAIs is a cause for concern, and whilst the population we provide treatment for is vulnerable, the HCAI figures reported in 2017-2018 were not as high. It is important to follow agreed protocols and pathways to ensure that the HCAIs are avoided. Practices which should support: ✓ PVC/VIP scoring; ✓ PVC insertion packs and the sticker to be affixed to notes - documentation is vital; ✓ Roadside cannula insertion and possible HCAI risks following admission. Critical Care have developed visual stickers to support with identifying these; ✓ Intentional Rounding – CP, SW and HW have made arrangements to meet on 13th November, 2018 to discuss this further. **Query** – PVC insertion packs and ChloraPrep may not always be used in Theatres. CF to discuss with Theatres OM proposed that regular checks of lines inserted are undertaken and these are to be led by the Lead and Senior Nurses. There should also be Clinical Director investment. VS will review the data to support with further analysis. C-Difficile: No cross contamination – patients are in isolation or in the process of being isolated. RCA process: completion of these is essential and the lessons learned templates are being completed. STOP Campaign is being re-launched 5th November, 2018, with ward visits plans and a stand available in the Concourse during w/c 12th November, 2018. Directorates to advertise and support. Good hygiene is fundamental, including hand hygiene. LD queried whether NM could circulate the Bare Below the Elbows/Hand Hygiene letter to further support this focus. VS advised that the Clinical Board are reporting a compliance of 85% for Hand Hygiene. YH advised that blood culture pack compliance is low – this needs to be attended to. Flu Update	**CF** **All** **CF** **VS** **ALL** **VS/YH** **All** **All**

	MH advised that data was being collated and submitted weekly to ensure data quality. Flu vaccinations in Rookwood Hospital was queried due to possible accessibility issues. Current compliance was discussed and also the availability of vaccinations to the over 65 years category of people. ***For information:*** • Llantrisant Dialysis Unit – 2 patients have alleged increase in HCAI incidences. Dr Vinod Ravindran is leading a review of this.	**MH** **VR**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee Not discussed	
3.2	Exception reports and escalation of key QSE issues from Directorate QSE groups See below under Urgent Business	
3.3	Datix Update HW provided a summary of the overdue incidents requiring review. She thanked those in attendance for the ongoing support in reducing these figures.	
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business Patient Management System (PMS) Upgrade: Saturday 17th November, 2018 – confirmed attendees were aware of this. Lorazepam Shortage: **Query** – awareness of alterative options – this was confirmed by the attendees. OM advised that following a staff assault from a patient on Critical Care, the patient has been prosecuted. Further details will follow. CF raised the issue around the 'shackling' of patients who are prisoners when there is a risk/incidence of violence/aggression/absconding and when there is no risk especially when prisoners are seriously ill or at end of life..	
PART 5: ITEMS TO BE RECORDED AS RECEVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information: Neutropenic Sepsis Pathway	
PART 6: DATE OF NEXT MEETING		
6.1	Friday 23rd November, 2018, 8am, in the Critical Care Resource Room, UHW. *Please send you apologies in advance.*	

MEDICINE CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE MEETING
MINUTES

HEALTH & SAFETY FOCUS

Thursday 20th December 2018
9am – 11.30am
Classroom 2, UGF A Block, Main Hospital, UHW

Attendees:	**Jane Murphy (chair)** **Kath Prosser** **Suzie Cheesman** **Barbara Davies** **Gemma Murray** **Ian Dovaston** **Emma Mitchell**	**Fran Wilcox** **Derek King** **Rachael Daniel** **Jonathan Davies** **Gill Spinola** **Roisin Kirby *(minuting)***
Apologies:	**Rebecca Aylward** **Sarah Follows** **Carol Evans** **Denise Shanahan** **Dr Jeff Turner** **Mudassir Pasha**	**Rebecca Owen-Pursell** **Dr Joe Grey** **Sharon O'Brien** **Delyth Jones** **Ben Durham** **Sarah Edwards**

PRELIMINARIES		**Actions**
A1	Welcome and Introductions The group were welcomed by JM, who advised that she was chairing in RA's absence. There was no presence from Acute or Emergency Medicine resulting in the QSE meeting not being quorate.	
A2	Apologies for Absence As above.	
PART 1: HEALTH & SAFETY		
1.1/ 1.2/ 1.3	Feedback from the UHB Health & Safety Operational Group RD provided the group with the following feedback: - A Police sergeant is now based in Hafan y Coed, UHL. They are assigned to the whole of the UHL site, not only Mental Health areas, - The Obligatory Responses to Violence in Health has now been circulated throughout the HB, which was drafted in order to protect UHB staff who that become victims of violence, - The recently updated Latex allergy policy, CCTV policy and Environment policies are available via the Intranet, please feedback any comments or concerns to the authors directly, as appropriate. RD also noted that there was no MCB representative at the group, which was a cause for concern.	

	JD, H&S Advisor, introduced himself to the group, advising that his current role within the UHB is to assist departments outside of Capital Estates Clinical Board with regards to contractor management. This is following the HSE reviewing our contractor management policy, with their findings advising that the policy left a lot be desired. JD advised that since commencing this work he has established that there have been several occasions in which external contractors have worked on site and not had any form of Induction which poses significant risks. JD advised that he would forward appropriate policies and procedures to RK for them to be circulated in conjunction with these minutes, and was happy to be contacted directly by staff for advice going forward to ensure compliance. JD also advised that it was important to consider that contractors are not just building contractors, but also include external service and equipment engineers too.	
1.4	<u>Fire Safety Report</u> For noting.	
1.5	<u>Workplace Inspection Update</u> Nothing to note.	
1.6	<u>Exception Reporting & Escalation of Key H&S Issues from Directorates</u> Clinical Gerontology BD advised the group of the ongoing issue with the Hoverjack based at UHL site, stating that the UHW Hoverjack was transferred to UHL and has been damaged whilst it was being utilised in Hafan y Coed, meaning that it is no longer fit for purpose. There is now a significant risk as the Hoverjack owned by Specialist Services, which is currently the only one on site, in UHW is now damaged as well. BD advised that, to combat this ongoing issue, the Clinical Gerontology directorate have submitted a capital bid for a Hoverjack specifically for their directorate to alleviate pressure on their wards. Discussion ensued with the group in agreement that the equipment is not particularly robust and susceptible to damage, however, there is currently only one manufacturer for this equipment so there is currently no choice other than to purchase from them. BD also advised that she and the DMT had ongoing significant concerns with regards to the broken hoist on Ward West 6, which has been out of order for over 7 months, largely due to a tenuous maintenance contract with the manufacturer, Argo. Manual handling have loaned the ward a hoist as an interim measure, but ultimately this is an expensive piece of kit that is not being utilised and the ongoing situation is negatively impacting patient care. JM will escalate this to Geoff Walsh to progress this. Internal Medicine EM advised that Ward C6 has some broking flooring that need to be repaired asap, and parts of Ward A4's ceiling are falling down which could become dangerous. It was also noted that Ward A1 has areas where paint is peeling off the walls, which makes the environment looked tired and unpleasant for both patients and visitors. Other than this there are no other major issues for noting. JM advised she would discuss the aforementioned with David Pitchforth, Senior Nurse.	**JM** **JM**

	Gastroenterology GS advised that ongoing hoist issues on Ward W1 are the directorate's main cause of concern. She continued that the Rheumatology Day Unit environment is an ongoing issue, with the area not fit for purpose. Liza Collins, Deputy Director of Operations, has escalated this issue to the Estates team again. No Emergency / Acute Medicine directorate representative at the meeting to provide an update.	
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP & ACCOUNTABILITY		
2.1/ 2.2	<u>Minutes of Previous Meeting / Matters Arising</u> The group were in agreement that the minutes of the last meeting were of an accurate record. All outstanding actions / matters arising in the last meeting were stood down and completed.	
2.3	<u>Patient Story</u> GS presented the group with a story regarding a patient on Ward West 1. The patient, who was reduced mobility, was bowel prepped ready for a Colonoscopy the following day. Unfortunately, the staff nurse on duty did not complete his admission documentation correctly, and also did not assess his level of dependency. When the patient was going to be taken to the toilet and moved via the hoist, the staff found that it was compromised. After a risk assessment completed, it was established that it was unsafe to use. This however meant that the patient was advised that they would have to use a bed pan. The patient felt his dignity was compromised and was unhappy with the situation. On review, the staff on duty confirmed that they had not attempted to locate another hoist as time is of the essence when a bowel prep had been given. In hindsight, the staff should have made efforts to source another hoist for the patient and the site manager should have been contacted. It was established that manual handling had two batteries that could have been used, and SRC had multiple hoists which could have been borrowed. GS assured the group that the staff involve have reflected and lessons have been learned.	
2.4	<u>Feedback from UHB QSE Committee</u> Please click the link below to access the notes of the last meeting. http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee-	
2.5	<u>Directorate QSE Minutes – Exception Reporting</u> Clinical Gerontology BD advised that their ongoing cause for concern are pressure damage issues. Gastroenterology GS advised that main areas of focus are falls reduction and reflection from patient story. GS also advised that contact had been made with representative form the Paeds Gastro team so discussion could occur with regards to the differences in transfer of care for our 16-18 year old cohort of patients. EM stated that she would be keen to see any related documents as she currently has two 17 year old patients within respiratory and palliative care. GS advised she would forward this to EM. GS will also forward to RK so she can circulate in conjunction with the minutes.	**GS**

HEALTH PROMOTION PROTECTION & IMPROVEMENT		
3.1	Flu Plan 18/19 KP advised that the current figures were extremely disappointing, with the MCB's current uptake figure now at 50.1%. In comparison, the front runner, CD&T, are currently at 66.1%. In order to achieve 65% target, the MCB would need to vaccinate another 300 staff. Emergency and Acute Medicine's directorate figures are particularly concerning, so they will be the main target area after the Christmas and New Year break.	
3.2	TB Risks in the C&V Health Board Population Deferred to next meeting, as Dr Simon Barry was not present.	
SAFE CARE		
4.1	New SIs KP advised the group that the MCB currently has a total of 34 open SIs. This month the MCB have so far had 13 SIs, with 8 to be presented for closure today: In76906 – Injurious injury from an unwitnessed fall resulting in a fracture to the left neck of femur. All risk assessments completed in line with UHB best practice. Identified as a high falls risk. Post falls procedures; not screened on the floor for any potential long bone injury. Hover jack not used to safely manoeuvre the patient from the floor in line with UHB and NICE 2015 best practice. Falls simulation training being undertaken within the Clinical Board In77541 – Injurious injury from a witnessed fall resulting in a fracture to the right neck of femur. Post falls procedures not undertaken in line with UHB and NICE 2015 best practice. Falls simulation training being undertaken within the Clinical Board In77421 – Healthcare acquired Grade 3 avoidable pressure damage In78133 – Unavoidable healthcare acquired pressure damage. Secondary to an increase in the number of healthcare acquired pressure damage being reported within this clinical area an overarching action plan has been developed which includes ongoing education and training for all staff (including new starters),additional mattress selection training provided by Medstrom, guidance on the correct process for fitting sheets on new Prom mat mattresses, raising pressure damage awareness at Safety Briefings, improvements with documentation and engagement with all patients/relatives and carers. In60061 – Injurious injury from an unwitnessed fall which resulted in a fracture to the left neck of femur. Identified that there was a delay in the fracture being diagnosed as this was difficult to establish on initial review of the electronic film. Delay in formal report being received and reviewed secondary to a bank holiday period. Also, a further missed opportunity for the ward consultant to review the x ray film and report when ward rounds undertaken. In76967 – Unavoidable healthcare acquired Grade 3 pressure damage. BD advised that at the last UHB Health and Care standards meeting, it was noted that there is still a supply of bed sheets circulating through the UHB which are not fit for purposes and need to be disposed of. The introduction of green bags solely for the use of disposing these mattresses will be occurring imminently. KP advised	**KP**

	that going forward in January, the UHB will only be reporting avoidable pressure damages to Welsh Government, which is pleasing. In55490 – Never Event: patient admitted to the Assessment Unit and received a unit of blood intended for another patient. Route causes identified as incomplete training and competence assessment procedures. Complex process but the All Wales transfusion chart is designed to guide staff safely through the process, could it be more explicit. Use of temporary staff unfamiliar with local procedures to assist with this task. Inadequate awareness of safety systems, ie, weakness of double checking procedures. Incomplete competence assessment procedures for the agency nurse. Absence of a central electronic data collection tool to record and monitor clinical competence compliance. The Laboratory Medicine Directorate needs to progress implementation of the Blood Track system as part of the All Wales Laboratory Information Management System in line with scheduled implementation programme. All actions taken to date include: Immediate actions taken: The nurse staff involved has been supported and informal counselling provided. The nurse was withdrawn from the administration of all medicines until further training and supervisory support was implemented. The Cardiff and Vale Procedure for the management of staff involved in medication errors has been undertaken. Attended Medicines Management training 5/12/2017 and 12/03/2018 and resumed normal practice Attended intravenous drug administration training 15/12/2017 Attended infusion device training 16/05/2018 and assessment of new pumps 06/09/2018 Completed blood transfusion administration assessment 28/12/2017 Written reflection undertaken on the error and lessons learnt 04/07/2018 The bank and agency induction checklist is completed for all staff new to the clinical area as a means of orientating them to the department and local/UHB policies and procedures Communication to all staff members across the Medicine Clinical Board to re-inforce UHB Blood Transfusion Procedure was completed 18/10/2017 and shared via group social media website. In addition an Internal Safety Notice ISN 2017 003 was shared at Medicine Clinical Board Quality, Safety and Experience meeting November 2017 Practice Development Nurses across the Medicine Clinical Board are monitoring and assessing staff for blood transfusion. This information is shared at Clinical Board Quality, Safety and Experience meetings to update in terms of progress and barriers Each clinical area has a blood transfusion assessor who can review individual members of staff's competencies All areas are required to inform competency assessments and updates at ward level which notifies the Learning, Education and Development department (LED) for the Electronic Staff Record (ESR) to be updated It is reinforced to nursing staff via their Nursing and Midwifery Council Code of	

	Conduct of the need to work within the limits of their competence. This is further reinforced during staff revalidation procedures The UHB Blood Transfusion Group is reviewing its Terms of Reference to ensure it is monitoring compliance with training and education requirements. This is as set out in transfusion related patient safety solutions issued by Welsh Government and the former National Patient Safety Agency In 2014 the Welsh Blood Service Better Blood Transfusion Team reviewed the requirements of the former National Patient Safety Agency's (NPSA) Safer Practice Notice due to challenges reported by all Health Boards in meeting the competency assessment requirements. Following discussion at the All Wales Clinical Advisory Group, All Wales Alerts Working Group and NHS Wales Nurse and Medical Directors, a range of measures were suggested to assist Health Boards/Trusts in managing the requirements. Further to this incident, LED department has raised concern deviating from the requirements of the NPSA Notice. The UHB has taken a view that the priority is to strengthen recording and mechanisms of this clinical competency before deviation from the NPSA Notice can be further considered The UHB Learning and Education Department are working to record clinical skills and competence on ESR on a new module. Clinical skills competencies can be recorded on ESR with a three year expiry date in line with UHB competency update requirements. When the clinical skill competence is updated at ward level, notification is sent to LED for the ESR to be updated. Through the recording of competence achievements on ESR, reports with compliance and non-compliance can be generated LED are working with the Blood Transfusion Team on the clinical skill of 'administration of blood' competence The All Wales Transfusion Chart is due to be discussed at a Welsh Blood Service meeting December 2018 A Consultant Anaesthetist provides ad hoc training sessions on Human Factors within the Health Board. A half day session on Human Factors to blood transfusion link nurse programme was held in May 2018 with a full day session session scheduled as part of the programme Leading Improvements in Patient Safety. The Head of Patient Safety is exploring options for funding Human Factors in the UHB In65589 – Gentleman attended the Assessment Unit at UHW and was unfortunately held on an ambulance with a WAST non paramedic crew for a significant period of time secondary to pressures across the UHB. As the patient was being transferred from the ambulance stretcher to a trolley the patient suffered a cardiac arrest and sadly died. Cause of death was established as renal failure and an underlying metastatic carcinoma of unknown origin. Reported to Her Majesty's Coroner with no inquest required. RCA concluded that it was difficult to establish that if the patient had been transferred to a trolley sooner if the outcome would have been the same. Significant learning and actions undertaken include the requirement to ensure that all patients who are expected into the Assessment Unit are triaged within 15 minutes and escalated if unable to undertake this. Internal professional standards in place. Departmental Escalation updated to support the escalation of any patient and off loading delays. Additional	

	co-ordinators in place to facilitate flow in the assessment unit. Two hourly huddles embedded across the Acute and Emergency footprints. Extended Senior Nurse cover within both departments to support staff and flow. A Standard Operating Procedure is being developed to support staff within the Assessment Unit when they can no longer accept patients into the unit. The Medicine Clinical Board Hub is well established and provides senior support and decision making to aid patient flow through all areas. Out of hours responsibility falls to the Site Manager and Senior Manager on call with plans made at the last capacity meeting 18:00 with Clinical Board presence. Lightfoot Workshops have commenced across the Clinical Board to look at pathways to improve patient flow including admission avoidance, diagnostics. BD advised that at the last UHB Health and Care standards meeting, it was noted that there is still a supply of bed sheets circulating through the UHB which are not fit for purposes and need to be disposed of. The introduction of green bags solely for the use of disposing these mattresses will be occurring imminently. KP advised that going forward in January, the UHB will only be reporting avoidable pressure damages to Welsh Government, which is pleasing.	
4.2	<u>Patient Safety Alerts / MDAs / ISN</u> For noting.	
4.3	<u>Endoscope Update</u> An update regarding the recent Pentax endoscopes contamination issue: it has been established that two of our scopes have been affected, meaning that approximately 120 patients could be potentially at risk of exposure to a blood born virus. A communication update will be circulated after the Christmas and New Year break.	
4.4	<u>Revised National Falls Audit</u> KP advised the group that the last National Falls audit was completed by Dr Anthony Johansen, Consultant Orthogeriatrician, in 2014, and there has since been a change to the assessment style, which is now a continuous audit system. This will focus on patients who have sustained injurious hip injuries only. KP will circulate any further updates as they occur.	
EFFECTIVE CARE		
5.1	<u>Director of Nursing Quality & Safety Reports</u> JM advised that other than the amount of open eDatix reports and some ongoing IP&C issues, her and RA are really pleased with progress in all directorates. JM also noted that the MCB are currently at 93% compliance with regards to answering and closing complaints, and JM thanked the group for the increased efforts.	
5.2	<u>Infection Prevention & Control Update</u> DK presented the group with this month's IP&C report, advising that the MCB are currently at 172 days since the last MRSA incident, and 19 days since the last eColi. The report was circulated prior to the meeting and will again be circulated in conjunction with these minutes. JM asked the group to continue efforts to close down any open RCAs, noting that a particular RCA from B7 which has been open for over a year. JM / GM will contact B7 Ward Manager, to action the closure.	**JM/GM**

	DK confirmed that he would close down the open RCA from last year's winter ward (West 3). Discussion ensued with regards to particular situation in which a Consultant has reported cDif in patient that was dying from another cause which is an inaccurate representation of the scenario. JM asked DK to ensure that IP&C team feed the inappropriateness of this back to the Consultant in question, with DK advising that Consultant Microbiologist Dr Rishi Dhillon will be setting up a meeting in order to feedback this information.	**DK** **DK**
DIGNIFIED CARE		
6.1	Read About Me Compliance in Read About Me throughout the MCB was quite low, so Denise Shanahan, PCIC Consultant Nurse, asked GM to complete an audit. GM found that audit scores were rather low, due to staff not completing the workbook correctly. Therefore, GM created a checklist to ensure Read About Me compliance going forward. The checklist and audit findings were circulated to the group prior to this meeting. EM confirmed that the checklist will not be a long term addition, but will be utilised in the short term to inform staff of the correct procedure. Another audit will be completed at end of January to ascertain whether compliance levels have improved. JM queried whether this booklet will be used on the Heulwen winter ward. EM will confirm this and advise JM outside of the meeting.	**EM**
TIMELY CARE		
7.1	Model Ward Feedback KP presented the group with a compliment letter from a patient's daughter regarding the care had received. For noting.	
7.2	My Orange Smile – Be Patient With Me EM had to leave meeting early due to diary clash so was unable to present this item. Deferred until the next meeting. JM queried whether all the posters and badges associated with the campaign had been rolled out in all Directorates. GS and FW advised that they had not yet received them in their areas. JM to chase this outside of the meeting.	**JM**
INDIVIDUAL CARE		
8.1	National User Experience Framework Feedback – 2 Minutes of your Time – Relevant Improvement Plans JM advised that she had been working with Aron White and Beverley Evans from the Corporate Nursing team, in order to present the data back to the ward staff in a summarised, concise format. JM presented a short video slideshow to the group, which condensed and broke down the reoccurring themes of feedback over the last 6 months. The video was well received by the group. BD queried the timeliness of the information, as some of the data presented could be up to 6 months old. JM advised that we would be able to amend this. This work has been well received by colleagues so far, and will be tabled at the next UHB NMB meeting for shared learning.	
8.2	Complaints and Trends For noting. JM asked that the group ensure that both documents circulated prior to this meeting be disseminated widely through their directorates and working areas.	**All**
STAFF & RESOURCES		
9.1	Winter Pressures – Staffing	

	JM advised the group that 14 beds on Winter pressure ward, Heulwen, have been opened and are currently being utilised for IP&C patients. The main challenge regarding the winter ward is that the remaining beds are due to be opened at the end of January, but at present we do not have enough resource to safely staff the other end. At present, the MCB SMT do not feel it is safe to open to ward, and the Triumvirate are drafting a paper to the Executive team advising that, without further support from the other Clinical Boards, the additional beds cannot be utilised. Further update will be provided at the next meeting.	
ANY OTHER BUSINESS		
10.1	Feedback on MCB Educational Hub GM and ID advised that the MCB Educational Hub is well established and being utilised well, with almost 200 members. JM encouraged ID to contact the Comms department so that they could signpost more staff to the Hub. KP advised that the new MCB IP&C Newsletter could go on there too. Sam Davies Unit – Praise for Dementia Work BD noted that the Sam Davies Ward, Barry Hospital, were mentioned in Christmas message from Maria Battle regarding their good work concerning Dementia.	
DATE & TIME OF NEXT MEETING		
	Thursday 17th January 2019, 9am – 11.30am, Venue Classroom 2 UHW	

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 6th November 2018, 08:00-10:30 hours
Council Room, A Bl, UGF, UHW

CONFIRMED MINUTES

Present

Linda Walker	Director of Nursing, Surgery CB	LW
Richard Hughes	Consultant Anaesthetist (Chair)	RH
Gillian Edwards	Lead Nurse, T&O	GE
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Ophthalmology	AJ
Angela Jones	Senior Nurse, Resuscitation Service	AngJ
Babs Jones	Educational Lead, Perioperative Care	BJ
Mark Bennion	Clinical Governance Facilitator, Perioperative Care	MB
Claire Mahoney	Infection Prevention & Control	CM
Adrian Turk	Pharmacy	AdT
Graham Roblin	Quality & Safety Lead, ENT	GR
Chris Williams	Quality & Safety Lead, Ophthalmology	ChrW
David Scott-Coombes	Quality & Safety Lead, General Surgery	DSC
Simon White	Quality & Safety Lead, Trauma & Orthopaedics	SW
Rafal Baraz	Quality & Safety Lead, Anaesthetics	RB
Jan Collins	Senior Nurse, Perioperative Care	JC
Lewis Jones	Service Manager, Ophthamology (for Patient Story)	LJ
In attendance:		
Sarah Watts	Legal Services (for Item 1.6)	SarahW
Edwina Shackell	PA, Surgery Clinical Board	ES

Minute	Subject	Actions
18/142	**Patient Story: Ophthalmology: In53281** **LJ** presented the background to this Never Event. The NICE guidelines for Wet AMD stipulate 14 days from referral to treatment. The delay of 29 days in seeing the patient had resulted in an inability to treat the condition. The patient is currently listed for a cataract procedure, but the prognosis is guarded. Key findings: ▪ Lack of available clinic capacity. ▪ Referral process: all Wet AMD referrals are sent straight to diagnostic clinic, with a conversion rate of 20 – 40%. Patients not requiring treatment could possibly be seen in other clinics. The potential impact of on those clinics was noted. ▪ Complex new outpatient booking process: nurses were using a paper system, with Medical Records being asked to input onto PMS and set a 'To Come In' (TCI) date, resulting in an incomplete PMS audit trail. ▪ Variation in booking process: there was potential, as in this instance, of the patient being made aware of the importance of the appointment via the optometrist, but this not being validated by secondary care. ▪ No formal process for escalating patients booked outside 14 day process.	

	Root causes: ▪ Insufficient New Outpatient Wet AMD capacity. ▪ Complex booking process with no clear ownership. The patient's 2 periods of unavailability had been incorrectly recorded on the PMS Inpatient record, not Outpatient record. There was a lack of audit trail on PMS or email of the patient being offered earlier dates. The patient did not recall being offered earlier dates. Possible variation in phone contact as no guidance or flow chart were available. ▪ Undefined escalation process. Recommendations: ▪ Audit of AMD referrals to establish suitability of patients. One consultant had offered to review patients to see if they would be better suited to other clinics. ▪ Potential options being discussed for a pre-diagnostic clinic to take place led by qualified nurse or optometrist. ▪ AMD coordinator to take over booking of patients with agreed written guidance and process flow-chart in place. ▪ Escalation process in place to report patients who are not being seen within 14 days from referral as per NICE guidelines. Discussion: ▪ It was confirmed that incidents of patients waiting over 14 days to be seen must be reported via Datix. ▪ It was noted that work at Clinical Board level is underway to address the imbalance of number of referrals and number of outpatient appointments available. ▪ Concern was noted regarding the projected growth of population and its impact on the service. ▪ It was acknowledged that the number of Serious Incidents/Never Events escalated to the Welsh Government would be expected to trigger a WG response in terms of investment.	
PART 1: PRELIMINARIES *(Chair)*		
18/143	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
18/144	**Apologies for Absence** Received from Clare Wade, Catherine Evans, Adam Wright, Oleg Tatarov, Ceri Chinn.	
18/145	**Declarations of Interest** None declared.	
18/146	**Approval of the minutes of meeting held 25th September 2018** The Minutes were **APPROVED** as an accurate record.	
18/147	**Matters Arising** The Action Log of meeting 25th September 2018 was reviewed: <u>18/41: 25/9/18. AWMSG Ref 2224. Cefuroxime 50 g powder for intracameral injection, authorised by Clinical board for use</u>. CW confirmed that this had been discussed at Ophthalmology Quality and Safety session, when it became apparent that there were two preparations. CW sought advice from AdT whether both were pre-preparations. **Action: AdT to confirm**. <u>18/105: 3/7/18. Intralipid Paediatric Dosing Guideline.</u> RB to request that an e-mail confirming that this had been discussed with Paediatric Anaesthetists, be sent to RH. **Action: RB.** **<u>Note post meeting</u>: confirmatory email received from Mari Roberts 8/11/18, Consultant Paediatric Anaesthetist. CLOSED.**	**AdT**

	18/105: 3/7/18. Orthopaedic Thromboprophylaxis regimes. SW advised that the consultant body had wanted to switch to aspirin. This was currently on hold, as aspirin is an off licence drug. To be discussed again this month. There were implications associated with documented informed consent. NICE guidelines advise use of aspirin, but the data sheet does not cover aspirin. AdT confirmed that this would never be covered by licence. Documented informed consent is needed. **Remain action log, update next time. Action: SW** 18/121: 25/9/18. NATSIPPS Progress Report. Agenda item. **CLOSED.** 18/123: 25/9/18. Healthcare Standards Audit: General Surgery, Urology, Head & Neck to be provided. Action: AJ to check. **Post-meeting note: Action plans received 9/11/18. CLOSED.** 18/127: 25/9/18. Nice Guidance: MTG37 March 2018. Unclear why attributed to Mr Roblin. **Action: LW to review and reallocate as appropriate.** 18/127: 25/9/18. Nice Guidance: IPG611 April 2018. Confirmation required from Mr Tatarov or Professor Kynaston. **Action: ES** 18/129: 25/9/18. Training of staff to use Evac Chairs. Noted that this was a corporate issue. **CLOSED.** 18/136: 25/9/18. Open Inquests: T&O Concern received via Specialist Services, incident 1/7/18. Surgery CB had been unaware this had gone to Inquest. Deferred in absence of Cath Evans. **Action: update next meeting. CE.** 18/139: 25/9/18: Serious Incidents: Ophthalmology. LW advised that the investigation work was underway, in close cooperation with the Consultant Ophthalmologists. Updates would be provided. **CLOSED**	**SW** **LW** **ES** **CE**
18/148	**Legal and Risks Services** SarahW explained the role and remit of the Legal and Risk Services team with its dedicated Cardiff Clinical Negligence team. The estimated cost as at 16/17 of settling all claims in Wales, is £546 million. This was because lump sums awarded are no longer discounted as investments no longer gain 2.5% interest. Cardiff and Vale UHB currently have 268 open Clinical Negligence (CN) claims. The breakdown was described in terms of potential costs. Clinical Board support is sought to reduce the number of claims, the damages paid and the costs of settling claims. Key to reducing the number of claims is to focus on: • Effective Communication – between teams/handover/with patients (manage expectations) • Follow Guidance/Internal Protocols and Guidelines • Clear internal protocols - the Darnley case (another Health Board) was described. • Administrative errors – tight procedures • Supervision of junior staff • Be open when things go wrong • Learn from claims/incidents/concerns. How do you extract and share learning? • Liaise with other directorates to share learning. • Documentation – good and easily found. E.g. email trails need to be disclosed. Claims will be forthcoming for misinformation	

Key to reducing legal costs:

- Engage**,** be involved in your claims
  - The longer a claim goes on the more costs increase. It could be a challenge to get comments from clinical staff, and the longer they run, the more claims cost.
  - If in proceedings costs go up faster
  - Be pragmatic/realistic early on – avoids wasting time and money
  - If they are involved early on, if a claim goes to trial, staff will be fully prepared
- **Understand the law**
  - Breach of duty of care. Legal training on what is a legal claim can be provided.
  - Causation
  - Injury

Putting Things Right (PTR) - provide fully considered reports quickly

- Part 24 – factual. Do not get expert opinions on breach of duty to care. Experts are not part of the legal proceedings which can make a claim difficult to defend.
- Part 26 – qualifying liability
- Real opportunity to avoid costs

Investigating Officers (IO) must ensure documentation is well kept.

- **Legal process – when will you be involved?**
  - Comments - pre-action, expert reports. An independent expert in the same field is needed.
  - Input re expert witnesses
  - Factual witness statements
  - Attendance at conference/s
  - Attendance at court
  - In-house overviews

Why are lawyers advising we settle this wholly indefensible claim?
Taking to trial is a judgement call, an analysis of risk/benefit.
If the Health Board takes case to trial, and wins, it does not get legal costs back.
Other factors taken into consideration were described.

Why defend a low value claim?
Important reputationally and the right thing to do, and gives a clear message that the UHB doesn't just settle.

Discussion: key points:

- Emails. An update from Information Governance had been received in which required sent emails to be deleted and not stored. This is a concern. Were they retrievable from a server? SarahW believed this may be the case. However if emails refer directly to a patient, they should be stored in the patient record, or electronically.
- Locum staff and handling of complaints. All complaints are now dealt with by the UHB Concerns Team, with the complainant becoming increasingly stressed by the delay. There can be a six week delay in Concerns contacting the clinician. SarahW's view was that if written comments can be submitted as soon as possible, or speak to the patient on the ward, this could avoid the formal route. Legal and Risk is encouraging mediation i.e. IO, clinician and Concerns Manager to meet patient/family in mediation.
- Responsiveness of Legal and Risk Team was raised as a concern. In response to a question concerning a specific case raised by AngJ, SarahW asked that the details be emailed to her for review.
- Adherence to written guidelines. It was noted that there were expertly written guidelines for specialties for example anaesthetists. If a guideline was not adhered to as a professional judgement, where would colleagues stand? SarahW acknowledged that there could be a very good clinical reason why a

	specific protocol was not followed, but the guidance would be part of the evidence. The key is for Legal & Risk to be informed that the guidance exists.	
PART 2: PATIENT SAFETY AND QUALITY		
18/149	**System Failure – MteD access** An IT failure in the electronic discharge system was noted to have occurred on average once a month over the last 6 months. 1. The consequences for the discharged patient was that although patients could be given a paper TTH as historically for their GP, there would be no electronic information on the patient's stay. A growing number of patients' electronic information has been suspended. There was no mechanism for the sender to know whether the electronic communication had reached the GP or not. There was no trigger for the sender to go into the system and complete it. 2. Mitigation of risk. Teams are being asked to complete TTHs electronically throughout the patient's stay. 3. All Clinical Boards are being asked: ▪ Paper TTHs – where did colleagues want these sited? 24/7 access essential. ▪ How will Clinical Boards identify patients discharged where an electronic TTH is not done? Discussion: Key issues ▪ What action is IT taking? How would we know which patients have gone through and which haven't? ▪ Instances of Drs not looking for the TTHs, which then go nowhere. Rotation of Junior Doctors can result in them not completing and closing down TTHs. ▪ Lack of time to deal with an IT error when discharging numerous patients. ▪ Onus is on IT to let departments know what has/hasn't gone through. IT have no mechanism for seeing what has not gone through. Colleagues need timely information of when the system recovers and what hasn't gone. ▪ AMD for IMT: deemed they are responsible to resolve this issue and/or inform teams. ▪ If a discharge summary is written partly on a yellow TTH, is this worth then inputting electronically for completeness? ▪ The Clinical Board is being asked for a contingency plan for an IT problem. **Action: AdT to raise with IMT to determine what plans there are to resolve this.**	**AdT**
18/150	**Standing Item: NatSIPPS Progress report** The Clinical Board has made good progress: Perioperative Care: Confirmed that all procedures are being reviewed on a rolling basis, and converting to LocSIPPS. The Status template had been completed as required. Trauma & Orthopaedics. LocSIPPs on Botox injection being worked through, and reviewing specific procedures as they arise. General Surgery, ENT, Ophthalmology and Urology to update next meeting. **Action: AJ**	**AJ**
18/151	**Director of Nursing Q&S Report October 2018** Serious Incidents reported to WG September 2018: Closed some long term incidents. Pressure damage incidence appears to have increased.	

	Medicine CB had reported an increase in pressure damage during the period of roll out of new beds. The UHB pressure damage group have oversight of such issues. Work is ongoing with regard to patients coming into Surgery beds with Grade 2 and progressing to Grade 3. UHB prevalence survey due in January/February 2019. Colleagues were reminded to open Datix reports. 185 over 60 days remain in the queue. Mental Capacity Act training. The Clinical Board is required to achieve compliance, particularly for Medical staff. Could this be progressed during an audit session? It was noted that ESR was not working. LW had escalated this to LED. Drug errors – 12, 4 of which are attributed to other Clinical Boards. Patient Surveys. Some comments are of concern. Top concern is waiting times. Concerns: 33 (a reduction) 76% managed through informal resolution. Informal response time 83% Formal concerns responded to within 30 days 80% improving. Overall a positive month. IP&C: E Coli a concern. In particular, Urology patients from the community with e.g. MRSA/CDiff, E coli. CM confirmed that positive samples taken within 24 hours of admission are not attributed to the Clinical board. **Action: CM to send guidelines to ES for circulation** C diff decrease. CM noted an approximate 50% decrease across the Health Board compared to the same period in 2017. Staff Aureus – concerning. CM referred to a recent Link Practitioner Study Day. Approximately 32% of bacteraemias were line related. VIP scoring reflects an apparent increase. It was acknowledged that the placement of VIP score at the back of patient documentation was not helpful. It was also felt that ANTT was a factor. CM advised that other Clinical Boards were reporting a lack of documentation for patients having cannulas inserted in theatres. **Action: Perioperative to address.**	**CM/ES – completed 6/11/18** **BJ/CC**
18/152	**Directorate Assurance Reports:** 1. General Surgery & Wound Healing, ENT, Urology & Ophthalmology. Report to follow. **Action: AJ** 2. Perioperative Services. See report. Key issues: ▪ Incorrect lens strength, cataract surgery. Never Event. ChrisW noted a concern regarding biometry in clinic. ▪ Endoscope decontamination. Incorrect decontamination of 2 scopes. Investigation underway. ▪ Refurbishment of decontamination room, main theatres. Out to tender. Contingency plans in place whilst room out of use. ▪ Use of Recovery for Critical Care patients. The Directorate and Clinical Board are in discussion with Specialist Services. A discussion regarding Day of Surgery Admission ensued around the table. LW advised that the assumption is that the patient goes to theatre, and a bed is found	**AJ**

	afterwards. It was acknowledged that the protection of DOSA beds could be overridden by Patient Access out of hours. The consequence was that patients were being looked after in Recovery. 3. Anaesthetics. See report. 4. Trauma & Orthopaedics. Report provided 8/11/18, saved on Shared drive. Key issues: ▪ Two reports of tourniquets left on patients. ▪ Two patients' NEWS score not escalated.	
18/153	**Exception reports from Directorates/Working Groups** 1. General Surgery, Vascular, Wound Healing. Nil. 2. Head & Neck, Maxillo-Facial and Ophthalmology. Nil 3. Urology. Nil 4. Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: ▪ Cardiac arrest on Heulwen ward. Staff have been asked to attend the Coroner's hearing. The anaesthetic team had experienced difficulty accessing the area due to door security access. It was noted that the arrest was well managed. RB advised that the process for ensuring all trainees were able to access essential areas had worked well. LW advised that there was no badge failure in this instance and was a systems failure which is being looked at. ▪ Serious Incident: Awareness under anaesthesia. The outcome of the investigation had been that the machine was faulty. MB to raise with RB/RH. ▪ Lack of airway equipment in some areas at UHL. RB reported that anaesthetists were extremely concerned. LW advised that this issue should be addressed by the anaesthetists with the person in the area responsible for putting the equipment on the Asset Register. RH advised colleagues to complete an incident form each time there was an issue with equipment. This had not been actioned. LW advised RB to escalate to named staff. Risk assessments and incident forms to be completed every time a piece of kit is missing. **Action: RB** ▪ Anaesthetic colleagues had raised the issue of equipment at UHL in relation to ENT lists. Resolution to this was in progress. 5. Trauma and Orthopaedics • Annual review of National Drug Registry had taken place 5/11/18. SW noted a slight concern regarding hip infection rates 2%, compared with the National 1%, Excellent would be 0%. The Orthopaedic Infection QI Group are looking at ways to improve this situation. **Action: QI Group Minutes to be received at this meeting**	**ES**
18/154	**Project Highlight Report: C.PMO.17.18.006 Stoma redesign 13/8/18** LW explained that she sat on the All Wales group. Welsh Government had mandated that this service be brought back in-house, which may have a significant cost implications for the Clinical Board. **RECEIVED and NOTED.**	
18/155	**Alerts and other Safety Notices** <u>NICE Guidance</u> 1. Surgery CB summary spreadsheet 2. IPG611 April 2018: Prostate artery embolization for lower urinary tract symptoms caused by benign prostatic hyperplasia (With HK) **Action: ES to chase** <u>Patient Safety Notice</u> 4. *ISN:2018/004: 4 October 2018: Fresenius Syringe pump users in acute secondary care*. Clinical Engineering addressing, checking syringe drivers. 5. *ISN:2018/006L 12th October 2018: Laryngoscope on resuscitation trolley*	**ES**

	inoperable due to no batteries. Ang J advised that this had been a unique situation, not assembled. Daily and Monthly trolley check forms had been amended. MDAs 6. *MDA/2018/29(Wales): 10 October 2018: BenchMark Automated Slide Stainer series – FLO LOK III Reagent Dispenser Issue for IHC and ISH kits including INFORM HPV III Family 16 Probe (B*). Not relevant to Surgery CB. 7. *MDA/2018/030(Wales): 10 October 2018: Flex connectors in Halyard Closed Suction Kits – risk of interruption of ventilation*. Not used in the Clinical Board. 8. *MDA/2018/032(Wales): 10 October 2018: Various trauma guide wires – risk of infection due to package failure*. Not used in the Clinical Board. MHRA 9. *2015/008/020/291/010 TL/2018/22: Serf Novae Stick acetubular cup in combination with Zimmer Biomet CPT femoral stem*. Not used in the Clinical Board. Public Health Link *10. CEM/CPhA/2018/15a: 28 September 2018: Epipen And Epipen Junior – Supply Disruption.* Being managed nationally. *11. CEM/CMO/2018/5: 18 October 2018: Protecting those aged over 65 from flu* It was noted that the UHB has not purchased this vaccine. AdT advised that 50 doses had been secured for inpatients. Nationally managed supply. 'Flu outbreak on B2 noted. 12. *CEM/CPhA/2018/16c 23 October 2018: Valproate Pregnancy Prevention Programme* – an Update for Pharmacists. **NOTED.** *13. CEM/CPHA/2018/16b 22 October 2018: Epanutin (Pheytoin) 30mg/5l Oral Suspension – Supply disruption.* **NOTED.** Public Health Wales Briefing *14. 24 October 2018: European bat lyssavirus found in serotine bat, England (adapted from PHE briefing).* **NOTED.** *15. 26 October 2018: Start of Respiratory Syncytial Virus (RSV) season in Wales.* **NOTED.** *16. 17 October 2018: Enterovirus D68 associated with severe respiratory disease and acute flaccid paralysis/myelitis.* **NOTED**. *17. Guide to clarify the Change to using Boric Acid Universal Containers within Microbiology.* **NOTED.**	
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
18/156	Key Messages from Board/ Committees/ Groups 1. UHB Medicines Management Group Notes 6th September 2018 ▪ Cancer associated thrombosis clinic/shared care. Ongoing discussions. ▪ Hydroxychloroquine retinal monitoring. Prescribed by Rheumatologists, total of 800 patients. This had been flagged to Mike Bond, Surgery Director of Operations. Chris W confirmed that the consensus is that the service can be provided, but needs to be funded. Potential for community or virtual clinic service. 2. UHB Medicines Management Group Notes 4th October 2018	

	▪ Hydroxychloroquine as above. Ongoing. ▪ 3e –medicines prescribing pathways and Health pathways work. Canterbury work involving e.g. Urology. ▪ Pain pathway review meeting with Primary Care 8th Nov. ▪ 4c – Start Smart then Focus - audit tool. Mandated for Junior Doctors. 3. Updates on understanding and reducing infusion related infection 22 Oct 2018 IV summit London 23rd Nov. 4. SBAR and Standard Operating Procedure for Managing Concerns from Staff. **NOTED** 5. Clinical Board IP&C Group – meeting deferred non quorate 22nd October; rearranged for 19th November 2018 6. Clinical Board H&S Group. Meeting 24th October 2018 – verbal update, deferred in absence of Clare Wade. 7. Infected Blood Inquiry retention of Medical Records. Letter from the Medical Director. Directorate teams are tasked with identifying and retaining at directorate level all relevant patient records 8. Decontamination Committee Minutes 3rd August 2018. **NOTED.**	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
18/157	1. IP&C RCA database and IP&C Surgery Clinical Board Update – discussed above. 2. Falls Report. injurious falls year to date. No common themes. 3. Pressure Damage Report – discussed above. Continue to monitor	
18/158	**National and UHB Audit Reports:** 1. Mortality Reviews A Stage 1 Mortality Review is to be conducted by a Junior Doctor in the Bereavement Office at the time of death certificate completion. Compliance is very poor. **Actions: CDs to remind Junior Staff.** **Action: LW to circulate out after Clinical Board, Friday 9th November** (subsequently cancelled) AngJ advised that all 2222 deaths have a Level 2 Review, but that data is not included. The question was asked, does there need to be more senior input at Level 1, as Juniors are failing to complete these?	**CDs** **LW**
18/159	**LIPS Progress Report – Perioperative Care** Nil to report. LIPS days frequently changed. Perioperative staff cannot be released to participate. **Action: Remove Perioperative from the Workplan 18/19.ES**	**ES**
18/160	**HIW/CHC visits** <u>AU/SAU CHC Report 2nd September 2018</u> LW advised that the Health Board had received the report on 7th September 2018 regarding A&E, but this was incorrectly labelled SAU. As the inspection was carried out on a Sunday, SAU was not open on the day, but the report referred back to a report 2 years previously when SAU was on A1L, which was SAU at that time. The report is currently sat with Medicine, with input from surgery.	
18/161	**Transfusion Committee** 1. Minutes of meeting 11th July 2018 2. Incident Report 1st June 2018 to 31st August 2018 **NOTED.**	
18/162	**Health Care Standards Self-Assessment** No update. Next iteration due Jan/Feb.	

PART 5: GOVERNANCE		
18/163	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. <u>Open Sis, No Surprises</u>: Discussed above. 2. <u>Regulation 28 report & Open Inquests</u> One inquest 20/3/19. The Clinical Board had formally requested that it be informed of concerns which proceed to Coroner's inquest, to enable staff attending to be appropriately supported. Coroner's cases formerly managed by Patient Safety are now being managed by the Concerns Team. This is of concern and will be raised at Anaesthetic Quality & Safety. **Action RH** 3. <u>Ombudsman's Report: 201700182L Recommendations</u> The report was reviewed. Key findings were noted: Deemed lack of informed consent (pre-dated Montgomery) Poor documentation The Report Recommendations included: ▪ An apology will go from the Chief Executive's office. ▪ The report to be used as a case study and it is discussed by its hip consultants to identify any further learning areas. This had been discussed at Trauma & Orthopaedic Quality & Safety 5/11/18/ **Action: SW to present to a future Board meeting, for shared learning with other Directorates.** 4. <u>Serious Incidents</u>: 1. Closure forms sent to WG since 1st January 2018. **RECEIVED and NOTED.** 2. Closed SIs report – please see Director of Nursing Report at 2.2 above. 5. <u>Complaints, Claims and other Concerns</u> 1. All New Personal Injury claims 1/4/18 to 30/9/18 – staff. **NOTED.** 2 No closed PI claims for the period. 5. <u>Learning from any closed claims</u>: CN-LLAN-2032: Checking pregnancy before Surgery. Settled, overall cost £4.5m.	**RH** **SW/ES**
18/164	**Patient Surveys:** National Survey Report for Surgery (Sept 2018) **NOTED.**	
18/165	**Research & Development** Joint Announcement CU and CVUHB: Establishment of a Joint Research Service Cardiff and Vale and Cardiff University will be partnership working in Research and Development.	
PART 6: DATES OF NEXT MEETING **Tuesday, 15th January 2019, 08.00 – 10.30 Seminar Room B, A Bl, UGF.**		
PART 7: URGENT BUSINESS		
18/166	<u>Perioperative Care:</u> BJ reported that a surgeon had attempted to bring a 16 year old into theatre (via the dental stream) within the previous two weeks. The Theatres Receptionist had correctly prevented entry. It was noted that the Medical Director had recently issued a clear directive that under 16s were categorically not permitted in an operating theatre.	
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
18/167	**Recent Reports & Communications** <u>Welsh Health Circulars</u> 1. WHC (2018) 030: 28 September 2018: Sensory Loss Communication Needs (Accessible Information Standard) 2. WHC (2018) 034: 31 July 2018: BCG Vaccine Supply and Ordering in	

	Wales 3. WHC (2018) 035: 10 October 2018: Welsh Government Policies for feeding in the first year of life – adoption of SACN recommendations 4. BAUS Report on the Endo-urology Residential Operative Course 5. WHC (2018)041: 5 November 2018: Raising Awareness of Carbon Monoxide Poisoning and Action Required by Health Professionals.	
18/168	**Directorate Q&S Agendas/Minutes** 1. Anaesthetic Q&S Minutes 11th September 2018 Received post-meeting: 2. Trauma & Orthopaedic Q&S documentation 17th October 2018	

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 26th June, 8.30am, Meeting Room, Clinical Board Offices Lakeside UHW

Preliminaries		**ACTION**
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing (Chair) Michelle Abel, Infection Control Nurse Bev Thomas, Asst HOD, Community Child Health Directorate Eirlys Ferris, Senior Midwife, Obstetrics & Gynaecology Directorate Cheryl Evans, Directorate Manager, Obstetrics & Gynaecology Directorate Matt McCarthy, Patient Safety Team Heather Gater, Interim Head of Therapies, Acute Child Health Directorate Ian Sprigmore, Directorate Manager, Acute Child Health Directorate Anthony Lewis, Clinical Board Pharmacist Mary Glover, Lead Nurse, Acute Child Health Directorate Laura Bassett, Risk Manager, Obstetrics & Gynaecology Directorate **In Attendance** Kirsty Hook, Board Secretary (Minute Taker) Nicole Parish, Clinical Psychologist, Acute Child Health	
1.2	**Apologies for absence** Angela Jones, Paula Davies, Suzanne Hardacre, Rachel Burton, Meriel Jenney, Sarah Evans	
1.3	**To receive the Minutes of the previous meeting 22nd May 2018** The minutes of the meeting were agreed to be an accurate record.	
1.4	**QSE bring forward action log / Matters Arising** The updated action log was noted for information on previous actions. There were no specific matters arising to note for this meeting.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **O&G** • Point of Care Flu Results from PHW were noted as 89.9% for 17/18. • 12 RCA's ongoing in Obstetrics and 1 RCA and 1 Case Review in Gynaecology which are being worked through • Security Tags for Babies are now implemented following the recent procurement process for the new system. • Grade 2 Pressure Area reported in Gynaecology. This has been reviewed and all measures were implemented however the family had chosen not to turn the patient. This has been documented in the notes. • Decontamination of the scopes work continues and it was agreed that a resolution is required. • X3 Medication Errors reported in May. These cases have been investigated.	

	• Post Mortem Consent Workshop is planned for 5th July • SANDS room almost complete on Delivery Suite and work is underway on the dignity suite following funding received from SANDS to complete. • Work continues on staffing and joint working with Cwm Taf Health Board with regards to governance and supporting them to address some issues there. Gaps in medical staffing, x2 locum posts are being advertised. **Acute Child Health** • RCA's have decreased, 2 active and 1 for external review at Great Ormond Street. • Hand Hygiene "Hands" on Gwdihw Ward has worked well with children. The Directorate are now looking to roll out into other areas. • Ten Fold Errors have increased. There is significant work being undertaken to address these in order to reduce. The Directorate are not an outlier compared to other Health Boards for paediatrics however there is more reporting being undertaken. Lessons learnt and information sharing is being undertaken. It was agreed that an audit and data collection would be undertaken in order to ascertain if there are specific trends or areas that require enhanced review. • Patient information boards are being implemented shortly. • Recruitment is ongoing and a number of vacancies within therapies have been appointed. There are still pressures within therapies for maternity leave. • RTT position is 36 weeks delivery for Quarter 1 and Quarter 2 is being worked towards. X2 Consultant Surgeons are commencing in July which will increase the WTE to 6 again. Nursing Staff recruitment is continuing and a further advert has been progressed. NICU staffing is precarious at present, however staff are being flexed from other areas in order to help manage the gaps whilst recruitment continues. **Community Child Health** • Welsh Government have confirmed the allocation for Immunisations. Recruitment is underway in order to recruit ahead of the campaign commencing in September. • Consent forms for HPV were missing between the school and Global Link. These have been received, however learning with regards to tracking needs to be addressed to avoid in future. • RCA being completed re influenz administration. This will be presented at the next Q&S meeting to share lessons learnt. • 1 RCA ongoing regarding wheelchair dependent child in mainstream school with community acquired pressure ulcer. This will be presented at the next Q&S meeting to share lessons learnt. • Administration errors in Ty Hafan has been identified and this is being investigated. Further discussions are taking place with regards to increased pharmacy support for Ty Hafan. • Restrictive Equipment • Ty Gwyn School increase in children will impact on health provision as there is no increased provision available. A task and finish group is being developed to review the impact of this. • Recruitment continues across all areas. • Waiting times being reported - OT reported at 13 weeks SLT and Physio reported at 11 weeks. Primary Mental Health is reporting at 85%.	**AL** **PD**
2.2	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** There were no specific items to note for this meeting.	
2.3	**Paediatric Surgery Update** Monthly meetings with the Executive Team continues. Handover and ward round activity is continuing to be monitored.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients & Staff** **Presentation on Mindfulness Sessions**	

	Nicole Parish was welcomed to the meeting and provided an update on the mindfulness sessions that are being run for staff. This was arranged for two main reasons including demanding/pressured settings and the effect that this can have on individuals, as well as increased "defensive" practice resulting in increased tests etc. Mindfulness has an excellent evidence base for decreasing stress levels. The sessions are arranged for lunchtimes every two weeks (1pm in the Children's Hospital for Wales). They are very well attended sessions and whilst this has been arranged initially for Acute Child Health staff, all are welcome to attend. Due to potential difficulties in ability to attend sessions, training sessions and drop in sessions have been provided in order to give teams the tools to use themselves. Feedback received has been very positive. Work is taking place with Occupational Health to look at opportunities for joint working across further areas.	
SAFE CARE		
4.1	**Update on Serious Incidents** 6 open at present. X1 joint investigation is required with neighbouring health board in relation to the recent case associated with oncology patient who has sadly died. It was agreed that the scope of the investigation needs to be clarified with regards to the pathway for the patient.	**MM**
4.2	**Closure Forms for noting / Sign Off** **In58701 – For noting (already submitted to WG)** The closure form was noted for information. The case has been through PRUDIC and M&M and all learning has been shared. **In37818 – For sign off** This has been reviewed through M&M and through RCA and there were increased pressures across all units in Wales and England, however a non-commissioned bed was opened and staffed at UHW which allowed the child to be transferred. This was done in a timely manner and there was no indication of any undue delay. This closure form was agreed and MM agreed to submit to Welsh Government.	**MM**
4.3	**SBAR's for Sign Off** **RK 239516 (this is the external RCA from Feb 17)** This case relates to a neonatal skull fracture following forceps delivery An external review was undertaken by ABMU, and a further external expert review was requested. This review has been undertaken and the findings are that there was no breach in the care provided. Further discussions are taking place as to how this information will be fed back to the family. **KW 25362** This case involved an unexpected term neonatal admission from the Midwifery Led Unit. An RCA investigation was carried out where the root causes were noted as: 1. Failure to record fetal heart rate on partogram as per NICE (2017) CG190 Intrapartum guidelines 2. Failure to recognise increase in baseline. 3. Failure to escalate concerns regarding fetal concerns. 4. Failure to escalate concerns re acuity. 5. Chorioamnionitis There were a number of lessons learnt as part of the investigations and the following recommendations were agreed.	

	1. To review the clinical practice of the midwife involved in the case and commence health board processes as relevant. 2. Standardisation of partogram use when implementing intermittent auscultation. 3. The midwife in charge on the MLU should not care for women in labour and be co-ordinating the activity. 4. Improved documentation and consistency by MDT in notes when a baby requires resuscitation. 5. Radio controlled clocks to be available in all intrapartum areas to ensure the consistency of times. All actions have been completed and it was agreed that the SBAR could be signed off. **CJ 250012** This case involved an unexpected term neonatal admission from the Midwifery Led Unit. An RCA investigation was carried out where the root causes were noted as fetal hypoxia due to unknown infection of the placenta and membranes in the absence of concerns with maternal or fetal wellbeing in the intrapartum period led to the unexpected neonatal admission. Lessons learned identified: 1. The MLU coordinator was not available to support MW2 due to her providing care to other labourers but on this occasion was not a contributory factor to the outcome. 2. Escalation for the MUM to attend could have been earlier to provide further support. 3. Patients should have been informed why the midwife was leaving the room and where the call bell was if she required assistance. Recommendations: 1. The senior midwife co-ordinating the MLU should be free to co-ordinate rather than be allocated a patient. 2. Women/ their birth partners should be informed where the call bell is if they require assistance. 3. The routine enquiry should be asked in the antenatal period. 4. Urinalysis should be undertaken at each antenatal contact. 5. New prescription charts should be used for each admission. All recommendations have been reviewed and actions have been completed. It was agreed that the SBAR could be signed off.	
4.3	**Infection Prevention Control Update** The report was noted for information. • Audits and MRSA screening is being undertaken and are improving • C Diff targets have been reached. The RCA's have been received and there were no specific exceptions to report. • RCA for E Coli are no longer required. • HPV in Paediatrics are leading the way and is very positive. • ANTT Training was noted. A position statement has been requested and the scope will need to be reviewed. • Air Conditioning is being implemented on Rocket Ward. • Meetings have commenced for the final phase of the Neonatal Build and this is progressing well. • The targets have not yet been released and it was agreed that this information will be circulated once received. • Hand Hygiene reminders are being sent out to reiterate the importance of hand hygiene for all staff. It was noted that visiting medics have been highlighted.	
4.4	**Safeguarding** There were no items to note for this meeting.	

4.5	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Message from Welsh Government - Drug Alert Class 4 (For Information): Kyowa Kirin, Bleo-Kyowa Powder For Solution For Injection (Bleomycin Sulfate), Pl 16508/0046 • Patient safety notice 043/May 2018 - Supporting the introduction of the Tracheostomy Guidelines for Wales - Letter from Prof Chris Jones • Message from Welsh Government - MDA/2018/019 - JM103 and JM105 Jaundice Meters – risk of misinterpretation of measurement in hyperbilirubinemia cases. • Welsh Health Circular 2018 023 - The National Influenza Immunisation Programme 2018-19 • Message from Welsh Government - MDA/2018/018 - Various Arrow Critical Care devices – recall due to incomplete packaging seals • Patient Safety Notices 042 (perfusion fluid), 043 (tracheostomy guidelines) & 044 (full-term babies) • Message from Welsh Government - MDA/2018/016 - Home use and Point of Care blood glucose monitoring system: Accu-Chek Aviva, Accu-Chek Performa and Accu-Chek Inform II test strips – risk of strip error messages and false high and low blood • Message from Welsh Government - MDA/2018/015 - Gambro Ultrafilter U9000 microbial water filter for haemodialysis – risk of hypovolemia due to filter leaks during use • Message from Welsh Government - Influenza Season 2017-18 – Cessation of use of antivirals now recommended. The above alerts and guidance was noted. There were no exceptions to report for the Clinical Board and the group were asked to ensure that the information is disseminated widely for information and any actions as appropriate.	**ALL**
DIGNIFIED CARE		
5.1	**Latest Cleaning Scores Report** The latest cleaning scores report was noted for information. The Clinical Board is currently reporting at 98% in month. There were no specific issues to note, however it was noted that the ward managers should be involved as part of the audits. CH agreed to feed this back.	**CH**
TIMELY CARE		
6.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** There were no specific concerns to note from the last executive performance review. Two minutes of your time was discussed and it was noted that these are not appropriate for all areas. Work is underway to look at ensuring these are more relevant.	
INDIVIDUAL CARE		
7.1	**Update on latest 2 minutes of your Time feedback** Noted under item 6.1	
Staff and Resources		
8.1	**Feedback on current position for PADR / Sickness** The workforce report was circulated for information. Concerns were noted with regards to unsocial hours being reinstated and this will have a significant impact on sickness, particularly for out of hours.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
11.1	**Public Health Wales Violence Surveillance Report** The report was noted for information and onward dissemination as appropriate.	

ANY OTHER BUSINESS		
	RCA – IN61695 Child admitted to oncology with suspected meningitis. Concerns were raised as to suspected unsafe practice following a lumbar puncture being carried out. Since this investigation, the guidelines for clexane have been reviewed and updated. **RCA – Patient MM** It was agreed that the RCA/Note review would be shared for information. It was noted that this case related to a patient who was discharged home and suffered a cardiac arrest. The findings noted that there was no reason as to why the patient should not have been discharged home. Further discussions to take place as to the requirement of further investigation. It was agreed that this would be taken back through the Directorate M&M meeting for sharing. **Informal Concerns** Discussion ensued and it was noted that whilst these are resolved at source, there is a need to ensure that this information is appropriately recorded. **UHB Wayfinding and Accommodation Meeting** Presentation was provided with regards to the Welsh Language Standards and a plan is required as to the standards that need to be implemented. A workshop is being undertaken within the next few weeks and further information will be shared following this. **Antenatal Clinic at UHL** Work is being undertaken following the relocation of the Antenatal services currently being provided at UHL. Alternative accommodation is currently being reviewed. **Canon Ultrasound Contract** This is a new contract and all machines are being replaced, however there were significant concerns with regards to the additional cost requirements. Further discussions are taking place regarding this. Training programmes will then be implemented. **Infection Control Group** Discussion ensued with regards to a possibility of undertaking a Clinical Board IP&C meeting. It was agreed that this would be considered and further discussions would take place outside of the meeting.	**MA/CH**

DATE AND TIME OF NEXT MEETING
The next meeting is scheduled for **Tuesday 24th July, Meeting Room, Clinical Board Offices, Lakeside (CANCELLED)**

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE (H&S FOCUS)
Tuesday 28th August 2018
8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		**ACTION**
	Welcome & Introductions Meriel Jenney (Chair), Clinical Board Director Rachael Sykes, Health & Safety Advisor Paula Davies, Lead Nurse Community Child Health Suzanne Hardacre, Head of Midwifery Laura Bassett, Risk Manager, Obstetrics & Gynaecology Sarah Spencer, Senior Midwife Ian Hanton, Senior Nurse, Resuscitation Service (on behalf of Angela Jones) Mary Glover, Lead Nurse, Acute Child Health Ian Sprigmore, Directorate Manager, Acute Child Health Anthony Lewis, Clinical Board Pharmacist **In Attendance** Kirsty Hook, Board Secretary	
	Apologies for absence Cath Heath, Rachel Burton, Nigel Davies, Raj Krishnan, Jane Maddison, Michelle Abel	
PART 1: HEALTH & SAFETY		
1.1	**To note any specific Matters Arising from the last CB H&S Meeting dated 22nd May 2018** **Clinical Board H&S Improvement Plan** This plan was circulated for comments, additions or deletions following the meeting. It was agreed that this would be brought to the next meeting for final sign off and all were asked to forward comments to HG following the meeting.	**ALL**
1.2	**Feedback from UHB Health & Safety Operational Group Meeting** The minutes of the meeting were circulated for information. The key areas noted from the meeting included: • Results of Arjo Audit – replacement programme has been implemented. A repeat audit will be undertaken in November 2018. • HSE – 3 more concerns – lift out of service, contractor work being carried out in X-ray, Public Health Labs in UHL. All responses have been submitted to the HSE and no further action to date. • Pedestrian Access - A consultancy firm to carry out a survey on traffic management, which included pedestrian safety. The Health Board had requested that the survey be extended to also include the Tunnels, due to several recent incidents with high potential to cause serious injury, primarily involving vehicles and pedestrians. • Control of Contractors – Jonathan Davies has been appointed to manage the outside of Estates & Capital issues.	

1.3	**To note the latest Health & Safety Report** The report was noted for information. There are a few incidents that are outstanding for review within ACH. MG agreed to review and action appropriately. It was noted that service disruption, in particular staffing issues, medication errors and documentation errors are some of the highest reported incidents for the Clinical Board. There have been no incidents reported to HSE. X1 RIDDOR incident reported, however on investigation there were no specific contributing factors to note.	
1.4	**C&W Clinical Board Health & Safety Report Update** Discussed as part of item 1:1.	
1.5	**To note the latest COSSH Report** The COSSH status report was noted. It was acknowledged that there are a few areas that require updates and the group were asked to review and feedback as appropriate. PD noted that a number of areas within Community Child Health have been reallocated and have been completed.	**ALL**
1.6	**To note the latest Fire Safety Report** The Fire Safety report was noted for information. It was acknowledged that the compliance for Mandatory Training was noted at 72.94% for the Clinical Board. Discussion ensued and MG noted that there was a fault with the system on Jungle Ward resulting in 24hour alarms. This has now been resolved.	
1.7	**Workplace Inspections Update** Concerns were raised with regards to many community premises are resulting in staff working in poor conditions. This is regularly raised with the Estates Department however concerns are that only short term measures are being offered at present. It was agreed that this would be raised at the UHB Health & Safety Meeting in order to gain updates on longer term plans. Concerns were noted with regards to internal guttering above Delivery Suite resulting issues rotting seagulls and maggots coming through the ceiling. It was acknowledged that whilst this had been reported and resolved quickly, there were concerns are that this will continue to happen. It was agreed that this would be monitored and further issues escalated as required.	**RS**
1.8	**Feedback from H&S Staff Side** There were no issues to note from Staff Side for this meeting. Query was raised as to the name of the new representative for C&W Clinical Board. RS agreed to discuss with Stuart Egan and feedback.	**RS**
1.9	**Exception Reports and Escalation of key H&S issues from Directorates** • Lifts (concerns raised by CNO) – Feedback has been received from Estates that this issue is part of the Refurbishment Programme and anticipated this will be resolved within the next 12 months. RS to raise for discussion at the UHB Operational Health & Safety Group Meeting this afternoon as this continues to be a longstanding significant risk. • Lone Worker Devices – low usage has been noted however some issues relate to staff being on long term sickness. New staff will be reissued with devices, and reiteration of need to use the devices has been highlighted to all, however risk assessments would need to be completed for all prior to any device being removed. Discussion ensued and it was noted that there is a UHB policy that needs to be adhered to. PD agreed to review and ensure that the compliance be included as part of the Community Child Health Lone Worker Policy. RS agreed to send through policy to PD for information. It was noted that a new model for Community Midwifery is being implemented and this will include longer working days which will mean that the lone worker policy will need to be reviewed for all staff.	**PD** **RS** **SH**

	• Potential High exposure of nitrous oxide within MLU. Work has been undertaken to regulate the in/outflow and re-testing will be undertaken. There are no concerns as to any risks to health of staff and work continues to monitor. • Safe disposal of unwanted items was circulated for information to all for information and onward dissemination as appropriate.	**ALL**
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story – "Anna's Birth Experience"** Complimentary letter received from parents with regards to their consultant led/medical birth experience. It was agreed that this would be shared for information. SH provided the background to the care that was provided and received by Anna. It was noted that the experience was very positive, caring and they felt safe throughout. All staff included within the care have received feedback, and it was felt that this was a very positive example of communication and management throughout the patient pathway.	
2.2	**To receive the Minutes of the previous meeting dated 26th June 2018 for approval** The minutes of the meeting were agreed as an accurate record.	
2.3	**QSE bring forward action log / Matters Arising** The actions from the last meeting were noted and updated accordingly.	
2.4	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues or for consideration for Clinical Board Risk Register)** **O&G Directorate** • All Wales Maternity Strategic Vision and will include updated professional indicators and outcome measures. • 9 RCAs ongoing in Obstetrics and 1 RCA and 1 case review within Gynaecology, work is progressing • Gap and Grow development programme continues. There have been issues with ultrasound scanning and this is being monitored and reviewed. • X3 falls reported however there have been no adverse incidents • FGM service has commenced, and new midwife has recently been appointed • Blood Glucose machine required for transitional care ward to reduce variation – part of joint working between obstetrics and neonates. Work continues • New R&D lead has been appointed within the Directorate. • Development of a Dignity room on Delivery Suite is progressing • Monitoring process in place for all out of area women and monthly meeting with Cwm Taf Health Board continues. • Help and support has been provided to Cwm Taf Health Board as part of the transition arrangements for a period of 3 months as part of short term rotation to help with the fragility of the service. • CNO Visit on 8th August and the Cabinet Secretary visit is planned for September. **CCH Directorate** • 1 Data Protection Breach reported with regards to missing consent forms. The RCA is ongoing and further discussions to take place with Patient Safety. A tracking process is now in place and a number of recommendations will be implemented. • RCA with regards to no consent for Influenza administration in school has been completed and this will be presented at the next Q&S Meeting to share findings and lessons learnt. • DPA breach from a former employee. This was closed by the ICO however further information is awaited with regards to Duty of Candour. Further update will be provided when available. • Issues continue with regards to archiving and approval is awaited to relocate records from Lansdowne to Trefforest, however risks continue. • Additional sessions for pharmacy support within Community Child Health have been requested. • New Health Visiting Pathway for Looked After Children has been produced in response to a recent case and the need to ensure that there are robust processes in place for sharing of information and	

	management of looked after children placed pre adoption. This has been approved by Safeguarding Committee and was agreed for ratification. • Concerns were highlighted with regards to Cardiff & Vale LAC Children placed within ABMU and the delay of assessments. Measures are being put in place in order to bring these children back into clinics to be seen. • X3 LIPS projects progressing this year…. • Access to PARIS for CCNS service is being reviewed and a business case is being produced as to how this can be supported through the implementation of Netbooks. **ACH Directorate** • X3 ongoing RCA's, work is progressing. Recommendations have been received from Great Ormond Street relating to one case and this has been shared with teams as part of Q&S process. • Single Nurse Checking SOP has been produced and a comprehensive list of the single use drugs will be included for implementation. • Bid submitted for implementation of Hello My Name was approved through the Clinical Board Flu Monies and work is progressing to order and implement. • New Theatre suits have been implemented and have been very positively received by patients. • Work is ongoing in August and September cohort to continue to deliver the 0 patients waiting over 36 weeks for inpatient and outpatients. The Directorate has also been tasked to deliver 0 patients waiting over 26 weeks for outpatients by the end of Q2. • CNO Visit has been undertaken within ACH and discussions taken place in relation to Transition and CAMHS. • Recruitment work continues across a number of areas within the Directorate. • Issues with regards to the Bladder Service was highlighted and it was agreed that this will need to be resolved. Further discussions to take place outside of the meeting to agree actions and way forward.	
2.5	**Paediatric Surgery Update** Progress has been made to appointments to consultant gaps within the service. The service remains under high scrutiny from the Executive Team and WHSSC. Richard Skone has recently been appointed as ACD for Paediatric Surgery.	
2.6	**To receive the New Health Visiting Pathway for Looked After Children for approval** Discussed as part of item 2.4	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients/Staff** • Coffee, Cake and Catch up sessions taking place within Maternity • Mindfulness Sessions continues across ACH • Yoga for Staff continues	
SAFE CARE		
4.1	**Update on Serious Incidents** **Closure Form – In61666 for sign off** The closure form was noted and agreed for submission to Welsh Government. It was noted work continues with Patient Safety to expedite the implementation of the NRFit system device in order to prevent further issues going forward.	
4.2	**RCA's for noting** **SBAR LB 246060** This case relates to a complex birth delivery relating to shoulder dystocia and resulting in a midshaft fracture to the baby's left humerus. Lessons learnt from the investigation included: • Analgesia should be offered to all women attending in labour. • Urinalysis to be undertaken for all antenatal attendances.	

	The recommendations from the investigation included: • Formal interpreters should be used, staff to be reminded of the interpreter use in maternity guidance. • Urinalysis to be undertaken for all antenatal attendances. • Analgesia to be offered to all women attending in labour. The lessons learnt have been shared and recommendations completed. **SBAR GU 247936** This case relates to a neonatal unexpected death. The root causes of the investigation were found as fetal intrauterine sepsis leading to hypoxia and multi-organ failure of the neonate. The investigation has not found to have been exacerbated by any substandard obstetric or midwifery care. The investigation also noted that there were no direct lessons found for the outcome through the RCA but incidental learning was highlighted in relation to: • Documentation – It has been noted that there were not patient identifiers on every page in the records. • It is best practice to inform patients of samples taken. • The timing of CTG's should be checked as correct at the beginning of each trace. • The HVS was unnecessary as they are not recommended as routine for PV bleeds unless there is another indication to do so. Recommendations • All documentation must have a patient identifier on every page. • Patients should be informed of any samples that are taken. • CTG's should be checked as correct at the beginning of each trace and signed by the person commencing the trace. • Staff to be made aware that high vaginal swabs are not recommended as routine for PV bleeds unless there is another clinical indication to take one. The lessons learnt have been shared and recommendations completed.	
4.3	**Infection Prevention Control Update** The report was noted for information. There were no exceptions to note for this meeting.	
4.4	**Safeguarding** **Update from Directorates re: Safeguarding Matrix (to be completed by 7/9)** PD agreed to forward through for completion. Work is progressing and it was agreed that SH would contact Linda Hughes Jones following the meeting.	**PD/SH/ MG**
4.5	**Patient Safety / MDA Alerts (internal/external)/WHC** • Patient Safety Newsletter • Drug Alert Class 2 (Action Within 48 Hours): Children's Glycerine And Blackcurrant Cough Syrups Manufactured By Bell, Sons &Amp; Co, Pl 03105/0066 • Internal Safety Notice 2018/003 - Medication charts • Public Health Link - The Cyrus Project - Unsolicited Packages • MDA/2018/027 - Breast implants, all types, makes and models – Continue to report suspected cases of Breast Implant Associated - Anaplastic Large Cell Lymphoma (BIA - ALCL) • MDA/2018/028 - Orthopaedic bone plates and cortical screws: ADVANSYS MLP-DLP; ADVANSYS TTC; Large QWIX; TIBIAXYS and UNI-CP–Sterile – Risk of infection • Message from Welsh Government - Esmya (Ulipristal Acetate) For Symptoms Of Uterine Fibroids: Restrictions To Use And Requirement To Check Liver Function Before, During And After Treatment	

	All notices were noted for information and onward dissemination and action as appropriate. There were no exceptions to note for the Clinical Board.	
4.6	**PSN 044 - Resource to support safer care for full-term babies** Welsh Government have requested that work is undertaken to reduce the number of unintended admissions to NNU at term. Meetings have been held jointly between NNU and Maternity to identify areas where improvements can be made. Cora Doherty is leading this work and is required to return an action plan to Welsh Government by November 2018.	
4.7	**Medication Safety Briefing** The medication safety briefing was noted for information. The use of Valproate medicines and the risks for pregnant women was highlighted with regards to avoiding exposure in pregnancy unless a pregnancy prevention programme is in place. Links to the documentation was also included within the briefing for information.	
4.8	**Medication Safety Metrics – July 2018** Noted for information. There were no specific issues to note for this meeting.	
DIGNIFIED CARE		
5.1	**Latest Cleaning Scores Report** The latest cleaning report was noted for information. The Clinical Board are currently reporting compliance of 98% in month.	
5.2	**Jehovah Witness Documentation** Noted for information.	
INDIVIDUAL CARE		
6.1	**Update on latest 2 minutes of your Time feedback** Concerns were raised with regards to areas with long stayers and small turnover of patients. It was noted that work is being undertaken with Patient Experience team in order to ensure that the data is robust and meaningful. Within Obstetrics & Gynaecology an adaptation of the national two minutes of your time has been implemented and compliance is starting to improve.	
STAFF AND RESOURCES		
7.1	**To note the latest Workforce Report** It was agreed that the latest report would be circulated for information following the meeting. KH agreed to follow up outside of the meeting.	**KH**
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
8.1	**Cardiff and Vale UHB Business continuity – Systems Failure - MTeD access** The SBAR was noted for information outlining the protocol in place for systems failure for MTeD. It was noted that the paper system is the back up for the system failure however there was reiteration that this should not be used as the primary source. An action plan will need to be produced and it was agreed that progress would be noted at the next meeting.	**AL**
8.2	**C Section SSI Annual Report 2017** The annual report was noted for information. Significant work has been undertaken on the data provided and compliance has improved. Currently the Health Board are reporting the lowest SSI rate within Wales and the team have been nominated for the Nursing Times Awards. Congratulations were expressed on behalf of the Clinical Board for all the hard work that has been undertaken on this work.	
8.3	**RCOG Report – Each Baby Counts** The report was noted for information. Work is being undertaken to provide assurance that the recommendations are being met and progress being made.	

8.4	**Wales Audit Office - Review of Medical Equipment: Update on Progress – Cardiff and Vale University Health Board** Noted for information.	
ANY OTHER BUSINESS		
	None noted.	
DATE AND TIME OF NEXT MEETING		

The next meeting is scheduled for **Tuesday 25th September, 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 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

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE (H&S FOCUS)
Tuesday 27th November 2018
8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		**Documents/ Other Info**
	Present Cath Heath, Director of Nursing (CHAIR) Meriel Jenney, Clinical Board Director Anthony Lewis, Clinical Board Pharmacist Laura Bassett, Risk Manager Obstetrics & Gynaecology Directorate Cheryl Evans, Directorate Manager, Obstetrics & Gynaecology Directorate Suzanne Hardacre, Head of Midwifery Sarah Spencer, Senior Midwife, Obstetrics & Gynaecology Directorate Bev Thomas, Asst Directorate Manager, Community Child Health Directorate Donna Newell, Safeguarding Nurse Advisor Matt McCarthy, Patient Safety Advisor Mary Glover, Lead Nurse Acute Child Health Directorate Raj Krishnan, ACD Risk & Governance Acute Child Health Directorate Rachael Sykes, Health & Safety Advisor Paula Davies, Lead Nurse Community Child Health Directorate Jane Maddison, Acting Head of Therapies, Community Child Health Directorate **In Attendance** Sabreena Iqbal, Administrative Support Cora Doherty, Consultant in Neonatology (item 2.2 only)	
	Apologies for absence Wendy Bridges, Ian Sprigmore, Ceri Abbott	
PART 1: HEALTH & SAFETY		
1.1	**Feedback from UHB Health & Safety Operational Group Meeting** Feedback was provided on the last operational meeting held in August 2018. It was noted that there was no rep at the last operational group meeting and it was agreed that a representative would be agreed and attend future meetings. The main focus of the meeting was the presentation of the annual report and the key areas highlighted included; • 52% of incidents of Violence and Aggression to staff • Stress and staff shortages has increased significantly year on year • Mandatory training highlighted significant differences between E-learning and classroom training and reviews are being undertaken in order to review the competency based training with regards to this specifically in relation to manual handling • Hoists and management of hoists is being changed from estates to clinical engineering department which is hoped that response times and management of contract will improve. This is currently being worked through and anticipated to be finalised April 2019. • HSE enforcement notice was issued to Public Health Wales in relation to maintenance of laboratories which is being worked through and complied with.	**CH**

	• One enforcement notice from the Fire Service has been received since the last meeting with regards to ignition and fire sources within Mental Health services and this is being reviewed. • Health Records and lack of storage remains on the agenda as a significant issue. Concerns were raised that this is not moving forward and continues to pose a significant risk for archiving within the Clinical Board. Discussion ensued and queries were raised as to whether this should be added to the patient safety agenda as it is a significant governance issue. It was noted that this has been discussed at a Health Board level and work continues to try to progress and resolve. Further discussion ensued in relation to access to old notes within maternity services and it was noted that formal notification from CD&T Clinical Board Health Records has been received of the inability to access which is proving difficult for birth choices/consultant obstetrician clinics where this information is required to review care provided. CH agreed to discuss with the Director of Operations for CD&T.	**CH**
1.2	**To note the latest Health & Safety Report** The report was noted for information. Overdue incidents are being followed up regularly via Datix and work continues. Discussion ensued with regards to an increase in some of the reported incidents and it was noted that with regards to term admissions, these are being reported by neonatal and maternity so are being double counted. MM noted that work is taking place with Datix to resolve this and improve the process to avoid duplicate reporting. X2 RIDDOR incidents reported to the HSE relating to slips, trips and falls of members of staff. There were no specific lessons learnt highlighted from either incident that needed to be actioned. It was noted that the RIDDOR reporting over recent years remains quite static and there are no specific trends etc that have been identified.	
1.3	**C&W Clinical Board Health & Safety action plan** Discussion ensued and it was agreed that a further meeting would be arranged to review in detail and update as necessary to ensure that it is a robust working document. It was agreed an extra ordinary meeting would be arranged as soon as possible with key members.	**SI**
1.4	**To note the latest COSSH Report** Noted for information.	
1.5	**To note the latest Fire Safety Report** Noted for information. It was noted that a test evacuation drill had been undertaken at Global Link however there was an issue with the fire doors failing to open. Discussion ensued and it was noted that the Fire Officer agreed to review and resolve this. BT agreed to follow up on progress.	**BT**
1.6	**Workplace Inspections Update** Workplace inspections are continuing however it was noted that there has been no feedback received on recent inspections. It was noted that they have taken place within Maternity Services. SH agreed to follow up.	**SH**
1.7	**Feedback from H&S Staff Side** No feedback received to note for this meeting.	
1.8	**Exception Reports and Escalation of key H&S issues from Directorates** Discussed as part of item 2.4	

	Queries were raised in relation to any further update with regards to the maternity lifts. It was noted that feedback had been received that it was hoped that at least one of the lifts would be completed, however no further feedback has been received from Estates. SH agreed to follow up.	**SH**
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story – LP** Deferred to the next meeting. Surgery Clinical Board will attend the next meeting to feedback as this relates to a surgical case.	**CH**
2.2	**Patient Safety Notice 044 – Term neonatal admissions** Cora Doherty provided a presentation on unplanned term admissions to the neonatal unit and the implications following receipt of welsh government patient safety notice. Research has found that up to a third of neonatal admissions are felt to be unnecessary and avoidable. Joint working has been undertaken between both Obstetrics and Neonatal services in order to work through this process and pathway in order to look at options for improvement. Term admissions can affect the efficiency and lean working of the unit which impacts on the service. Within England, the term admissions have increased by 30% and the main reasons found included respiratory distress, hypoglycaemia, HIE and jaundice. Within UHW in 2017 there were 276 term admissions which contributes to approximately 50% of admissions, 206 of which were unplanned admissions. Guidelines of admissions have been reviewed and amended which is anticipated will reduce the unnecessary term admissions to the unit. It was noted that increased BMI (over 30) within pregnant women has impacted on the term admissions and a high number as a result of gestational diabetes in pregnancy. The HIPO guidelines have been reviewed and changes have been made with regards to fasting glucose however it was noted that work continues in order to ensure adherence to NICE guidelines for the management of gestational diabetes. There are a number of pieces of work that are being taken forward in order to review all issues associated with these admissions in order to ensure appropriate management of term admissions going forward including a review of point of care testing (POCT) which is being undertaken across the Health Board.	
2.3	**EU Professional standards** These are Internal Professional Standards for Winter Planning which have been produced within Medicine Clinical Board for adherence and sharing across all areas. It was agreed that this would be shared following the meeting if this had not previously been received.	**CH**
2.4	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues or for consideration for Clinical Board Risk Register)** **O&G Directorate** • Updated strategic vision for maternity services is ongoing with a stakeholder event taking place on 6th December with a plan to launch the vision in February 2019 • 10 RCA's ongoing in Obstetrics which includes x1 joint investigation with Neonatal. 2 RCA's ongoing in Gynaecology • External quad audit has taken place and the action plan is awaited. • Multidisciplinary team building training session has taken place and included neonatal colleagues. Feedback has been positive. • All Wales Fetal Surveillance standards have been submitted for translation to the Maternity Network • X2 Pressure incidents reported on C1 no concerns in care have been identified through either investigation.	

- 7 reported falls, 4 within Gynaecology however on review x2 were downgraded and 3 baby falls, one of which has been reported as an SI due to a fracture being sustained.
- X1 medicines management incident reported as a result of delay in antibiotic treatment
- All KPI's met for first year of clinical supervision
- MTED rollout was tested in Maternity but not suitable for electronic discharges for GP's due to possible breach of confidentiality and further discussions are taken place with regards to the practicalities of this use in Maternity.
- PROMPT train the trainer session taking place
- Maternity Instagram page was being reviewed however this is not supported corporately so will not be progressed.
- No RTT breaches reported in October and plan is to work towards zero for November also.
- Work is ongoing with regards to the move of antenatal services from UHL and scoping of suitable location is taking place
- RCN Wellbeing Week was well received.

ACH Directorate

- X2 RCA's ongoing one of which is external to the Directorate and one will be presented to the next Q&S Meeting
- Hand Hygiene audits continue, talks have taken place at the new induction sessions in order to reiterate the bare below the elbow message.
- X1 new case of E Coli reported on Rainbow ward
- MRSA screening is increasing along with the VIP scores
- Tenfold prescribing errors RCA is ongoing and a concern has now been received. Pharmacy involvement in handover has been taking place in Neonatal, and is being implemented within general medical wards. Lessons learnt are being shared with prescribers and staff administrating the medication. Posters to raise awareness are also being produced.
- Patient Information Boards are awaited and hoped that they will be implemented imminently
- No 26 week waits for new outpatients were reported and also no 36 week breaches have been reported for Surgery for October and plan is to work towards zero for November also.
- Launch of the Children's Rights Charter has taken place and the implementation of the Youth Board which is being jointly chaired by both Lead Nurses in ACH and CCH.
- Recruitment is ongoing within the Directorate on a number of medical posts. The new starters in nursing have now all commenced in post.

CCH Directorate

- OT review feedback is taking place to the Clinical Board 20th December
- Legionella outbreak reported in UHL Children's Centre is being resolved and the guidelines for flushing of the system are being displayed to reiterate the message.
- SL&T and Physio continue to manage the waiting list and further work is being taken forward with CSI team in January for Physiotherapy.
- RCA's are ongoing. Following the recent RCA in relation to non-consent for administration of fluenz there are numerous incidents with regards to immunisation and consent. It has been suggested that is progressed as part of a LIPS project to further investigate and look to streamline the process and ensure that the process is as safe as possible.
- X2 community acquired pressure ulcers which have been reported. These have been reported through safeguarding and RCA investigations are ongoing. There was also a pressure ulcer reported in school and work is ongoing to look at options for implementing a pathway within community. Meetings have taken place and there is a hospital based pathway but is not fit for community services.
- CCNS access to PARIS in the home has continued to be an issue. Costs of the netbooks is significant however it was noted that a plan to use some vacancy monies to pilot this initially in order to assess the impact. One of the recommendations made by Welsh Government with regards to the child that died in community care was that all staff would have netbooks and

	presently this is not being met due to the significant costs of initially £20k for 20 netbooks for the pilot. Transformation Bid was submitted but rejected as core service requirement. • Ombudsman investigation regarding SL&T has taken place however it was noted that they are satisfied that the Health Board has followed process and will not take further action. • Vacancies continue in some services. • Transition Pathway has been produced for ratification by the group. It was noted that work has taken place with PCIC Clinical Board and a pilot will now be taken forward, however noting that this pathway for the panel process is still in its infancy. It was agreed that this would be shared with ACH colleagues for information and comments prior to the pilot commencing within Community. It has been approved by CCH Q&S Meeting and also PCIC Q&S Meeting. • A pathway for managing male infants over 18months with delayed walking has been produced following the newborn screening for muscular dystrophy change in policy in order for the physiotherapists to triage any delayed walkers and this will be discussed with consultant paediatricians. This will be uploaded onto the intranet for implementation following ratification and sign off. • PMH is reporting 94% compliance and the Fluenz is currently reporting 51% and additional clinics have been implemented which is hoped will further increase this figure. Primary immunisations are currently at 94%. Neuro development is being reported at 29weeks and community paediatrics at 28 weeks. • Archiving at Lansdowne needs to be removed from Lansdowne by December and work is ongoing, however there have been financial costs associated with this and there is very little space left at Trefforest which is of a concern going forward. There was further discussion with regards to assurance from Estates in relation to asbestos removal at Lansdowne and that it was safe for the staff to go into the notes room. BT agreed to follow up with Estates.	**BT**
2.6	**Paediatric Surgery Update** No specific update to provide for this meeting.	
2.7	**Resectr Procedure** The procedure was noted for information. This is an outpatient gynaecology procedure completed under general anaesthetic and will be undertaken for a 6month period to trial new equipment which is being funded through the Bevan Commissioning and will be fully evaluated. This has been agreed through Directorate Health & Safety and now requires Clinical Board approval. Discussion ensued and it was agreed by the Clinical Board for implementation of the pilot.	**CE**
2.8	**Directorate Business Continuity plans** Work is progressing. It was noted that there was nothing specific to add for this meeting.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients/Staff** Noted as part of item 2.4	
SAFE CARE		
4.1	**Update on Serious Incidents& Update on CB E-datix performance** The report was circulated for information. Detailed within the report was the number of incidents being reported on serious incidence since the introduction of the E Datix system, along with types of incidents and numbers. An increasing trend of reporting was highlighted which is a very positive trend as it shows that staff are reporting incidents and lessons can be learnt from all incidents. Incident Q's were discussed and there has been increased movement in all areas. A number that are submitted awaiting review over 7 days has increased and this will need to be reviewed. It was noted that these will need to be followed up and reallocated where necessary. Requests were made in order to review the incident and close where possible. It was felt that with the new super users that have been implemented, this will also help robustly manage going forward.	

4.2	**RCA's for noting and agreeing actions** **IR 274353** Patient admitted to C1 with Grade 2 pressure area from Community which developed into a Grade 3. As part of the recommendations of the investigation it was noted that on admission patients should be asked if there are any previous body damage. Lack of communication of pressure area from both patients and community teams was also highlighted as this information was not disclosed by the patient or the community team. Information has been shared with community in order to share lessons learnt and improve processes going forward. It was agreed that a closure form could now be submitted to Welsh Government. **LB 273055** This case relates to a baby who suffered a skull fracture following instrumental delivery. This has been discussed through clinical risk meetings and a birth injury review tool had been completed. No concerns were highlighted with regards to delivery and care received. All procedures were followed. There was no direct learning from the investigation, however incidental learning was that timely reporting should be undertaken. **B O'B 276491** This case relates to a fracture sustained following the baby falling from mum's bed. CT scan and procedures were followed immediately and the fracture was subsequently found. A full investigation was carried out and no concerns were highlighted on the care provided and there was appropriate information given during the inpatient stay and appropriate actions taken and care provided following the incident. The recommendations from the investigation highlighted as; 1. QR code for video that was developed as part of 'babies don't bounce' LIPS project to be available around the unit. 2. Over bed cots to be purchased. 3. Audit of last 12 months of baby falls to identify any themes and trends. The SBAR was noted and the Clinical Board received assurance that all actions were undertaken. It was agreed that a closure form be submitted to Welsh Government	
4.3	**Infection Prevention Control Update and Flu vaccination profile** Circulated for information. No specific issues to note for this meeting.	
4.4	**Safeguarding** **Child Practice Review – Patient ESK** The case related an 18month old who had been admitted to the Health Board's care for numerous fractures and a traumatic incident which subsequently led to her death in 2016. The Child Practice review was commissioned in relation to the Child and Wellbeing Act. Key points from the review were that there may have been opportunities to explore the injuries further due to the number of cases and admissions, along with poor information sharing. As part of the action plan the safeguarding team have implemented a number of actions to strengthen processes such as information sharing amongst health professionals and local authority. These include; • Safeguarding midwife has fortnightly meetings and information along with birth plan etc is uploaded onto the PARIS and Euroking system. • Professional understanding of the looked after child process in order to heighten awareness as to the process and support required for looked after children and children within the adoption process. • All children under 5 presenting to the GP with Trauma and Orthopaedic issues will be admitted through the ED Dept	

	• Documentation has been enhanced to reference the parent that is in attendance and clearly state who they are addressing (this case involved same sex couple) in the notes. • Reporting a first fracture in ED must now be reviewed by a Radiologist The report concluded that there was a lack of professional curiosity with regards to the child's injuries. The child was invisible to all agencies and there were no concerns highlighted that the parents were struggling to cope with a child with complex needs. No assessments undertaken could have predicted the outcome of the child. Discussion ensued with regards to the support that needs to be provided to parents who have recently gone through the adoption process and it was noted that additional support is required. A presentation will be shared in order to highlight an increased awareness. PD agreed to circulate. It was agreed that this presentation should be provided at a Child Health Staff Forum in order to share lessons learnt widely. **Safeguarding Newsletter** Shared for information.	**PD** **RK/DN**
4.5	**Patient Safety / MDA Alerts (internal/external)/WHC** **MDA/2018/034** The MDA alert was shared for information and onward dissemination as appropriate. There were no specific concerns to highlight for the Clinical Board.	
4.6	**Medication Safety Briefing** Noted for information and onward sharing.	
4.7	**Medication Safety Metrics – July 2018** Noted for information. There were no specific issues that needed to be highlighted for this meeting.	
4.8	**Neurological Observations Chart - implementation plan.** It was agreed that this would be shared for information. It was noted that it was specifically pertinent for adults wards so would need to be shared with Gynaecology. MG noted that this was not fit for purpose for use on children's wards.	
DIGNIFIED CARE		
5.1	**Latest Cleaning Scores Report** The latest cleaning scores report was shared for information. There were no concerns to highlight as part of this meeting.	
INDIVIDUAL CARE		
6.1	**Update on latest 2 minutes of your Time feedback** Work is ongoing across all areas. There were no specific trends or concerns to raise as part of the meeting. Further updates will be provided as feedback is received.	
STAFF AND RESOURCES		
7.1	**To note the latest Workforce Report** It was agreed that the latest report would be circulated for information once received. There were no specific concerns with regards to sickness and PADR.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
	There were no items to note that had not been shared elsewhere on the agenda.	
ANY OTHER BUSINESS		

	Flu Programme It was noted that the Clinical Board are currently reporting 54% compliance and work continues within the Clinical Board.	

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 18th December, Meeting Room, Clinical Board Offices, Lakeside**

Dental Clinical Board

Minutes of Quality, Safety & Experience Committee Group Meeting
Thursday 10th January 2019 – 8.00AM
Small Seminar Room, Ground Floor, University Dental Hospital

Present:

Andrew Cronin (Chair)	(AC)	Beverly Withers	(BW)	Shannu Bhatia	(SB)
		Ivor Chesnutt	(IC)		
Barbara Chadwick	(BC)	Melanie Wilson	(MW)		
Dinah Jones	(DJ)	Gurcharn Bhamra	(GB)		

Apologies:

Rowena Griffiths	(RG)	James Gillespie	(JG)	Julia Charles	(JC)
Catherine Evans	(CE)	Nick Drage	(ND)	Eira Yassien	(EY)

In Attendance:

Jonathan Peck	(JP)

		ACTION
PRELIMINARIES		
1.1	**Welcome & Introductions** AC welcomed everyone to the meeting of the Quality, Safety and Experience Group. **Emma Stone presentation – Patient Identification Audit** Emma Stone presented to the group a summary of the implementations initiated from the results of a previous patient identification audit. The audit had shown poor compliance so far as operators identifying the correct patient was being treated by asking them to confirm their name, date of birth and current address. The group discussed and noted in particular: • Patients in the GA suite were now given barcoded wrist bands for identification. • The ID policy is in the new induction information. • Electronic check-in had been introduced so reception staff were not checking details on arrival. BC commented that an alert notice had been circulated regarding this in September 2018. • BC suggested the ID policy should be put into undergraduate teaching. • AC requested a copy of the presentation given by Emma Stone be circulated once again to all audit groups. • AC suggested a re-audit in the future to monitor the policy is being adhered too.	
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 11th November 2018 were reviewed and confirmed to be accurate and correct. **Matters Arising** There were no matters arising. AC informed the group that with regard to an action point in section 2.3 of the minutes; The new Orthodontic audit group lead was Andra Liepa.	
MONITORING & REPORTING – DENTAL CLINICAL BOARD SUB GROUPS		
2.1	**Oral Surgery, Medicine, Pathology & Radiology** **- Mr N Drage** The minutes from the OSMP Audit Group meeting held on the 14th December 2018 were received and noted. AC noted on behalf of Nick Drage (ND) that ND had now talked to all audit groups re the IRMER procedures and the 'risk/benefit' procedure will go live imminently on SALUD but will be later in the rest of the hospital due to delays in the printing of the new form.	
2.2	**Restorative Dentistry** **- Mr G Bhamra** The minutes from the Restorative Audit Group meeting held on the 21st December 2018 were received and noted. GB summarised the meeting and informed the group a number of presentations had been given which included: • **Amar Patel presentation** – Audit 6739, final year project update. • **N Drage presentation** – Changes to IRMER legislation. Ionising radiation (medical exposure) regulations 2017. ND spoke to the group about how risk information should be explained to patients. AC commented on the benefits of final year projects being presented to share their results and asked audit leads to encourage presentations.	
2.3	**Joint Orthodontic and Paediatric Dentistry** **- Mrs S Bhatia** The minutes from the Joint Orthodontic and Paediatric Dentistry Audit Group meeting held on the 14th December 2018 were received and noted. SB summarised the meeting and informed the group of several presentations: • **Helen Williams presentation** - Qualitative Research methods. • **Emily Jones presentation** - A summary of the antibiotic prophylaxis against infective endocarditis guidelines.	
2.4	**Community Dental Service** **- Mr J Gillespie** The minutes from the Community Dental Service Group meeting held on the 22nd November 2018 were received and noted. DJ summarised the meeting which included: • Acknowledgement of the well-received presentation from Dafydd Thomas at the Dental Clinical Board Quality & Safety meeting held on 1st November 2018 – LIPS project 2018; Improving surveillance of antimicrobial	

	resistance in dental infections: Increasing access to specialist microbiology services for community based dental clinics. Cwm-Taf will hopefully continue with providing samples to Oral Pathology at the DH when transfer complete. • Mobile unit still being used in Ely. • DJ had reminded the group that staff are to be identified by title when completing incident reports and not by name. • BW summarised a violence and aggression incident. (Datix In81146). A father became aggressive when bringing their child for an appointment. BC queried whether the child was present at the time. BW confirmed the child was present. BC queried if anything had been actioned with regard a safeguarding referral for the child. BW commented that although a consideration no referral had been made. DJ will discuss further with appropriate departments to decide how to progress. • DL queried whether posters were now available with regards the changes to IRMER legislation. Ionising radiation (medical exposure) regulations 2017. AC will follow up. DJ commented on the incident report which showed several incidents involving ultrasonic tips fracturing. DJ noted that there had also been issues with the tips in Community Dentistry. GB commented that the issue had been discussed at audit with questions asked on what procedure the long and short tips were actually being used for as this was important. IC also commented that manually bending / altering the tips contributed toward breakages.	DJ AC
2.5	DSG HSC: Minutes of the Dental Division and School H & S Advisory Group - M Wilson	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Patient Story / Audit Presentations	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
4.0	WHC/2015/001 - Improving Oral Health for Older People Living in Care Homes in Wales – Dinah Jones WHC 2008 (008) – Designed To Smile – Dinah Jones	
SAFE CARE		
5.1	Risk Register- Rowena Griffiths review and revision	
5.2	**Incident Reports** • Incidents 251018 - 040119 The document was received and noted.	
5.3	**Medicines Management Audit Report** MW summarised the latest meeting which included: • External audit of sharps boxes October 2018; excellent results with 100% compliance for relevant areas. • Hand hygiene results 98 % November • Members of DCB leading on national audit of antimicrobial prescribing in secondary care; to be presented at Audit groups throughout February.	

	MW informed the group that ZOLL training needed to be completed by 80% of staff before the defibrillators were introduced to the hospital. Currently a further 20 staff need to receive training. Emma Stone has arranged training for February. MW informed the group that there was currently no ramp access to the back of the hospital and tunnel usage was restricted. BW noted that the patient chaperoning procedures and guidelines were being reviewed with a focus on what staff need to be available for medically compromised patients. IC took this opportunity to inform the group that Cardiff & Vale UHB will no longer have pharmacists to dispense medication. The process will be outsourced to a private company who will be based in the hospital concourse. IC noted that given the options available it had been decided that COPPS prescriptions will be issued in the dental hospital which will need to be collected from community pharmacies. IC will circulate an email in the near future.	
5.4	New Medical alerts	
5.5	Medical devices/equipment issues	
5.6	Decontamination CDS WHTM01-05	
5.7	HIW Inspections and report	
5.8	Infection, Prevention & Control Clinic inspection reports and improvement plans	
5.9	NatSSIPs – Julia Charles	
EFFECTIVE CARE		
6.1	**Monitoring of CB Clinical Audit plan** • Ongoing audits. The document was received and noted. AC informed the group that there had recently been 3 'break glass' incidents brought to his attention. All 3 incidents had been by the same person. AC had interviewed the person involved but still had little understanding as to why this person would need to access confidential patient records as part of an audit project. The group discussed. AC and IC to discuss the matter in detail after this meeting.	
6.2	Research and development	
DIGNIFIED CARE		
7.1	Initiatives to improve services for people with: • Dementia Nothing to report • Sensory loss Nothing to report • Mental Capacity Act Nothing to report	

TIMELY CARE		
8.1	RTT – Eira Yassien Waiting list issues – Eira Yassien Nothing to report	
INDIVIDUAL CARE		
9.1	**Concerns** • Concerns 251018 - 040119 The document was received and noted. AC noted in particular In21915 and summarised for the group. All procedures were followed. Parent did not bring child back for follow up appointment. No harm came to the child.	
9.2	**Compliments** • Compliments The document was received and noted.	
9.3	Safeguarding	
9.4	Patient Experience	
STAFF AND RESOURCES		
10.1	Employee of the Month	
10.2	Staffing levels – Eira Yassien	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
Any Other Business		
	AC informed the group of a proposed National Mouth Cancer Audit. IC noted this was also discussed at the last MCN meeting. AC will speak to Dr Sivarajasingam to discuss and clarify.	AC
	AC shared with the group a list of Dental Quality & Safety group attendees which was discussed and amended as necessary.	
	DJ informed the group that as part of the Designed to Smile program the Lift the Lip training for health visitors was being rolled out with a view to reducing the incidence of caries in pre-school children.	
	IC updated the group that Eira Yassien and Sharon Matthews had presented on sensory loss for the dental clinical board at the CVUHB clinical senate.	
	BC commented that she had recently completed a BAOS (British Association of Oral Surgeons) Antimicrobial E-Learning package which she found to be extremely good and fully recommended its use and circulation. MW noted that the package would be circulated in the near future.	

	BW informed the group that patient experience questionnaires were now on clinics and would be running for 2 weeks.	

Date and time of next meeting:

Thursday 14th March 2019	8:00 AM	Large Seminar Room