Bundle Quality, Safety and Experience Committee 18 June 2019

Agenda attachments

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	No items to report
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3 THEME 2: SAFE CARE

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3.2 Point of Care Testing Alert

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3.3 Position Paper - Model of Stroke Rehabilitation and Workforce

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3.4 Ophthalmology Report

3.5 Car Parking - The Impact on Patients and Staff and how this is Managed

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4 THEME 3: EFFECTIVE CARE

4.1 Clinical Audit Plan (Local and National)

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5 ITEMS RECEIVED FROM CLINICAL BOARDS QUALITY, SAFETY AND EXPERIENCE COMMITTEE

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

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6 ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE

7 REVIEW OF THE MEETING

8 DATE AND TIME OF NEXT MEETING:

17 September 2019 at 9.00am
Woodland House, Heath, Cardiff CF14 4TT

(Room TBC)

AGENDA

QUALITY, SAFETY & EXPERIENCE COMMITTEE
18 June 2019 at 9.00am
Coed y Bwl, Woodland House, Heath, Cardiff CF14 4TT

1.	**Standing Items**	
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 16 April 2019	Susan Elsmore
1.5	Action Log from 16 April 2019	Susan Elsmore
1.6	Chairs Action taken since last meeting	Susan Elsmore
1.7	**Quality Governance**	
1.8	Patient Story and Clinical Board Assurance Report: Specialist	Dr Navroz Masani
1.9	Quality, Safety and Improvement Framework	Carol Evans
1.10	Patient Experience Framework and Improvement Indicators	Angela Hughes
1.11	ESSURE (issues with the failure of the process)	Ruth Walker
1.12	Infected Blood Inquiry - Update	Ruth Walker
1.13	HTA CAPA Plan Closure Letter	Fiona Jenkins
1.14	**Policies and Procedures:** 1. Ionising Radiation Risk Management Policy 2. Exposure of Patients to Ionising Radiation Procedure 3. Exposure of Staff and Members of the Public to Ionising Radiation Procedure 4. Radioactive Substances Risk Management Policy 5. Radioactive Substances Risk Management Procedure	Fiona Jenkins
1.15	Feedback from Effectiveness Review	Nicola Foreman
2.	**Theme 1: Health Promotion, Protection and Improvement**	
2.1	Health and Care Standards Self-Assessment	Carol Evans
3.	**Theme 2: Safe Care**	
3.1	Cwm Taf UHB Maternity – Cardiff and Vale UHB Lessons Learnt	Ruth Walker
3.2	Point Of Care Testing Alert	Peter Durning
3.3	Position Paper – Model of Stroke Rehabilitation and Workforce	Fiona Jenkins
3.4	Ophthalmology Report	Steve Curry Presentation
3.5	Car Parking – A position paper and impact on patients and staff, how this is managed	Abigail Harris
4.	**Theme 3: Effective Care**	
4.1	Clinical Audit Plan (Local and National)	Peter Durning
5.	**Items Received from Clinical Boards Quality Safety and Experience Committee**	
5.1	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
5.1.1	Clinical Diagnostics and Therapeutics – March and April 2019	Steve Curry
5.1.2	Mental Health – May 2019	
5.1.3	Primary, Community and Intermediate Care – May 2019	

5.1.4 5.1.5 5.1.6 5.1.7	Specialist Services – March and April 2019 Medicine – March 2019 Surgery – March 2019 Children and Women – March 2019	
6.	**Items to bring to the attention of the Board/Committee**	Susan Elsmore
7.	**Review of the Meeting**	Susan Elsmore
8.	**Date and time of next Meeting: 17 September 2019 at 9.00am, Corporate Meeting Room, Woodlands House, Heath**	Susan Elsmore

UNCONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 23 APRIL 2019 CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL WALES

Present:		
Susan Elsmore	SE	Committee Chair
Maria Battle	MB	UHB Chair
Michael Imperato	MI	Independent Member - Legal
Dawn Ward	DW	Independent Member – Trade Union
In attendance:		
Steve Curry	SC	Chief Operating Officer
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
Christopher Lewis	CL	Deputy Director of Finance
Graham Shortland	GS	Executive Medical Director
Ruth Walker	RW	Executive Nurse Director
Alun Tomkinson	AT	Clinical Board Director - Surgery
Ann Jones	AJ	Patient Safety & Quality Assurance Manager
Clare Wade	CW	Acting Nurse Director – Surgery Clinical Board
Ian Wile	IW	Director of Operations – Mental Health Clinical Board
Jayne Tottle	JT	Director of Nursing – Mental Health Clinical Board
Mike Bond	MB	Director of Operations – Surgery Clinical Board
Val Wilmot	VW	Clinical Nurse Specialist
Glynis Mulford	GM	Secretariat
Apologies:		
Akmal Hanuk	AH	Independent Member – Community
Gary Baxter	GB	Independent Member - University
Robert Chadwick	RC	Executive Director of Finance
Observer:		
Urvisha Perez		Wales Audit Office

QSE:	WELCOME AND INTRODUCTIONS	ACTION
19/04/001	The Chair welcomed everyone to the meeting and noted that it was quorate. A special welcome was given to Urvisha Perez from the Wales Audit Office.	

19/04/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
19/04/003	**DECLARATIONS OF INTEREST** The Chair invited Board Members to declare any interests in relation to the items on the meeting agenda. The following declaration of interest were received and noted: ▪ Michael Imperato, Independent Member (Legal) declared a conflict of interest in respect of the Blood Inquiry. The declaration was formally noted and it was agreed that Michael Imperato would leave the meeting for any discussions related to the Blood Inquiry.	
19/04/004	**MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON 19 FEBRUARY 2019** The Committee reviewed the Minutes of the meeting held on 19 February 2019. **Matters Arising:** **19/02/008 - PCIC Clinical Board Assurance Report:** In relation to the environment issue with flooding at Riverside, the Executive Director of Nursing reported that there had been communication with the teams and patient safety visits undertaken. In respect of the mobile units in the Ely Hub and Splott Clinic, it was confirmed that there would be further communication with the team as to date no feedback had been received on the work undertaken. It was confirmed that the Executive Nurse Director would discuss the action needed outside of meeting. **The Committee Resolved - that:** a) the minutes of the meeting held on 19 February 2019 be approved as an accurate record. b) the action needed in relation to the Ely Hub and Splott Clinic would be left to the Executive Nurse Director to discuss outside of meeting.	RW
19/04/005	**COMMITTEE ACTION LOG** The Committee reviewed the Action Log and noted that: ***19/02/010 – Gosport Independent Panel Report:*** There had been a delay in filling the role of the UHB's Medical Examiner. It was confirmed that NHS Shared Services would be responsible for the Medical Examiner recruitment exercise and that a further update would be brought to a future Committee meeting by the Executive Medical Director. ***19/02/007 – Patient Story:*** The Committee was content that this action had been completed.	GS

	18/196 – Emerging Themes from UK Maternity Service Reviews: The Executive Nurse Director confirmed that the report on maternity services at Cwm Taf Morgannwg University Health Board would be published on 30 April 2019 and following publication a report would be brought to the Committee for consideration. ***19/02/012 – Assessment Unit, UHW – Response to the CHCs Concerns:*** The Executive Nurse Director confirmed that a report would be presented at the private session of the Board scheduled for May 2019. **The Committee Resolved – that**: a) the action log be received and noted. b) all completed actions be archived.	
19/04/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** It was confirmed that there had been no Chair's Action taken since the last meeting of the Committee. The Chair also confirmed that at the private session of the Committee held on 19 February 2019: ▪ Steps being taken to improve radiological reporting times were discussed ▪ A paper on gastroscopy and colonscopy decontamination was presented. ▪ The Blood Review was discussed. It was noted that Michael Imperato, Independent Member – Legal, left the meeting due to his declared conflict of interest. ▪ An overview of Safeguarding matters was provided.	
19/04/007	**PATIENT STORY** The Director of Operations for the Surgical Clinical Board introduced the patient story that was titled '*Patient Knows Best'*. The Clinical Board's Director and Clinical Nurse Specialist delivered a presentation and as part of this it was confirmed that: ▪ there was a need to individualise and improve the patients' journey through the care system as patients were having to repeat their information at various points in the care process and at each appointment. Patient's needed to be placed at the centre of the care process and a single shared record would assist this. ▪ *Patient Knows Best* (PKB) PKB works on any computer, anywhere, anytime as long as you have internet access. It has the ability to hold a patient's medical data, connect to wearable activity devices, communicate with the patients' healthcare team and track signs and symptoms. It was noted that PKB is safe, secure and approved for use by the NHS. ▪ PKB enabled timely feedback from patients and therefore supported the quality and safety assurance agenda. The system strengthened engagement as it enabled the team to communicate	

regularly with patients. It was confirmed that funding had been provided to enable a project to test the use of PKB.

- the use of PKB as part of the paediatric tracheostomy care pathway, enabled close links to be developed with patients and their families as both staff and parents were trained how to look after a tracheostomy. It also enabled families to ask questions and get advice quickly.
- the use of PKB as part of the establishment of virtual clinics had commenced and was an area where development continued. It was confirmed that the approach had been used in audiology with good results in the area of cochlear implants as implants could be tuned away from the hospital site. It was noted that the approach empowered patients to make decisions about their own care and had led to a reduction in the number of patient needing to be seen in clinic; overtime this could lead to decrease follow up appointments.
- the use of PKB to issue questionnaires to assess the need for a follow-up appointment for young people with a hearing impairment had reduced follow-up appointments. It was noted that previously individuals had been seen routinely every three months.
- providing patients and their families with access to appointment slots helped reduce cancellations and DNA rates as they were able to move appointments to suit their availability.
- the PKB project was a transformational piece of work on the digital and as part of this the use of Patient Reportable Outcome Measures (PROMs) would need to be considered.
- the Clinical Nurse Specialist role was evolving as part of the PKB development work.

The Committee Resolved - that:

a) the Patient Story be noted

19/04/008 **SURGERY CLINICAL BOARD ASSURANCE REPORT**

The Director of Operations for the Surgery Clinical Board introduced the Surgery Clinical Board's Assurance Report and outlined the arrangements, progress and outcomes in relation to the Quality, Safety and Patient Experience agenda over the previous 12-months. In providing an overview of the detailed Assurance Report it was confirmed that:

- a well-established formal Quality, Safety and Patient Experience (QSPE) that meets bi-monthly, was in place and that this structure is formally replicated by each of the Clinical Directorates.
- The Clinical Board's Risk Register was monitored at Directorate and Clinical Board level. The top three risks on the Clinical Board's risk register as at March 2019 were discussed, these were confirmed as being:

  - The fabric and plant of the main theatre suite at UHW. The

Committee was advised that remedial works had been carried out on the theatres that posed the most significant concern.

- Escalating pressures from medical outliers. It was noted that an escalation process was in place to attempt to accommodate all Surgical patients within the Clinical Board's bed base. It was also confirmed that work being taken forward with Lightfoot enabled the consideration of real time data.
- Increasing Bank/Agency use. The Committee was advised that there were challenges in relation to the recruitment and retention of registered nurse and Allied Health Professionals, although a viable work plan was in place for the future.

- a formal clinical audit plan was in place, which includes both local and national audits. The need to invest in resources to enable regular and consistent data input to national databases was highlighted.
- between 1 April 2018 and 31 March 2019, 52 *Serious Incidents* and three *No Surprise* events had been reported to Welsh Government. It was noted that the learning from Serious Incidents had been taken forward as a team ensuring ownership and understanding at all levels.
- the Clinical Board's Director of Nursing facilitated a UHW wide group to consider and address pressure damage issues. A summary of the work streams delivered over the last 12-months was discussed. As part of discussions the Independent Member - Trade Union, asked if comparisons between the number of reported grade 3 and 4 pressure damage incidents had been made. In response, it was confirmed that there had been a change to reporting arrangements that required only avoidable Grade 3 and 4 damage to be reported.
- Root Cause Analysis (RCA) reviews of the 12 falls reported between 1 April 2018 and 31 March 2019 that had resulted in an injury had not identified any trends or themes.
- four Never Events had been reported during the previous 12-months, all of which had (or were in the process of having) RCA reviews undertaken. It was confirmed that following the completion of a RCA relating to a medication incident changes had been made to pharmacy systems.
- PADR rates were low and the need for these to be improved was acknowledged.

The Committee congratulated the Surgical Clinical Board for its work over the last 12-months and for the improvements made. The leadership of the Clinical Board Director was acknowledged.

The Committee Resolved - that:

a. The progress made by the Surgical Clinical Board be noted.

b. the assurance provided by the Surgery Clinical Board be acknowledged.

19/04/009	**MENTAL HEALTH SERVICES FOR OLDER PEOPLE – IN-PATIENT CARE IMPROVEMENT PROJECT THROUGH ALOS REDUCTION** The Director of Operations and the Director of Nursing for the Mental Health Clinical Board presented the Committee with an overview of the steps being taken to reduce the average length of stay (ALOS), bed numbers and the resources associated with elderly inpatient care. As part of the overview it was confirmed that: ▪ The Mental Health Service for Older People's (MHSOP) Directorate had a total of 115 beds, of which a little over half (66) were acute assessment beds. ▪ Mental Health services has seen 40% of its beds close over the last 11 years with two MHSOP wards closing in the last five years. ▪ The service on average sees a split of 22% / 78% functional / dementia patients within in the inpatient service, which often results in placing functional patients on a dementia ward. ▪ the MHSOP service, remains an obvious national outlier, for high ALOS and bed numbers in the UK, specifically for its elderly population in hospital beds. It was noted that the MHSOP was initially working towards reducing the number of beds by 9/10 within the 2019-20 calendar year, with a further 4/5 beds released in quarter four. This would require an average length of stay of 89-91 days, which would be in line with upper quartile ALOS in benchmarking peer organisations. The Committee was advised that the intention was to either reduce a small number of beds on each of the assessment wards or close an entire ward. It was confirmed that the latter would require Community Health Council involvement at an early stage for engagement/consultation purposes The Committee was advised that a number of work-streams had been implemented to improve efficiency and effectiveness, including: ▪ discharge planning from admission ▪ effective reporting and monitoring of ALOS and inpatient pathway performance ▪ staff training and awareness of long lengths of stay ▪ closer working with social work, Complex Care Commissioning Team and community teams ▪ Multi-Disciplinary Team (MDT) working and ward rounds ▪ Clarity of MDT roles and responsibilities ▪ Optimisation of support services such as crisis and day services. The dementia service has all the ingredients of a community service that is capable of keeping people out of hospital, with a crisis team, nursing home liaison service and a typically resourced integrated community service. ▪ appointment of a pilot Band 7 clinical post in MHSOP to look at improving inpatient pathways and ALOS in MHSOP ▪ the provision of support by Judith Hill, Head of Integrated Care to	

look at LOS and patient flow; focussing on care at the right time and in the right place.

The Executive Nurse Director advised the Committee that there was Regional Partnership Board funding set aside for dementia and confirmed that that community developments were progressing at a good pace.

The committee Resolved – that:

a) the work being conducted by the Mental Health Clinical Board be noted

b) a phased bed reduction programme of up to 14/15 beds in 2019/20 be supported.

19/04/010 **MENTAL HEALTH CLINICAL BOARD: REPORT ON MEDICAL COVER FOR MENTAL HEALTH PATIENTS WITH PHYSICAL HEALTH NEEDS ON THE LLANDOUGH HOSPITAL SITE**

The Executive Medical Director and Executive Nurse Director provided the Committee with a verbal update in respect of the situation in relation to medical cover for mental health patients with physical health needs on the Llandough Hospital site. As part of this update it was confirmed that:

- concerns had been highlighted with regards to the availability of medical support in the event of a cardiac arrest. The Committee was advised that in the case of an emergency it had been agreed that the cardiac arrest team would attend Llanfair Unit on a 2222 call. It was noted that further work was needed to firm up arrangements for the transportation of patients to the most appropriate care facility.
- there would also be occasions when the most suitable course of action would be to make a 999 call (e.g. following a fall and/or fracture) and Clinical Boards had been asked to communicate this information to their frontline staff.
- if a clinician contacted WAST and was clear that the patient was acutely unwell, WAST had given assurance that they would respond in a clinically based way and transport the patient as an appropriate priority. If any problems arose in relation to ambulance transport, it was confirmed that the team had been advised to go through the Executive Medical Director and/or Executive Nurse Director.
- The Hospital at Night arrangements at Llandough Hospital was an area in need of strengthening. It was noted that support had been offered and the medicine team had been asked to undertake risk based assessments
- The Executive Medical Director confirmed that he was content with resuscitation arrangements at Hafan y Coed, and confirmed that all psychiatrists had been reminded of their responsibilities in respect of the physical health needs of their patients. It was noted that a senior nurse had ben delegated responsibility for providing support in relation to physical health needs, and that the team had

access to the GP service for the management of chronic conditions.

- It was acknowledged that as additional specialities were introduced on the Llandough Hospital site the risks and complexities aligned to the Hospital at Night would need to be closely monitored.

The Committee Resolved – that:

a) the verbal update provided by the Executive medical Director and Executive Nurse Director be noted.

19/04/011 **COMMUNITY HEALTH COUNCILS REPORT: ONE SIMPLE THING – COMMUNICATION IN THE NHS AND THE UHBs RESPONSE**

The Assistant Director of Patient Experience provided the Committee with an overview of the findings of the Community Health Councils report *One Simple Thing – Communication in the NHS* and the UHBs response. The Committee was advised that:

- the report was an all-Wales report and so the findings were generic rather than UHB specific.
- The report was structured around nine themes, namely:
  - Attitude, understanding and listening.
  - Empathy when delivering bad views
  - Keeping people informed and involved
  - Appointments
  - Using technology
  - Coordination of care and communication across services
  - Using Welsh
  - Meeting individual needs
  - Raising concerns
- communication was one of the biggest themes arising from concerns raised by patients of the UHB.

An overview of the steps being taken by the UHB to improve communication was provided.

The Committee Resolved – that:

a) the findings and recommendations set out in the Community Health Councils report *One Simple Thing* and the UHBs response be noted.

19/04/012 **ANNUAL QUALITY STATEMENT FOR 2018-19 (FIRST DRAFT)**

The Executive Nurse Director presented the Committee with the draft Annual Quality Statement (AQS) for 2018-2019 for approval. The Committee was advised that for the 2018-19 financial year the requirements for submitting the report had been brought forward by three months. The Committee noted that the draft AQS had been reviewed by the Management Executive and comments made addressed.

	A high level overview of the draft AQS was provided by the Patient Safety & Quality Assurance Manager. As part of the overview it was confirmed that: ▪ The draft report had been developed in collaboration with colleagues across the health board and in partnership with the Community Health Council, as well as through engagement with the Stakeholder Reference Group. ▪ Each chapter of the AQS was aligned to a Health and Care Standards theme, and contained three components including the Quality, Safety and Improvement framework, patient and staff story and examples of improvements and areas to focus on during 2019-2020. ▪ The patient and staff stories included in the AQS had been developed with clinical teams and patients across the UHB to reflect the approach being taken to ensure that care is being provided in the most appropriate settings. ▪ Due to the timeframes for publication final year figures around performance and delivery would be inserted following the approval of the draft and before publication. ▪ The AQS was subject to audit by Internal Audit prior to publication. ▪ The approach to developing the AQS was changing and guidance from Welsh Government was awaited. It was noted that it was likely that the UHB would develop a website with up to date Quality, Safety and Experience information. ▪ Feedback on the draft was required by 30 April. Due to the timing of the May Board meeting it was necessary to agree arrangements for the sign-off of the draft AQS by the Committee. **The Committee Resolved – that:** a) the draft Annual Quality Statement be approved, subject to any comments received by 30 April 2019. b) final sign-off of the Annual Quality Statement, on behalf of the Committee, would be delegated to the Committee Chair.	All
19/04/013	**POLICIES FOR APPROVAL** The Executive Nurse Director presented the following Policies and related Procedures for Approval: ▪ **Labelling of Specimens Submitted to Medical Laboratories Policy and related Procedure:** This policy and supporting procedure describes the requirements for accurate positive identification of the patient from whom the specimen was taken, the clinical details surrounding the patient and the person and location where the result should be sent. ▪ **Venepuncture for Non Clinically Qualified Research Staff Policy and Related Procedure: T**his policy and supporting	

	procedure identifies the key standards required to ensure the safe practice of venepuncture by research staff without clinical qualifications working within Cardiff and Vale University Health Board **The Committee Resolved - that:** a) the Labelling of Specimen's Submitted to Medicine Laboratories Policy and related Procedure be approved b) the Venepuncture for Non-Clinically Qualified Research Staff Policy and related Procedure be approved	
19/04/014	**HEALTH AND CARE STANDARDS ANNUAL AUDIT REPORT** The Health and Care Standards Annual Report was presented by the Executive Nurse Director; a video accompanied it. The Committee was advised that feedback received from patients as part of the annual audit had confirmed the high standards of care provided across the UHB, with an overall satisfaction rate of 92% (91% in 2017 & 89% in 2016). It was also noted that nearly all patients (98.4%) who participated in this year's audit reported that they had been 'always' or 'usually' treated with dignity and respect during their stay or attendance to hospital. The Committee discussed the areas that had received low feedback scores i.e. sleep and rest with an overall patient satisfaction rate of 77.82%; provision of help and advice to prevent damage to skin - 79%; 63% in relation to question: *Were you able to speak Welsh to staff if you needed to?* and 73% in relation to: *parents were encouraged to attend ward rounds (paediatric & neonatal areas).* The Executive Nurse Director advised the Committee that a comparison of compliance with operational standards over the last three years demonstrated that clinical areas had achieved greater and more frequent improvement, specifically in relation to: ▪ Nutrition and Hydration: staff knowledge of dietary requirements, frequency of beverage rounds, frequency of water jug changes and availability of snacks ▪ Care planning & evaluation of care for people who lack capacity ▪ Evaluating the care of people with substance misuse problems ▪ Provision of smoking cessation information ▪ Medication charts completed fully and correctly Reduction in compliance, totalling more than 5% over three years, were confined to the following standards: ▪ Fire restraint doors are free from obstruction or closed ▪ Assessment of cultural & spiritual needs ▪ Reviewing patient hygiene and continence needs within agreed timescales ▪ Patient documentation captures their preferred name	

The Independent Member, Legal asked whether timescales for implementation were attached to the Standards, and whether the impact of non-compliance had been clearly set out. In response, it was confirmed that the Health and Care Standards established a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for improvement. It was also confirmed that many of the Standards are overlapping and interrelated, and that where concerns had been highlighted a further audit would be undertaken.

The Executive Nurse Director confirmed that a number of the areas for improvement highlighted by the Annual Audit had already been identified by the UHB and as a result improvement work was already progressing. Such areas included, length of stay, pressure damage, discharge and patient flow.

The Chair of the UHB advised that in relation to the Standard relating to the spiritual and pastoral care needs of people and their carers it had been recognised that staff needed further guidance and support to ensure that they asked the right questions in the right way. The Independent Member, Trade Union offered her support and assistance in this task.

The Committee discussed the feedback received in relation to cleanliness and it was recognised that often the age of the UHB estate impacted on a patient's perception of cleanliness. It was agreed that such perceptions needed to be appropriately addressed.

The Committee Resolved – that:

a) The continued improvements made across most standards, especially in relation to; nutrition & hydration, evaluation of care for people with substance misuse problems, availability of smoking cessation information, full completion of medication charts and care planning for people lacking capacity be noted.

b) The high parent satisfaction (95%), based on over 300 responses, achieved within Children's Community Directorate be noted. The Committee also noted that this high rating had the effect of increasing the UHB's overall patient satisfaction to its highest recorded level (92%)

c) The reduced compliance with Standards, that had occurred for three consecutive audits be noted.

19/04/015 **PATIENT SAFETY SOLUTIONS (STANDARD 2)**

The Assistant Director of Quality and Safety presented a high level update on the UHB's position in relation to Patient Safety Solutions, which include alerts and notices from Welsh Government. The Committee was advised that:

- overall compliance with Patient Safety Solutions where the deadline had passed was 93% (compliant with 51 out of 55).
- Two Safety Solutions had been recently issued by Welsh Government, and work was underway to ensure compliance by the

required deadline:

- PSA009 – Wrong selection of orthopaedic fracture fixation plates
- PSN047 – Management of life threatening bleeds from arteriovenous fistulae and grafts

- The UHB had been unable to confirm compliance with the following Safety Solutions:
  - PSA008 – Nasogastric tube misplacement: continuing risk of death and severe harm. It was noted that the particular issue to address with the Alert related to uptake of competency- based training for all staff who undertake the procedure, regardless of seniority.
  - PSN030 – The safe storage of medicines: This Notice is subject to further consideration by Welsh Government.
  - PSN040 – Confirming removal or flushing of lines and cannulae after procedures. It was confirmed that the outstanding issue to address relates to amending the 'sign out' section of WHO surgical safety checklists in operation. The UHB is currently undertaking a review of all Directorate WHO checklists for this to be considered.
  - PSN043 – Supporting the introduction of the Tracheostomy Guidelines for Wales. It was noted that an audit of all patients in the community who have a tracheostomy is currently being undertaken.

The Committee acknowledged the improvements made by the Patient Safety Team.

The Committee Resolved – that:

a) the Patient Safety Solutions update be noted.

19/04/016 **PATIENT FALLS (STANDARD 2.3)**

The Executive Director of Therapies and Health Science provided the Committee with an overview of the work undertaken in respect of falls prevention and described the UHB's proposed approach to falls prevention going forward. An update on the launch of the Falls Prevention Framework and the outcome of the first Community Falls Prevention Alliance workshop held in March 2019, was also provided.

The Executive Director of Therapies and Health Science advised the Committee that data analysis by Lightfoot has identified that there were:

- 500-600 attendances (including Paediatrics) to the Emergency Department (ED) at UHW as a result of falls each week.
- 40-50 of those patients aged 75+ discharged from ED following a fall, will re-attend ED.
- 7 patients aged 75+ were admitted per week with fractured neck of femur, with an average length of stay of 20-45 days, occupying 30-50 beds at any one time.

	It was also noted that the key focus of the '*Falls Framework: Reducing Risk and Harm*' was primary prevention and the community falls pathway. It was confirmed that the UHB had: ▪ recently entered into a partnership with Canterbury District Health Board. As part of the Health Pathways and Alliancing approach a Community Falls Prevention Alliance had been set up to address the primary prevention, healthy ageing and community services prevention and management aspects of the framework. ▪ already made significant progress in implementing a number of schemes such as Model Ward, Get me Home and End PJ Paralysis which all contribute to promoting independence and preventing decline. ▪ facilitated the first meeting of the Community Falls Prevention Alliance on 25 March 2019, bringing together representatives from multiple services and organisations An update on Stay Steady Clinics; Simulation Training for inpatient staff and Staying Steady Schools was also provided. It was also confirmed that team members from Canterbury would return in May to continue the work on systems development. **The Committee Resolved – that:** a) the progress made by the Falls Delivery Group in the development of the Framework and Community Falls Alliance be noted. b) the new Falls Framework: Reducing risk and harm across the UHB be shared, spread and embedded. c) the development of the Community Falls Prevention Alliance Scope development of an Inpatient Falls Prevention Alliance to address inpatient falls prevention and management be developed. d) uptake and embedding of Simulation Training for inpatient staff be encouraged. e) the second running of Staying Steady Schools scheme for 2019 be implemented. f) Stay Steady Clinics and improved WAST referral pathways to CRT across UHB (Transformation Bid funding dependent) be rolled out. g) links and availability of strength and balance exercise groups in the community to improve long-term outcomes be improved.	
19/04/017	**PRIMARY OUTCOME: PEOPLE ARE SUPPORT TO MEET THEIR NUTRITIONAL AND HYDRATION NEEDS, TO MAXIMISE RECOVERY FROM ILLNESS OR INJURY (STANDARD 2.5)** The Executive Director of Therapies and Health Science presented the Committee with an overview of the UHB's approach to the assessment of compliance against the Health and Care Standard 2.5. As part of this overview the criteria and evidence used to undertake the assessment was discussed. It was also noted that good progress had been made in many areas notably staff catering and public health with reference to the	

delivery of the corporate health standard framework.

The Committee was advised that the implementation of a Model Ward across four wards within the UHB had enabled a standardisation of nutrition and hydration practices across the inpatient setting. It was also noted that the Model Ward had been accepted as a Bevan Exemplar and for a research grant.

Progress in implementing the improvement actions identified as key deliverables for 2018-19 was discussed. The following next steps were brought to the Committee's attention:

- The Nutrition and Hydration Bed plan to be embedded in ward routine and processes as the tool that is used to record patients dietary needs and for the Nursing and Midwifery Board to mandate its use for all wards across the UHB requires further work
- Ward managers take up the role of supporting the implementation of the bed plan on the ward through raising awareness of the benefits of using the tool and auditing its use on the ward
- Review the role of the qualified nurse in overseeing the meal service and develop a role profile
- Ensure new descriptor for dysphagia (IDDSI) knowledge is embedded across the Health board
- Development of a suite of models of delivery for nutrition training offer in the light of reduction in nurse induction time
- Address concerns highlighted in the CHC visit and HIW report around nutrition and hydration at front door following. No funded dietetic service in the Emergency Unit
- Subject to business case approval the Implementation of All Wales catering IT system
- Roll out of model ward for Nutrition and Hydration to other wards in the UHB subject to a funding stream

The Committee acknowledged the work of Rebeca Aylward, Director of Nursing, Medicine Clinical Board and Judith Jenkins, Head of Dietetics in respect of the Model Ward. Committee Members also offered their congratulations to the Multi-Disciplinary Team who had been successful in securing a UK award for efficiency improvements in respect of nutrition and hydration at a the Hospital and Caters Association (HCA) national conference. It was noted that this was the first time the Wales branch of the HCA had won an award in 12-years.

The Committee Resolved – that:

a) progress against the actions identified as key deliverables for 2018-19 be noted.

b) The new challenges set out in the report be noted.

c) A copy of the power-point presentation that accompanied the paper be circulated to Committee Members.

19/04/018	**OVERVIEW OF REGULATION 28 REPORT 2018/19** The Assistant Director of Patient Safety and Quality provided the Committee with an update on the Regulation 28 reports issued by the Coroner to the UHB during 2018-2019. It was noted that during 2018-2019 the Coroner had issued five Regulation 28 reports and had written to the UHB on two further occasions to raise issues following the conclusion of an inquest. The Committee was provided with a brief overview of each of the five cases: The Committee was advised that in two of the cases the UHB had not been informed of the inquest, as a result UHB staff had not been given the opportunity to provide assurance to the Coroner on the processes in place. The UHB's involvement could have potentially avoided the issue of a Regulation 28 report. The Committee was informed that a request for the Coroner's Office to liaise with the corporate departments prior to Inquests had been made. **The Committee Resolved – that:** a) the overview of the recommendations made by Her Majesty's Coroner be received. b) the actions undertaken in response to the internal investigations and Coroner's recommendations be noted.	
19/04/019	**ENDOSCOPY DECONTAMINATION – PATIENT NOTIFICATION EXERCISE** The Executive Nurse Director provided the Committee with an overview of the Endoscopy Decontamination Patient Notification Exercise (PNE), reminding the Committee that during a decontamination process undertaken in August 2018, the UHB had identified that a gastroscope and a video colonoscope had not been adequately decontaminated in line with the manufacturer's decontamination re-processing instructions. The Committee was advised that this had happened because each endoscope contained a sixth internal channel that staff were unaware of. The Committee was advised that: ▪ A multi-disciplinary Serious Incident Management Team (SIMT) had been established and the UHB was worked closely with colleagues from Public Health Wales to investigate the matter. ▪ A total of 111 patients underwent procedures involving the endoscopes. ▪ Patients who received procedures with the two endoscopes may have been placed at a very low risk of infection from blood borne viruses (hepatitis B, hepatitis C and HIV). Based on this clinical advice, Public Health Wales did not recommend screening for all patients as the risk is very low. However, a telephone line was set up and if a patient wishes necessary arrangements for a simple blood test screening for BBV, can be made.	

	▪ No other six channelled endoscopes were in use in the UHB and all endoscopes in use, were being decontaminated in line with manufacturer's instructions. ▪ The UHB, with the support of Public Health Wales and the Community Health Council, carried out a PNE in the weeks commencing 25th March 2019 and 1st April 2019. ▪ A helpline was provided by Public Health Wales and this was made available from 26th March 2019 – 29th March 2019 and from April 1st to April 5th form the hours of 09.00 to 17.00hrs. ▪ Fourteen patients had contacted the UHB via the telephone helpline and eight of those wished to undergo tests. The Committee Chair thanked Clare Wade for preparing the paper and acknowledged the amount of work that had gone into ensuring the PNE was effective. It was confirmed that the information and learning would be shared with other Directors of Nursing and Clinical Boards. The Executive Director of Therapies and Health Science also commended the work of the team and highlighted the need for a central decontamination department and strengthened centralised decontamination facilities and standard UHB wide procedures. It was agreed that the Executive Director of Therapies and Health Science would bring a progress update to a future Committee meeting. **The Committee Resolved – that:** a) the actions taken in response to the decontamination incident be noted. b) the outcomes arising from the Patient Notification Exercise be noted. c) all the necessary steps had been taken to avoid a re-occurrence of this incident and that all reasonable steps had been taken in respect of the affected patients d) the learning from the incident and Patient Notification Exercise should be shared Directors of Nursing and Clinical Boards e) a progress updated should be scheduled for a future meeting of the Committee.	FJ
19/04/020	**CANCER PEER REVIEW: THYROID (STANDARD 3.1)** The Executive Medical Director outlined the findings of the initial review of the UHB's Thyroid Cancer Services which took place on 3 December 2018. As part of his summary the Executive Medical Director noted that while no immediate risks had been highlighted, the following serious concern had been noted: ▪ *Rare, advanced and complex cancer cases*: As the number of cases are small the panel suggest the MDT should agree the criteria for rare and complex cancer cases to be referred to a nominated specialist centre/s for treatment and management.	

	The Executive Medical Director outlined the six areas for improvement highlighted as part of the review. It was confirmed that the improvements needed required collaborative working at a regional level and through the Cancer National Network. The fact that members of the Peer Review team also had a role as part of the Cancer National Network was noted. The Executive Medical Director confirmed that he would continue conversations outside the meeting with the Cancer National Network to ensure their full engagement. **The Committee Resolved – that:** a) the report on the Thyroid Cancer Peer Review be noted. b) appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.	
19/04/021	**NATIONAL HIP FRACTURE DATABASE (NHFD): IMPLICATIONS OF THE 2018 NHFD ANNUAL REPORT FOR PATIENT CARE IN CARDIFF AND THE VALE** The Executive Medical Director provided the Committee with an update on the NHFD, confirming that the 2018 Annual Report focused on case mix adjusted 30 day mortality and six new Key Performance Indicators (KPIs). It was noted that Welsh Government require UHBs to report quarterly on their progress against the six KPIs. The eight key findings set out in the NHFD Annual Report, and the UHB's response to these were discussed by the Committee. It was confirmed that: ▪ Findings highlighted a need to re-design the admission and treatment pathways; ▪ Work was in hand to unify the approaches to pre-op. and post-op. care bundles for hip fracture and general trauma patients. ▪ The Clinical board had invested in two trauma nurse practitioners to support patient flow from the Emergency Unit to the perioperative phase ▪ value ward based social worker (± AHP) will be explored through the Lightfoot work streams. ▪ Two different teams would be created and be responsible for flow at the front and back door and design the metrics. A separate team would be formed for the theatre environment who would redesign the way the list was run inside the theatre. Work needed to be undertaken with the ambulance service and for patients to be prepared for theatre. Less theatre time and beds would be used and instead of discharging back to residential home patients could be discharged to their home. ▪ The Challenge was the need for clinicians both in and out of hospital to adhere to the pathways and deliver on making change	

	occur. ▪ The Clinical Board would be happy to update the Committee on the progress of the Lightfoot work later this year. **The Committee Resolved – that:** a) the Surgical Board action plan be agreed. b) an update on the Lightfoot work be added to the Committee Work Plan.	GM
19/04/022	**HEALTHCARE INSPECTORATE WALES (HIW) ACTIVITY UPDATE** The Assistant Director of Quality and Safety provided the Committee with an update on the inspections and reviews undertaken by Healthcare Inspectorate Wales and the findings arising. It was confirmed that: *Thematic reviews* ▪ The final report of a review of *Patient discharge from Hospital to General Practice* was issued in August 2018. It was noted that an action plan was under development and would reported to the Committee in June 2019. ▪ The report of the All Wales Joint Thematic review of Community Health teams was published in February 2019. It was noted that the UHB had developed an improvement plan to address the findings. ▪ The UHB had participated in phase 1 of a review that set out to answer the question *How are Healthcare services meeting the needs of young people?* It was noted that although a phase 2 was anticipated it was not undertaken. HIW published their final report on 22 March 2019 and this will be reported in full at the Committee meeting scheduled for June 2019. *Special reviews* ▪ In March 2018, HIW commissioned an Independent Review of how Abertawe Bro Morgannwg University Health Board (ABMUHB) handled abuse allegations made against (KW). One of the patients who made an allegation against KW was a patient of Cardiff and Vale UHB and, as the UHB remains a commissioner of learning disability services from ABMUHB, it was recognised as a stakeholder in this process. It was noted that a stakeholder meeting was held on 19 April which was attended by the UHB who have fully engaged in the process as required. *Announced visits* ▪ Vale Locality Mental Health Team: Feedback was largely positive. There were no immediate assurance issues. It was confirmed that the UHB had submitted an improvement plan and was currently awaiting confirmation that HIW was satisfied with the steps being taken to address the findings. It was confirmed that the findings would be reported to the Committee in more detail in the next	

report to Committee in June 2019.

Unannounced inspections

Two unannounced visits had been undertaken, namely:

- a visit to Mental Health Services at Hafan Y Coed during the week commencing 18 March 2019. It was noted that feedback was very positive with no immediate assurance issues and that the findings would be reported in more detail at the June 2019 Committee meeting
- The Emergency and Assessment Units (EU/AU) at University Hospital of Wales during week commencing 25 March 2019. It was noted that while the reviewers could not speak highly enough of the staff that they met over the three day visit, immediate assurance issues in relation to the suitability of the Lounge area in the AU as an area for unwell patients who want to sleep and/or lie down, staffing levels in the Medical Assessment care Unit (MACU), checks in relation to the resuscitation trolley, fridge temperatures had been identified.

The Committee was provided with an overview of the immediate actions taken to address the concerns raised and it was noted that in lieu of the fact that the HIW report was yet to be received a more detailed discussion would take place in the private session that followed.

Primary Care Contractors

It was noted that an announced visit to a Dental Practice in Cardiff and the Vale had resulted in an immediate assurance issue in relation to the recording and monitoring of fridge temperatures. It was noted that this had been addressed by the practice and that HIW had confirmed that they were satisfied with the action taken. It was confirmed that a full update on primary care inspections would be presented to the June 2019 meeting of the Committee

The Committee Resolved – that:

a) the level of HIW activity across a broad range of services be noted.

b) the appropriate processes were in place to address and monitor the recommendations.

c) a further report be considered when the Committee met in June.

d) HIW be reminded of the need to send copies of all reports to the Chief Executive so that robust corporate governance arrangements could be implemented.

19/04/023 **COMMITTEE SELF-ASSESSMENT OF EFFECTIVENESS**

A verbal update was provided by the Director of Corporate Governance on the Committee's Self-Assessment of its effectiveness. It was

	confirmed that the Communications Team were coordinating feedback from Committee Members using Survey Monkey, and that survey questions would be circulated by the end of the week. **The Committee Resolved – that:** a) the verbal update on the Committee Self-assessment process be noted and an update be provided at the meeting of the Committee scheduled for June 2019.	NF
19/04/024	**ITEMS RECEIVED FOR NOTING AND INFORMATION** The Assistant Director of Patient Safety and Quality provided a summary and update in relation to the key patient experience, quality and safety issues escalated by Clinical Boards. As part of this summary the following points were highlighted: *Clinical Diagnostics and Therapeutics Clinical Board* ▪ Issues had been raised by Podiatry in relation to heel pressure ulcers, and escalated to the Chair of UHB Pressure Ulcers Group so that themes and trends could be reviewed. It was noted that the Clinical Board would continue to ensure that such issues were escalated. ▪ Phlebotomy at Barry was reporting a marked increase in demand on its services and there has been an increase in complaints from patients. It was noted that information had been sent out to GP Practice Managers regarding the service, and an extra phlebotomist has also been sent to Barry Hospital to provide additional resource. *Specialist Services Clinical Board* ▪ The issues related to Urology Services for spinal injury patients in Rookwood remained unresolved. It was noted that Urology had raised concerns about the suitability of the area provided in Rookwood for the service but the nature of these concerns remained unclear. ▪ The Joint Accreditation Committee ISCT and EBMT (JACIE) inspections of the South Wales BMT Programme had been positive especially regarding Quality management/data management/processes/protocols, but the state of the physical facilities at UHW site (adults) had been highlighted as a weakness. **The Committee Resolved – that:** a) the key patient experience, quality and safety issues highlighted in the report be noted and further updates brought to future meetings of the Committee.	RW
19/04/025	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD / COMMITTEE**	

	The Committee Chair confirmed that the following items should be brought to the attention of the Board: ▪ The Committee's feedback on the Annual Quality Statement and the action agreed. ▪ The key findings and recommendations arising from the Annual Health and Care Standards audit. **The Committee Resolved – that:** a) the Committee's feedback on the Annual Quality Statement and the action agreed, together with the key findings and recommendations arising from the Annual Health and Care Standards Audit be brought to the attention of the Board.	SE
19/04/026	**REVIEW OF THE MEETING** The Committee Chair facilitated a review of the meeting. Members confirmed that: ▪ Discussions and the level of scrutiny was improving in terms of depth and maturity, with open recognition of the key challenges. ▪ the meeting had been managed well in terms of timing and ensuring a focus on the key issues. **The Committee Resolved – that:** a) the review of the meeting be noted.	
19/04/027	**ANY OTHER URGENT BUSINESS** No other business was raised	
19/04/028	**DATE OF THE NEXT MEETING OF THE QUALITY AND PATIENT SAFETY COMMITTEE:** Tuesday, 16 June 2019, Woodlands House, Heath, Cardiff	

ACTION LOG

QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING
16 APRIL 2019

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
QSE 19/04/023	Committee Self-Assessment of Effectiveness	Update to be provided on Self-Assessment	18.06.19	N Foreman	**COMPLETED.** On agenda for June 2019
QSE 19/04/021	National Hip Fracture Database (NHFD): Implications of the 2018 Annual Report for Patients in Cardiff and Vale UHB	An update on the Lightfoot work to be added to the committee workplan		GM	**COMPLETED**
QSE 19/02/013	Concerns and Clinical Negligence Claims	Stroke Rehabilitation Centre - to present a position paper to a future meeting Ophthalmology – to gain better understanding regarding service improvement activity. A report would be considered for a future meeting. Car parking – to provide a further update at the next meeting	19.02.19	F Jenkins S Curry A Harris	**ALL COMPLETED.** On agenda for June 2019
QSE 19/04/012	Annual Quality Statement for 2018-19	Feedback on draft required by 30 April	30.04.19	All	**COMPLETED**
QSE 19/02/012	Assessment Unit, UHW – Response to the CHCs Concerns	To have feedback on the footprint work and discussion with Surgical Clinical Board. To see a trajectory of improvement and vision of where this was going and for the Chief Operating		S Curry	**COMPLETED.** Discussed at private Board meeting

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
		Officer to undertake this			
QSE 18/053	Quality Safety & Improvement Framework	Receive detailed outcome based report	17/04/18	C Evans	**COMPLETED.** On agenda for June 2019
QSE 18/203	Point of Care Testing	To be reviewed in six months' time.	18/12/18	R Walker	Update at QSE June 2019 meeting
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	S Curry	**COMPLETED.** Update provided at QSE April 2019
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 their babies in Cwm Taf.	18/12/18	C Evans	**COMPLETED.** C Evans spoken with Melanie Wilkey and Director of Operations for Children and Women
QSE 18/190	Patient Story	An update to be provided at the April meeting and a report on what is the medical cover for mental health patients with physical health needs on the Llandough site to be brought to a future meeting	19/02/19 18/12/18	G Shortland / R Walker	**COMPLETED.** A verbal update will be provided at the April 2019 meeting and a report will be submitted to a future meeting.
Actions In Progress					
QSE 19/04/025	Items to be brought to the attention of the Board / Committee	Feedback on Annual Quality Statement and action agreed Key findings and recommendations arising from the Annual Health and Care Standards to be brought to future meeting	25.07.19	S Elsmore	Items to bring to the attention of the Board
QSE 19/04/020	Endoscopy Decontamination – Patient Notification Exercise	To provide a progress report to a future committee meeting	17.09.19	F Jenkins	
QSE 19/02/010	Gosport Independent Panel Report	An update will be brought on the Medical Examiner Role	17.09.19	G Shortland	A delay in filling the role was reported in April's meeting. The NHS Shared Services would be responsible for the

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
					recruitment exercise. An update would be received at a future meeting.
QSE 19/02/008	PCIC Clinical Board Assurance Report	No feedback had been received regarding the mobile units in the Ely Hub and Splott Clinic. The Executive Nurse Director would discuss action needed outside the meeting	18.06.19	R Walker	Verbal Update
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 April 2019 Verbal Update: QSE April 2019
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 provide an update on the lifts refurbishment programme at the June Committee meeting	18/12/18 19/02/19	S Elsmore A Harris	The Committee chair to write to Sharon Hopkins as lead in commissioning to provide assurance that all LTAs would have a proforma with a specific quality clause around the commissioning function and would go to the ME meeting for further discussion. A report will be presented in June meeting with schedules up to 2021.
Actions referred to committees of the Board					

Report Title:	**Specialist Services Clinical Board Assurance Paper**								
Meeting:	**Quality, Safety and Patient Experience committee**						**Meeting Date:**	18th June 2019	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Executive Nurse Director**								
Report Author (Title):	**Jessica Castle, Director of Operations** **Ceri Phillips, Lead Nurse Cardiothoracic Directorate**								

SITUATION

This report provides details of the arrangements, progress and outcomes within the Specialist Services Clinical Board in relation to the Quality, Safety and Patient Experience agenda over the last 12 months. It will highlight the achievements, progress and planned actions of the Specialist Services Clinical Board in its aim to continue to improve and develop this very important agenda within the Clinical Board.

BACKGROUND

During the financial year 2018/19, the Specialist Services Clinical Board comprised seven clinical Directorates with associated clinical services and sub-specialties. The Clinical Board delivers a number of highly specialised services serving both the South East region and wider all Wales population. The services also generally provide secondary care services to the local Cardiff and Vale population. For certain specialities, services are provided on a South Wales and All Wales basis. The Clinical Board has a budget of £157m and a current workforce establishment of 1,690WTE staff.

The services provided by the Clinical Board are predominantly Welsh Health Specialised Services Committee (WHSSC) commissioned and provide for the wider regional and Welsh population. Services are structured through the seven Directorates outlined below:

- Cardiothoracic Services
- Critical Care
- Haematology & Clinical Immunology
- Medical Genetics
- Nephrology & Transplant
- Neurosciences
- Artificial Limb & Appliance Service (ALAS)

The Specialist Services Clinical Board has a well-established formal Quality, Safety and Patient Experience Committee (QSPE) that meets every 3 weeks which is co-chaired by the Director of Nursing for Specialist Services Clinical Board and the Medical Lead for Quality and Safety who is a Consultant Intensivist. This structure is formally replicated in each of the Clinical Directorates. The QSPE group has two key sub-groups that report to it; a Health and Safety

group and Infection Prevention and Control group. The Health and Safety group meets quarterly and the Infection Prevention and Control group meets bi-monthly. They have formal terms of reference, are formally minuted and have a range of different stakeholders who attend to ensure that there is wide engagement in the overarching quality and safety agenda.

This report provides assurance of the progress being made within the Specialist Services Clinical Board with regard to:

- The Welsh Government Quality Delivery Plan for the NHS in Wales
- The Clinical Board's Operational Plan and IMTP
- Quality & Safety agenda
- Infection, Prevention and Control Annual work programme
- Health and Care Standards
- Patient Experience
- Financial and Information Governance
- Organisational Development and Workforce Planning
- National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)

ASSESSMENT AND ASSURANCE

The Clinical Board has an agreed agenda and comprehensive work plan for the next 12 months. The plan includes monitoring service delivery against required standards, monitoring and managing risks through the e-Datix reporting system and the risk register.

Assurance is received via the robust mechanisms which are in place such as the UHB's Internal Audit processes and through the Clinical Board's QSPE group and formal business meetings all of which have very strong medical, nursing and managerial representation and are fully minuted.

In summary the Specialist Services Clinical Board Quality, Safety and Patient Experience strives through strong leadership to:

- Ensure that there is a continuous review of the quality and safety risks and take action to mitigate these on an ongoing basis.
- Continue to maintain a culture of improving quality, safety and patient experience throughout the Clinical Board.
- Continue to develop a culture of excellent staff engagement in the quality and safety agenda.

ASSESSMENT

Governance, Leadership and Accountability

Quality, Safety and Patient Experience is the highest priority for the Specialist Services Clinical Board which has a robust and well attended Quality and Safety group with strong representation from Nursing, Medical, Managerial and Allied Health Professionals from both within and external to the Clinical Board.

The Quality and Safety group undertakes an annual self-assessment against the Health and Care Standards and regular reviews and updates of the Clinical Board Risk Register. There is an opportunity at every meeting for exceptional risks or incidents to be highlighted and discussed.

The Clinical Board receives local updates from Directorates to inform the Clinical Board Risk Register as well as receiving information from commissioners (WHSSC) which may identify risks around service sustainability and offer mitigation in terms of addressing known risks through the annual planning process. The top 5 risks on the Clinical Board risk register in March 2019 are:

Risks	**Risk Score**	**Actions to Manage or Mitigate**
Insufficient Critical Care capacity to meet demand including insufficient numbers of commissioned beds for the population and to meet increasing demands for the service, workforce shortages to deliver services (in particular medical staff) and minimal options to expand the Critical Care service.	25	Critical Care escalation plan reviewed and areas for surge capacity identified (CITU and Recovery). PACU now open and fully functioning to support elective service. Nursing, junior and middle grade medical rosters in place with minimal gaps. Adverts for new consultant posts are out with locum shifts to cover any gaps in the short term. Footprint reorganised to free up additional capacity. 2 additional staffed beds opened on 1st October 2018 with a further 4 beds opened 1st February 2019. Capital and operational planning groups established to support longer term Critical Care expansion (physical infrastructure as well as workforce requirements). This mitigates some of the risk, but does not significantly downgrade it as modelling suggests we need 50 beds in order to routinely and sustainably meet demand by 2020.
Haematology - Lack of isolation cubicles and appropriate filtration on Ward B4H. Insufficient number of toilets/washrooms/en-suite facilities. Increased risk of cross infection, existing facilities difficult to access. Footprint for BMT patients inadequate.	25	Outline business case being drafted for WG funding to support a new build for Haematology/BMT. In the short term, an outbreak of VRE has meant temporary closure of B4H to enable remedial ward refurbishment work to be undertaken including air handling works in the isolation facilities on the BMT unit. JACIE report received which re-accredits the service and highlights positive patient outcomes whilst being severely critical of the poor patient facilities. At an individual level, toilets are isolated on a named basis for high risk cases with separate commodes for c.diff and BMT pts.
Neurosciences – Sustainability of services at Rookwood Hospital due to poor condition of infrastructure leading to frequent problems with availability of	25	"Making A Difference: Providing Better, Fairer Services" published outlining proposals. OBC approved by WG in 2016. FBC submitted and approved. Work commenced on new build at UHL Spring 2019. Timescale to move from

heating, hot water, pest control issues and access to rooms compromising ability to deliver basic nursing and therapies care.		Rookwood to UHL likely to be 18 months - 2 years. Some remedial work on Wards 4&5 and 7&8 has been undertaken. Directorate continues to escalate issues as they arise to Clinical Board and Estates.
Neurosciences – Continuity of neurovascular service	25	Neurovascular CNS in place and deputy. 1 new interventional neuroradiologist in post with a 2nd recruited and due to start Autumn 2019. Substantive consultant neurosurgeon in post. Interim arrangements agreed and formalized with Bristol to support emergency coiling for SAH patients during periods of leave.
Risk of patients dying while awaiting Cardiac Surgery waiting list, ability to meet 36 week RTT, ability to treat urgent patients, impact of staff shortages (theatre and CITU staff), impact of lack of access to inpatient beds leading to increased mortality and morbidity of patients on the waiting list	15	Joint working between Clinical Boards. Escalation through WHSSC. Daily validation of Cardiac Surgery waiting lists by the Directorate Management Team. Weekly monitoring of booking and scheduling, utilization and productivity. Fortnightly Cardiac Surgery operational meeting to discuss cancellations, late starts, overruns and staffing constraints. Cross cover of lists in place, weekend operating implemented. Ward C5 ring fenced, work ongoing with Network around repatriation policy to reduce LOS. Major risk to delivery is challenge around recruiting and retaining scrub staff, overseas recruitment undertaken, review of working practices. 5th Surgeon appointed. Exploring pooling of lists and targeting longest waiting patients first.

Healthy (Theme 1)

Specialist Services Clinical Board strives to positively promote the health of our staff and the wellbeing of our patients by proactively encouraging staff to take up the seasonal flu vaccine. As of the 31st March 2019 we had vaccinated 63.7% of our staff by a combination of using our own proactive flu champions and resources made available by the UHB obtaining the second highest number of vaccines undertaken by clinical boards within the Health Board. There is a proactive approach to encourage long stay patients to receive the vaccine in both Rookwood and Haematology.

All patients who attend a pre-operative assessment within Specialist Services are, if required, given advice on smoking cessation, safe alcohol limits and healthy weight management. The Clinical Board is currently making gains in the use of Prehabilitation and one example of this is the successful implementation of the Enhance Recovery After Surgery (ERAS) programme within Thoracic Surgery. The implementation of the ERAS principles have been successfully integrated into the Thoracic Surgery pathway via a cohesive multidisciplinary approach to ensure that:

- The patient is in the best possible condition for surgery,
- The patient has the best possible management during and after his/her operation; and
- The patient experiences the best possible rehabilitation, enabling early recovery and discharge from hospital, allowing them to return to their normal activities quicker.

The next stage is to implement day of surgery admission for appropriate Thoracic Surgical patients to improve patient experience and further reduce length of stay.

Nephrology & Transplant have successfully gained funding for a BALANCE programme for potential transplant recipient and donor patients. This is an 8 week programme designed and delivered by physiotherapy and dietician services. The aim is for patients to reach a target weight as part of the transplantation or live related donor programmes.

The Specialist Services Health and Safety group meets 4 times per year with representation from each Directorate across the Clinical Board, the Health and Safety team, Operational Services, Maintenance, Fire Advisors, plus other individuals or departments as required. The group reports to the Clinical Board Quality and Safety group and as such the minutes are shared for noting at this meeting. The Health and Safety group also has close links with the UHB Operational Health and Safety Group and any issues or concerns are escalated as appropriate. The group reviews themes of staff accidents and incidents and receives assurance around RIDDOR reporting and compliance with timescales.

The Specialist Services Clinical Board has proactively driven the dementia agenda over the last 2 years. ‘‘Read about Me’ originated from a group of proactive staff from within the Cardiothoracic Directorate following implementation of a LIPS project. Specialist Services Clinical Board has a dementia care plan and has some very proactive staff who embrace this important agenda.

In the last 12 months we have seen the following pieces of work being implemented successfully;

- Nephrology and Transplant implemented ‘Get Up, Get Dressed, Get Moving’ campaign as part of their LIPS service improvement to reduce length of stay within Nephrology patients. Within the timeframe of the project length of stay was reduced from 11.5 days to 8.6 days. The ward has also seen a reduction in falls and pressure damage over a similar timeframe. This has now been implemented in all other areas of Specialist Services as appropriate. This campaign is also incorporated into pre-operative patient information for the renal live donor programme, to try and promote importance of movement post-surgery.
- A number of ward areas within the Clinical Board have undergone ward refurbishments improving the ward environments for patients who are cognitively impaired.
- The Cardiothoracic Directorate are currently working with a newly established charity ‘Daring to Dream’ to raise money to improve patients’ experiences by improving décor of day rooms/visitors rooms, providing tablets for patients to use, supplying radios and head phones and providing a regular hairdressing service for our long-term patients.
- The Cardiothoracic Directorate are undertaking monthly audits to ensure the ‘Read About Me’ scheme is embedded in our wards and there is a plan to implement in all other areas of Specialist Services.
- The Clinical Board regularly attends the UHB Dementia Training Steering Group.

- Neurosciences have secured a successful bid from the Kings Fund to improve the patient environment for cognitively impaired patients and are purchasing noise meters for each of the ward areas.
- Critical Care Directorate have secured funding to implement music therapy within all areas of Critical Care.
- Neurosciences have secured funding from endowments to implement music therapies and establish a choir in Rookwood.
- Learning Disability champions are in place in all areas within Specialist Services with the Learning Disability bundles fully implemented in all areas.

Safe Care (Theme 2)

Pressure Damage
Over last 12 months the Pressure Damage group has completed the following:

- The CNS's for wound healing continue have provided education sessions and bespoke teaching on the wards and in the community setting. This is in addition to the work completed by Practice Educators within the Clinical Board.
- The CNS team have reviewed the training they provide to ensure it is fit for purpose and have relaunched the Wound Link Nurse role and have commenced link nurse days which have been well attended.
- The Pressure Damage Task & Finish group has looked at some of the complexities around the bed management contract and have worked closely with Procurement on these issues. The group has been instrumental in gaining funding to be able to change every bed (apart from speciality areas such as Critical Care and Maternity) in the Health Board to a MMO 500 low rise bed along with a Promatt mattress. These beds and mattresses have been rolled out across the UHB in a structured fashion ensuring that staff are trained on the use of new Promatt mattresses which has replaced the older Primo Surface before the product is put in. Promatt is now used as the first choice basic mattress for general inpatient beds in the UHB.
- Specialist Services Clinical Board have implemented the use of stickers to be placed in the medical notes to highlight when an e-Datix has been completed, this has since been rolled out to other Clinical Boards. The aim of this is to reduce duplication of reporting. These can be ordered via Oracle and are available to all areas of the UHB.
- The Tissue Viability team have developed an information sheet for patients and their families to highlight the risk of pressure damage which is used for both inpatients and the community and this has been rolled out to all clinical areas within Specialist Services.

The following work is ongoing:

- Update and review the UHB audit tool documentation
- Input into the UHB Total Bed Management contract
- Developing a standardised approach to formulary ordering and management
- Roll out of a UHB patient passport and care plan
- Progressing work to meet the Welsh Information Standards for reporting of all stages of pressure damage to WG and the safeguarding process
- Inputting into the e-Datix process for managing pressure damage reporting to WG
- Implementation of Welsh Health Circular WHC (2018) 051 to ensure the correct reporting processes are in place

- Monitoring of Welsh Health Circular WHC (2018) 051 developing a Standard Operating Procedure to ensure robust governance arrangements are in place
- Roll out of the 'Guidelines for the Prevention and Treatment of Moisture Associated Skin Damage' (MASD)
- Inform the UHB's annual Health and Care Standards submission for standard 2.2 preventing pressure damage
- Roll out the All Wales PURPOSE–T risk assessment across the UHB
- Developing a process to review the learning from all serious incidents which were reported in 2018
- Developing new patient information leaflets for improving avoidable tissue damage

Patient Environment

Following previous inspections from the CHC and H.I.W that raised concerns that the Cardiothoracic Outpatients department located on 1st floor B/C link corridor was not fit for purpose, the Cardiothoracic Outpatient department was successfully relocated in April 2018 to T1. The investment has enabled an extensive redesign and refurbishment of the department to support the expanding service and ensure delivery of safe, quality and efficient care. The new environment has positively improved the patient experience, staff morale and improved efficiency with the growing service.

Similarly, Suite 19 (Renal Dialysis Unit) has undergone an extensive redesign and refurbishment and now operates as the David Thomas Dialysis Unit. Following a number of inspections the unit had been highlighted as having facilities of a poor standard. The refurbishment has enabled the following positive changes:

- New layout of unit to ensure Infection Prevention and Control regulations are adhered to with an ability to isolate patients with potential BBV or unknown status,
- All patients are now visible to the nursing staff across all areas of the unit,
- There is secure access on all entry and exit points to the dialysis unit with an intercom system installed, and
- An air-conditioning unit has been installed to individually regulate the temperature in different clinical areas and conditions of the unit.

Key quality improvement projects

- Funding has been confirmed for the relocation of Rookwood and the new build at UHL has now commenced.
- Implementation of MDT pre ward round safety briefing in Critical Care.
- The Spinal Bowel and Bladder Nurse Specialist – planning and development of an extra monthly nurse led clinic for cauda equina patients post discharge.
- An additional (2nd) Consultant has been appointed in the Spinal Injuries Unit at Rookwood to ensure a more sustainable service with continuity of consultant cover.
- Following the MHRA guidance on the use of Sodium Valprorate in women of child bearing age, a plan has been developed to ensure that all patients being prescribed Sodium Valprorate are reviewed by a Nurse and Medical Lead and a plan implemented.

Significant Quality and Safety Challenges

- Ongoing provision of services on the current Rookwood site remains a challenge due to the current infrastructure/environment.
- Lack of en-suite facilities in Bone Marrow Transplant cubicles.
- Ongoing capacity constraints in Critical Care and lack of isolation facilities.

- Lack of isolation facilities in Haematology Day Centre.
- Current outbreak of VRE in Haematology
- Ongoing leaks on B1/T4 due to pipe erosion.

New ways of working

- Developing ambulatory care for chemotherapy and supportive care for Haematology patients.
- Implementation of student volunteers in Rookwood on both Spinal and Neuro rehabilitation wards to provide support and company to the long-term patients.
- Nephrology & Transplant are now utilising Advanced Care Planning (ACP) for all patients who require renal replacement therapy. This is normally instigated by the CKD CNS team, it allows the patient to document any decision in relation to health and social care whilst they have capacity to do so.

Serious Incidents and No Surprise Incidents reported to Welsh Government

Between 1/4/18 and 31/3/19 the Specialist Services Clinical Board reported 42 Serious Incidents and 1 No Surprise event to Welsh Government.

Never events

There was 1 reported never event in this period, for which a robust RCA has been carried out.

- Retained foreign object post-operation – this involved a retained guidewire following insertion of a central line. A closure from has been submitted to WG after a full investigation.

All serious incidents are considered by the appropriate clinical teams and Quality and Safety Groups. Action plans are developed and progress and evidence of completion are reported to the Clinical Board Quality, Safety and Experience Group for assurance purposes.

The main themes for serious incidents over the last 12 months are as follows:

Administrative processes	2
Behaviour	1
Diagnostic processes/procedures	1
Infection control incident	1
Patient accidents/falls	2
Pressure ulcers	33
Therapeutic processes/procedures	1
Total	**42**

Patient safety related incidents

There were 1855 Reported Patient Safety related incidents occurring within the Specialist Services Clinical Board between 1/4/18 and 31/3/19.

The Top 10 themes were:

Patient accidents/falls	433
Pressure ulcers	424

Medication/biologics/fluids	216
Diagnostic processes/procedures	126
Medical devices, equipment, supplies	116
Infection control incident	82
Administrative processes	71
Blood/plasma products	71
Documentation	66
Therapeutic processes/procedures	65

Falls Prevention and Reduction
There were 213 falls reported between 1/4/18 and 31/3/19 where the level of harm was recorded as minor or greater. Injurious falls reviews have not identified any particular themes for the falls however they have given assurance that UHB policies, protocols and guidelines are being used in Directorates. The Clinical Board 'Falls' Lead is working with the UHB team and has initiated scenario based falls training which is being rolled out across the Clinical Board. Three sessions have been held so far with the training being well received.

HM Coroner's Inquests and Regulation 28 Reports
The Clinical Board has been involved in 13 inquests between 1/4/18 and 31/3/19 (where Specialist Services was the managing Clinical Board). The UHB received regulation 28 reports in relation to two of these inquests.

Relevant Coroner and Ombudsman reports and recommendations are considered by the Directorate and Clinical Board Quality and Safety Groups and the necessary improvements monitored through implementation.

Concerns, Compliments and Claims

Formal concerns
This is an area of significant progress for the Specialist Services Clinical Board in terms of providing timely and effective responses to patients, relatives and carers. Between 1/4/18 and 31/3/19 the Clinical Board received a total of:

- 135 formal concerns, of which 84.4% were responded to within the 30 day target. The Clinical Board has a robust process in place for tracking concern responses and the Clinical Board benefits from good clinical engagement from the multi-professional teams in undertaking notes reviews and providing statements.

Informal concerns
- 60.7% of total concerns received were managed via an informal process
- We received a total of 209 informal concerns between 1/4/18 and 31/3/19

The Clinical Board remains committed to being very proactive in contacting and meeting individuals who raise concerns at the informal stage in an attempt to achieve quick resolution for the patients and their carers, evidence of this work can be seen in the proportion of concerns the Clinical Board is able to resolve informally.

The top three key themes from the formal and informal concerns in Specialist Services are:

1.Clinical treatment / assessment (86)
2.Appointments (13)
3. Communication issues (7)

Compliments
The Clinical Board has received 14 compliments which have been logged formally. The main focus of compliments have been to highlight the care received by staff and compassion shown during end of life care. These are shared with staff appropriately.

Claims
The Clinical Board has had 12 clinical negligence claims opened between 1/4/18 and 31/3/19 which are split between the following Directorates:

Critical Care (3)
Neurosciences (7)
Nephrology & Transplant (2)

HCAI
The information below provides an overview of the Clinical Board position from 1/4/18 and 31/3/19 together with a summary of the key actions being taken to improve the position.

Clostridium difficile
There were 26 cases reported which was a reduction from the previous year of 33 cases.

Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia
There were 4 cases reported with the first one not until November 2018. This was a slight reduction on the previous year of 5 cases.

Methicillin Susceptible Staphylococcus Aureus (MSSA) bacteraemia
Unfortunately we have not achieved this target with 52 cases reported against a target of no more than 32. This has resulted in a back to basics review of all cases in this time period, looking for themes and learning points. There is a targeted action plan to look at these bacteraemias and demonstrate a significant reduction. The key actions are as follows:

- Strong focus on line related infections across the Clinical Board with a recent dedicated Clinical Board Quality & Safety meeting to agree the approach.
- Multidisciplinary approach to implement robust action plan to improve compliance and prevent infections.
- Weekly VIPS scoring audits undertaken in close collaboration with IP&C.
- In process of redesigning the Clinical Board RCA database by adopting the same principles developed from the UHB work on pressure damage. This will enable us to identify learning points/actions required. To discuss in Q&S forum to share learning across the Clinical Board.
- Following an increase in MSSA infections, daily Chlorhexidine washes and bi-weekly hair washing with a chlorhexidine shampoo cap were instigated within Critical Care.

Escherichia Coli (E. Coli) bacteraemia
There were 39 cases reported which was a reduction on the previous year of 43 cases.

P.aeruginosa
14 cases reported

Klebsiella spp
27 cases reported

Haematology have had an outbreak of Vancomycin Resistant Enterococci on B4H. The Outbreak Committee determined that one of the contributory factors was the poor state of the ward and consequently a refurbishment programme has been scheduled with the patients and staff relocating to Heulwen ward whilst the work is being undertaken.

In December 2018 a patient was found to have contracted TB on B4H. The infection was at a very low level and it was thought no other patients would be at risk but as a precaution (as Haematology patients are severely immunocompromised) 14 patients were identified as being possible contacts and they and their GPs were informed of the slight risk and advised to contact Public Health Wales if they developed any symptoms.

Following a declaration of Pneumocystis Jiroveci Pneumonia (PJP) outbreak in May 2018 we have received funding to improve bathroom facilities on T5 which was highlighted as a concern.

Haematology experienced a rise in *Corynebacterium Jeikium* bacteraemia associated with indwelling central and peripheral lines. To improve our infection rates the IV access and ward teams reassessed our staff's ANTT technique, carried out RCA's and worked with PHW to improve our infection rates.

Effective Care (Theme 3)

PREMS and PROMS
This work is being embedded into the Nephrology & Transplant Directorate. A co-collaboration has been launched and led by Cardiff & Vale looking at understanding how patients make choices with regard to dialysis therapies and how they may be influenced by access to social care and support (phase 1) and then how we can develop education and training tailored to patients (phase 2).

IV Administration
A recent change in infusion pumps highlighted that the volume required to prime the administration sets (dead space) was now approximately 25mls which presented a risk of the total dose of a drug not being administered. Practice within Critical Care has been updated to ensure delivery of the full medication dose. Therefore after each bolus or intermittent bolus infusion lines are flushed through with 25mls of sodium chloride 0.9% or glucose 5% from a 50ml bag. The infusion line is then discarded.

Audit
The Clinical Board has a formal audit plan in place, which includes both local and national audits. The results from these audits are fed back to Directorate and Clinical Board Quality, Safety and Patient Experience groups.

NatSSIPs
The Clinical Board has established a group to work collaboratively to share each Directorate's work undertaken to comply with the required National Safety Standards for Invasive Procedures (NatSSIPs) and develop Local Safety Standards (LocSSIPS). This will feed into the UHB programme.

Dignified Care (Theme 4)

Dignified Care inspections and CHC inspections carried out in 2018-2019 have not identified any areas of significant concern specifically in relation to dignity.

Haematology had 2 inspections during the last financial year from the HTA and JACIE, which the Directorate were successful in passing with some recommendations made to ensure we maintain our high standard of care.

The newly developed Band 5 induction programme for Specialist Services Clinical Board incorporates the UHBs Values and Behaviours that underpin it and the delivery of dignified care is specifically addressed.

It is expected that all wards participate in the monthly Health and Care Monitoring System Audits on a monthly basis and these indicators are reviewed at the monthly Nursing Board meetings attended by the Director of Nursing, Lead Nurses and Senior Nurses. They are also reviewed at the monthly Directorate Sister/Charge Nurse forums to share learning and progress identified actions.

The Clinical Board is in the process of a collaborative working initiative with Medicine to implement the Enhanced Care model to look after patients who have a cognitive impairment safely with the aim of preventing harm from falls.

The Epilepsy Unit has undertaken a piece of work to move patients from PR Diazepam to Buccal midazolam in the case of a seizure as a more dignified route of administration. Education has been carried out within the Outpatient Department and Radiology Department.

Clinical environments
There have been significant capital works that have taken place in the last 12 months to improve the environment and facilities for our patients and staff.

The redesign of the David Thomas Dialysis Unit has enabled a number of improvements with regard to dignified care. The unit reconfiguration has facilitated each bay to be separated to allow for privacy and dignity. Each cubicle has been designed with natural light or access to enhanced lighting and air conditioning to improve patient experience.

The relocation and redesign of the Cardiothoracic outpatients department has improved patient dignified care. Previously patients were waiting in a main corridor of the hospital, with a lack of privacy and inadequate toilet facilities. The new environment has positively improved the patient experience with better facilities and privacy.

Future work planned:

- Redesign and new build for the Cardiac Physiology department
- Haematology ward and Haematology day unit refurbishment
- Funding confirmed for relocation of Rookwood and new build in UHL

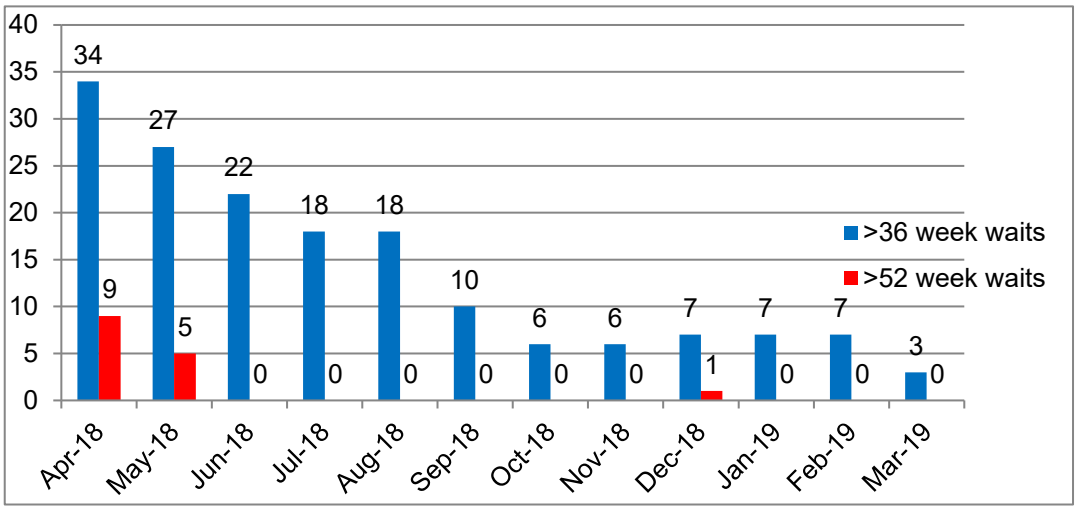
Timely Care (Theme 5)

Neurosurgery Waiting Times

The Neurosurgical service has faced significant challenges in delivering the waiting time targets to a maximum of 36 weeks with a number of patients waiting in excess of 52 weeks for surgery. During 2018, the service has been tackling excessive waiting times with the surgeons working collaboratively to reduce variation in waiting times with pooling of cases and a dedicated locum clinician focusing on long waiting patients. This has resulted in a significant improvement in the waiting list profile.

Historically, emergency demand and the number of patients waiting for repatriation has negatively affected the ability of the service to maintain elective flow which has contributed to increased waiting times, safety concerns and a poor patient experience. Together with support from all Health Boards in Wales, an investment in nurse practitioners and senior nursing support has seen benefits in reducing long waits for repatriation to the DGHs.

Neurosurgical Waiting Time Breaches by Month



Cardiology Treat & Repatriate Service

Successful redesign and implementation of the South East Wales Regional NSTEACS service has supported delivery of coronary angiography and PCI to 80% patients within 72 hours as per national guidelines. There has been a positive impact on patients' length of stay following the implementation of this service which now includes UHL, reducing the average bed stay from 8 days to 3 days.

Critical Care

Demand and capacity modelling undertaken in 2014 indicated that 50 Critical Care beds were required to meet the needs of the population. The Critical Care department was operating significantly above the recommended bed occupancy levels for Critical Care of 75% and often in excess of 100% which led to delayed admissions from Theatre Recovery and the Emergency Department. In 2018, funding was secured from Welsh Government for an additional 6 beds within the existing footprint of Critical Care at the University Hospital of Wales. Following a

successful recruitment drive two beds were opened in October 2018 and the remaining four opened in February 2019.

A review of the data confirms that these additional beds have increased our ability to admit patients who require Critical Care in a timely manner, in other words we have increased our ability to provide the right care, to the right patient in the appropriate place. Our bed occupancy has decreased from over 100% for the first four months of the year to consistently below 100% since all six beds were opened. We are now in the process of developing a business case to support the opening of a further six beds.

Individual Care (Theme 6)

Real time – We carry out short surveys as part on the 'two minutes of your time' initiative and have suggestion boxes on the Renal and Critical Care wards. Volunteers in Critical Care support patients to complete the questionnaires. We have also have had patient kiosks in several of our clinical areas where the views of patients, their carers and staff are captured. The planned installation of Patient/Visitor Ward Information Boards at the entrance to all ward areas across the UHB has helped us significantly with this agenda.

Retrospective – Patient stories are shared at relevant groups within the Clinical Board and at each Directorate Quality and Safety forums.

Proactive/reactive – Patient compliments are fed back to relevant staff. Also, where concerns are raised by patients and their carers we do share the concerns with the relevant staff member(s) in order that they can reflect on the patients' perception of the care they delivered and to make any changes that may be necessary.

Patient story telling is undertaken as part of the UHB Clinical Leadership Programme and it is this methodology the students use. Once the interviews are carried out the student submits their report to the Ward Sister/Charge Nurse and action plans if required are developed from this information.

Balancing – Concerns, compliments, clinical incidents, service user and family feedback are used to help the Clinical Board decide on its planning ideas such as redesigning its services.

Staff and Resources (Theme 7)

Finance

1. The financial position at the end of Month 12 (Mar 2019) is £0.675m surplus.
2. The Clinical Board savings target is £4.038m.
3. Progress against this target is:

£3.712m green identified 92%

£0.396m amber identified 10%

£0.000m shortfall against target

4. The recurrent full year effect CIP position is a £0.001m surplus.
5. The Full Year forecast is £0.010m surplus.
6. Variance to Forecast Year to date is £0.665m surplus.

Staffing
Specialist Services Clinical Board Workforce Summary Report April 2019 Data

Key Performance Indicator	Monthly Actual (Apr 2019)	Comparison with Previous Month (Mar 2019)	Comparison with Previous Year (Apr 2019)	2019-20 target
Vacancy Rate (WTE)	3.4%	3.71%	4.5%	5.00%
Turnover Rate (WTE)	6.28%	6.24%	N/A	7.0%
Sickness Absence Rate	4.09%	4.46%	4.97%	4.13%
PADR Rate	59%	58 %	66%	85.00%
Statutory and Mandatory Training Rate	67%	64%	N/A	85.00%
Medical Appraisal	71%	N/A	N/A	85.00%

Nurse Staffing Act
From April 2018 the nurse staffing act became a statutory requirement. The Clinical Board has successfully completed a substantial amount of work on staffing establishments in all clinical areas to incorporate professional judgment principles and data captured by the All Wales acuity tool data. All appropriate clinical areas within Specialist Services have now moved to daily acuity assessments to support the safe staffing act principles. Cardiothoracics are one of the pilot areas to input the live data electronically. All inpatient wards now have supervisory coordinators built into their establishments and protected management time for Ward Sisters/Charge Nurses.

Registered Nurse recruitment is a challenge for some areas within Specialist Services whilst other areas experience a higher turnover of registered nurses due to the challenges faced in these areas. Specialist Services have a robust action plan in place that incorporates the following to both recruit, retain and engage staff.

Recruitment
- Dedicated supported 4-6 week supernumerary time for all new registered staff joining a ward.
- Keeping in touch days where UHB staff contact staff those who have been appointed but may not be commencing employment for a few months. Specialist Services invite them into the workplace to talk to them about new initiatives and give them opportunity to meet with staff in the team they will be joining.

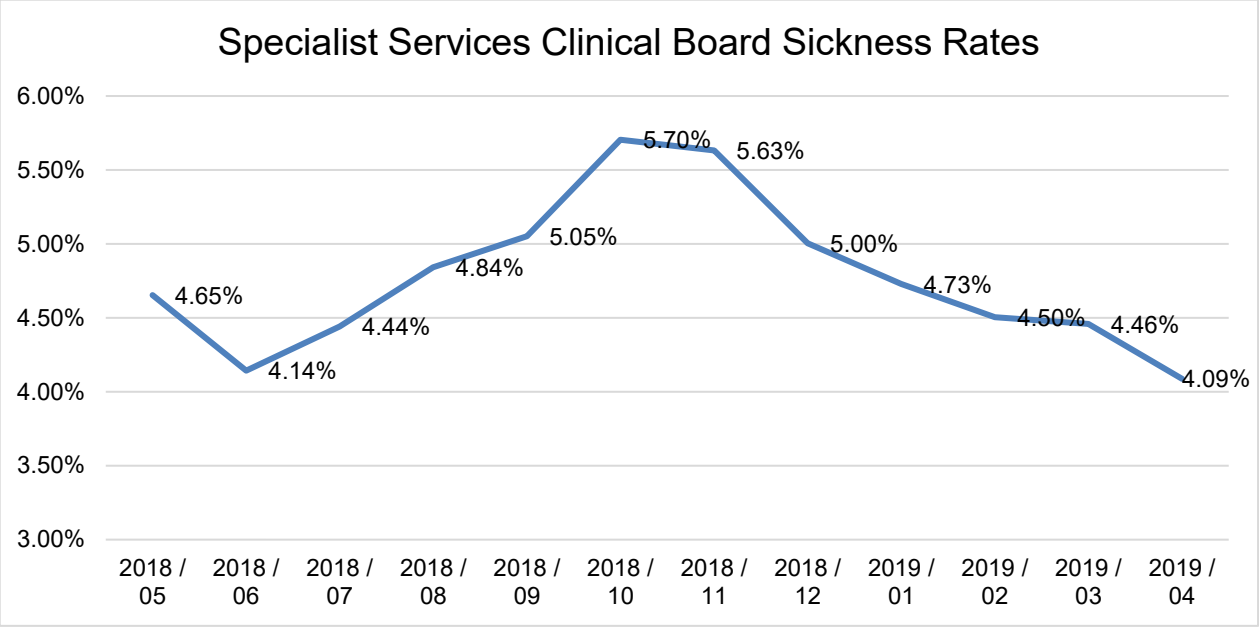
- Student Streamlining awareness events in CVUHB, at local Universities and recruitment events.
- Student Streamlining social media campaign.
- Social media recruitment videos.
- Recruitment events, both local and national in the U.K.

Retention
Whilst we have a very comprehensive work plan and action plan to try and address nurse retention such as holding celebration events, employee engagement events and trying to instil a feeling of being part of a bigger team such as via dedicated Facebook pages, it is still proving to be a challenge in certain areas due to the emergency pressures on the organisation. This is evident particularly within Critical Care. All areas are proactively undertaking exit interviews to gain greater intelligence in the reasons for leaving so that preventative work can be progressed.

Staff engagement
A significant amount of work has been carried out in the Clinical Board over the last 18 months to make this agenda a priority. The following are some of the highlights of the good work being done or being planned;

- Clinical Board and Directorate newsletters
- Promoting the Health Board values and behaviours, including values based recruitment
- Celebration Event
- Team Development
- Each Directorate having a workforce plan to enable them to develop their own staff
- Succession Planning
- Talent Management
- Leadership & Development Programme ongoing in all areas
- Keeping in touch days for New Starters
- Clinical Skills days for Nurses
- Professional Nursing Forums
- Registered and un-registered engagement groups
- Student Streamlining engagement sessions

Sickness absence
Great progress has been made in reducing the Clinical Board's overall sickness rates over the past 6 months. The rate for April 2019 was 4.09%, a reduction of over 1.6% compared to last October. The following graph illustrates a continuous reduction each month since this time.



Actions that have been put in place to help support managers with this agenda are;

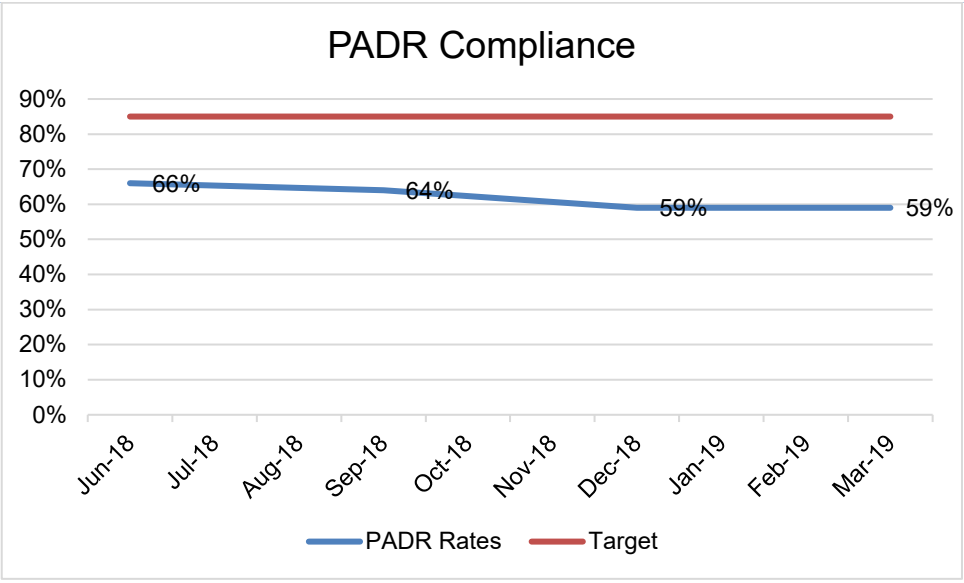
- Support for managers with both short and long term absence
- Bespoke training by the Workforce & OD Team
- Sickness Absence surgeries with Line Managers, to discuss individual cases
- Audit programme, focussing on hot spot areas to check
- Health & Wellbeing Promotion via sickness surgeries and training
- Redeployment and return to work opportunities for staff
- Identifying temporary redeployments to expedite their return to work

PADR compliance

PADR compliance has decreased gradually over the past 12 months from 66% to 59% against a UHB target of 85%. Some areas are reporting technical difficulties in recording PADRs on the ESR system and so further training is being undertaken to assist managers with this. Whilst some Directorates have attained the target, some have a significant improvement to achieve it during 2019/20.

Actions being undertaken to enable sustained improvement:

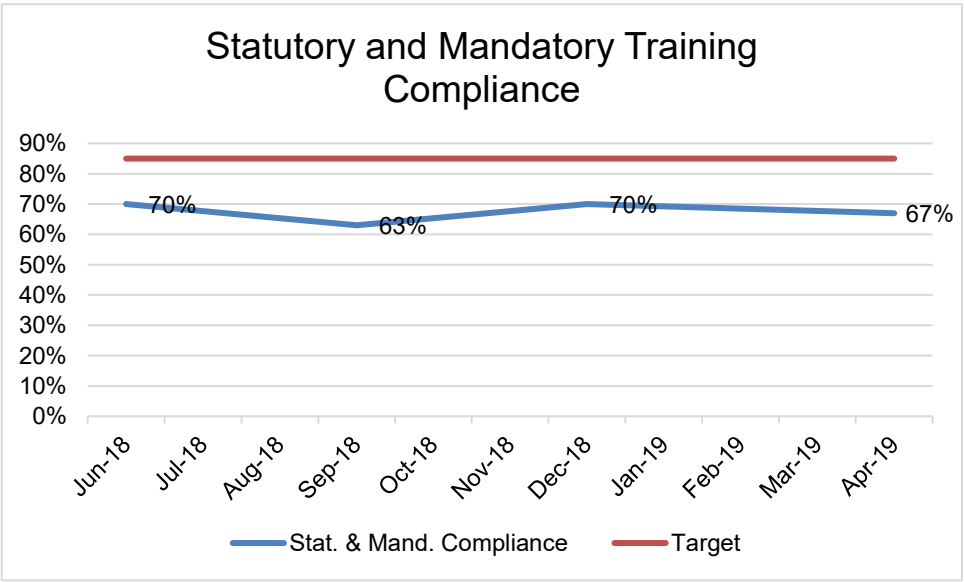
- Monthly reports for each department, ward and directorate are cascaded. These are RAG rated which easily identifies those areas who are not compliant.
- Progress is performance managed at each Directorate Performance Management meeting on a regular basis.
- Managers are encouraged to receive training and support from the ESR team to enable improved competence in using ESR.
- The revised pay deal will require all staff to have an annual PADR to enable them to move to the next increment. This will act as a lever to improve current performance and is being communicated widely.



Statutory & Mandatory Training
The Clinical Board have failed to achieve the 85% compliance rate for statutory and mandatory training in the previous year however a number of actions have been implemented which will enable compliance during 2019/20.

Actions to enable compliance:

- Mandatory May training was promoted widely and we are anticipating an improvement in the compliance rate for June 2019.
- Monthly RAG rated performance reports are sent to each area and these are performance managed.
- The Clinical Board have developed their own training in conjunction with LED which staff can attend as an alternative to the online training modules.
- The revised pay deal will require all staff to be fully compliant to enable them to move to the next increment. This will make staff more accountable to achieve full compliance.



Awards and Recognition

Many staff in the Clinical Board have received awards and recognition for the work they do to improve the patient/carers experience, outcomes and services. Also many teams and individuals have had their work published or they have been invited to speak at conferences or present posters.

Awards won in 2018/19

- Winner of the RCN Nurse of the Year Award for Advanced and Specialist Nursing (Haematology Senior Nurse Beth Ingram)
- Runner up of the RCN Nurse of the Year Award for Innovation in Nursing Category (Haematology Clinical Nurse Specialist - Charlotte Bloodworth)
- Runner up of the RCN Nurse of the Year Award for the Chief Nursing Officer Category (Cardiothoracic Lead Nurse Ceri Phillips)
- Runner up in the RCN Nurse of the Year Award for Clinical Nurse Specialist (Malisa Pierri, Epilepsy Clinical Nurse Specialist Neurosciences)
- Critical Care Research Team: 'Judges Award', Health and Care Research Wales Impact Awards 2019
- Sharon Warlow and Kymm O'Connor awarded Patient's Champion in the Medical Health Professions from Kidney Wales

Staff Recognition Awards:

- Patient Experience: Jayne Marchant and the Critical Care Team for 'The Wedding of the Year', Paul Twose @Quality Sustainability and Efficiency'

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The governance processes embedded in the core business of the Specialist Services Clinical Board and its Directorates
- Evidence of regular performance management reporting
- Independent review of the business of the Specialist Services Clinical Board by internal and external bodies such as Internal Audit, CHC, HIW, Welsh Risk Pool, Welsh Government
- Temperature gauge activities such as peer reviews, local audits (IPC, environmental) , Clinical Board walkabouts, benchmarking, unannounced inspections, acuity audits, healthcare standards, and patient experience questionnaires
- Nursing dashboard overview
- The Clinical Board recognises the key areas of improvement and actions required to further improve quality, safety and patient experience

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **NOTE** the progress made by the Clinical Board to date
- **APPROVE** the content of this report and the assurance given by the Specialist Services 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:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

REPORT TITLE:	**QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK 2017 – 2020: PROGRESS UPDATE 2018-19**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**16th June 2019**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	Assistant Director Patient Safety and Quality. Carol.A.Evans2@wales.nhs.uk								

PURPOSE OF REPORT:

SITUATION:

The purpose of this report is to present the Committee with a high level update on implementation of the Quality, Safety and Improvement Framework 2017 - 2020.

Progress on implementation of the Framework during 2018-2019 is reported through the UHBs Annual Quality Statement published on May 31st 2019.

ASSURANCE is provided by:

- The range of achievements during 2018-2019
- Identification of particular areas for focus during 2019-2020

REPORT:

BACKGROUND:
The Quality, Safety and Improvement (QSI) Framework was approved by the Committee in April 2017. Since that time the Patient Safety and Quality team have been working with Clinical Boards and specialist leads within the organisation to support implementation.

It supports, and is integral, to delivery of our Integrated Medium Term Plan and embraces the philosophy of Caring for people, Keeping People Well; supporting the broad organisational objectives of our overall UHB strategy –Shaping our future Wellbeing Strategy – that is, to deliver outcomes that matter to people and avoid waste, variation and harm.

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ASSESSMENT:

Our priorities are aligned with some of the key domains within the Health and Care Standards framework 2015, recognising that our colleagues in Public Health and in Workforce and Organisational development will be taking forward their own work to support the embedding of Standards within other domains. The Framework is also aligned with the UHB Patient Experience

Framework for 2017 - 2020.

Key achievements to date in each domain include:

Aim 1 - Governance, Leadership and Accountability

Main Achievements

- Human Factors training is incorporated in the Leading Improvement in Patient Safety Programme (LIPS) and a Head of Patient Safety has undertaken in-depth training with a view to establishing a UHB-wide training package.
- The Annual Quality Statement was published in line with WG requirements on May 31st 2019.
- The Patient Safety Team publish a quarterly newsletter.
- Two cohorts of LIPS were delivered taking the total number of people to 897 working on 170 improvement projects.
- A schedule of 11 Patient Safety WalkRounds™ per month is maintained.
- A further 5 Health and Care Standards have now been aligned with established groups/committees.
- A generic framework for QSE arrangements and commissioning has been implemented.

Areas for focus for 2019-2020

- The Safety Culture Survey is still outstanding.
- Align LIPS to the Transformation agenda.

Aim 2 - Safe Care

Main achievements:

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Health Care Acquired Infections-

- We are making good progress on reducing antibiotic prescribing in order to reduce antibiotic resistance. 60% of GP practices have met the national prescribing target.
- Aseptic Non-Touch Technique training and assessment continues.
- Better management of outbreaks of Norovirus and Influenza with collaborative working between Medicine CB and the IP+&C team.
- The Welsh Government target for C-Difficile and Klebsiella was met. Although the target for E. coli was not achieved numbers were reduced from the previous year.

Pressure ulcers

- We have improved the rate and quality of reporting of pressure damage in line with WG guidance and have produced guidance and educated staff on community healthcare acquired pressure damage in particular.

Falls

- Cardiff and Vale Falls Framework: Reducing risk and harm' completed and launched spring 2019
- There is ongoing Alliancing work with Canterbury NZ in relation to falls.
- The overall number of falls reported has remained constant. 47 injurious falls were reported to Welsh Government which has not changed since last year.

Patient ID bands

- The UHB has achieved compliance with PSN026 and NPSA 024 following the implementation of electronic printed wristbands. Around 150 printers have been installed

in clinical areas. The task and finish group worked with media resources to produce a training video which is accessible to all staff via the intranet.

Sepsis

- Hospital mortality from sepsis in wards with the Critical Care Outreach Service working 12 hours a day/ 7 days a week is currently at 10%. This is well below the national average of 20-25% mortality
- We have been submitting compliance with Sepsis 6 data to WG since August 2016 from areas covered by the Critical Care Outreach Service. Compliance with Sepsis 6 data is examined every month by the Consultant Nurse for Critical Care who is also the Sepsis Lead Nurse for the HB. Every episode of non-compliance is discussed with the team and relevant areas for further education with Ward staff are identified and addressed.

Acute kidney injury

- A pathway has been developed in response to an audit which showed that the management of Acute Kidney Injury (AKI) alerts in unscheduled care lacked appropriate response. Patients with AKI are managed by the Critical Care outreach via National Early Warning Scores in 26 clinical areas. AKI e- alerts are operational in Surgical Short Stay Unit and 5 surgical wards which are responded to by the Critical Care Outreach Team with the agreed AKI alert care bundle.

Safety incidents

- In 2018-19 16,621 patient safety incidents were reported in the UHB. Of these 15,173 caused no harm or minor harm to the patient. Incident reporting has increased which shows a positive reporting culture in the UHB.
- The number of 'Never Events' has increased from 4 in 2017-18 to 7 in 2018-19. Work has begun on developing Local Safety Standards for Invasive Procedures (LocSSIPs) in key procedure areas. A number of areas have completed.
- A significant amount of work has been undertaken to successfully reduce stillbirths from 43 in 2016 to 11 in 2018 which is below the UK average.

Nutrition and hydration

- Considerable work has been undertaken to improve nutrition and hydration including the implementation on the actions of the Patient Safety Notice (PSN045) with introduction of International Dysphagia Diet Standardisation Initiative (IDDSI) and ceasing use of 'soft'. Revalidation of the Gold corporate health standard award was achieved with commendation and exceeded 75/25% split towards healthy options.
- A 2 week menu has been further embedded based on patient and staff feedback and enhancement to incorporate finger foods and special provisions for MHSOP and longer stay areas.

Nurse staffing

- Daily operational meetings looks across in-patient ward areas and determines deviations from the planned rosters. This is a complex process involving professional and operational staff making decisions on maintaining nurse staffing levels throughout a 24 hour period.
- Several initiatives under Project 95 have successfully attracted the recruitment of nurses into the UHB including the overseas nurse adaptation programme which currently has 3 cohorts running; return to practice courses; student streamlining which has resulted in 167 students joining the UHB and the 70 nurses in September campaign which offered 48 nurses posts on the day with another 8 interviewed after that date.

Safe guarding

- A LIPS project to consider a multi-agency referral pathway for suspected cases of children being at risk of FGM has been implemented within Cardiff and Vale locality.

Suicide

- Suicide rates in Cardiff and Vale was 12.7 per 100,000 (EASR 2013 - 2017). This is a steady state over the past 4 reporting periods. Suicide prevention supporting guidance for practitioners is available for dissemination, and used as a basis for training in the UHB.

POCT

- Availability of training for new Point Of Care Testing users has increased across hospital sites. Wi-fi is now available for pregnancy meters meaning that meters could be rolled out in previously inaccessible areas to mitigate the risks associated with manual reading.

Medicines management

- The UHB Medicines Code is fully embedded within the UHB and an agreed plan of a 6 monthly update is in place.
- The e-learning programme to support MARRS is now complete and being rolled out within Nursing and Midwifery in the HB.
- A new RAG Rated Risk Assessment for PSN030 – Safe Storage of Medicines - is to be trialled and potentially rolled out across. Cardiff and Vale UHB.

Areas for focus for 2019-2020

- Support procedure areas to continue/complete LocSSIP development. Prioritise LocSSIP development for cross-UHB procedures, such as central lines, chest drains and NG tubes.
- Work to reduce Healthcare Acquired Infections continues to be a high priority.
- Explore ways to build on the wristband work to further improve patient identification, such as NHS England's Scan 4 Safety programme and GS1 standards.
- Work on preventing winter season outbreaks of infections.
- The future plan for the Medical Rapid Response Team is to review and plan to resolve each AKI on every patient suffering a new AKI and monitor all patients' kidney function that are having a high NEWS score or causing concern. Implement the AKI Pathway in Unscheduled Care.
- Review concerns highlighted in the CHC visit and HIW report around nutrition and hydration in Emergency Unit/Assessment Unit.
- An internal Safeguarding Audit will be undertaken in 2019.
- Implement Domestic Abuse G2 Training.
- Focus on suicide prevention in males and deprivation and cyberbullying in young people
- Identify clinical leads within Clinical boards to represent at POCT committee and incorporate POCT performance data into directorate Q&S forums.
- A full update of the medicines code is due in 2019.

Aim 3 - Effective care

Main achievements:

All Wales digitisation of nursing documents

- Several nursing/risk assessment documents have been standardised and approved for use across Wales and a pilot area agreed to run between June and September 2019. A roll out plan has been agreed from November 2019 onwards.

NICE implementation

- There are excellent examples across the UHB of service developments in line with NICE guidance. For example, for NICE standard QS13 end of life care- a supportive care service for heart failure patients has been set up in line with the guidance.
- Response rates to NICE guidance have increased year on year since 2016 and are at 63%. We are able to demonstrate an increasing ability to achieve full or partial implementation and show mitigation in place for non- implementation.

Clinical Audit

- In 2018/19 each clinical board developed a local clinical audit plan incorporating tier 1 and 2 audits. Tier 2 audits are identified to meet the quality and safety priorities of clinical boards.
- Our compliance with Patient Safety Solutions is now 95%.

Mortality reviews

- 78% of inpatient deaths have been subject to a Universal Mortality Review in 2018-19. The UHB continues to fully participate in the all-Wales Mortality Review Group. An interface between Datix and Business Intelligence Service has been developed to enable reported incidents to appear on the mortality review screen for deceased patients. Patients known to have a Learning Disability have a specific flag to identify them. Deceased patients with LD automatically trigger a level 2 review.

Areas for focus for 2019-2020

- Participation in the introduction of Medical Examiner roles across Wales which will increase the % of patients having a mortality review.
- Introduce a standardised level 2 mortality review tool.
- Evaluate the pilot of digitalised nursing documents and roll out accordingly.
- Continued focus on further improving compliance with NICE guidance
- Focus on supporting and encouraging clinical boards to have robust governance arrangements around clinical audit, including reporting arrangements and action plans.

Aim 4 - Dignified care

An update against part of this domain will be covered in detail in a report to the committee scheduled for June 2019 on implementation of the Patient Experience Framework.

Main achievements:

Language and communication

- Establishment of an Accessible Health Service Team at the Centre of Sign, Sight and Sound (COS) in October 2018
- DAISY online interpreting pilot
- Roll out of the Patient Communication Portal (online appointment information)
- Roll out of text (SMS) message reminders

- Dedicated email address for patients who are deaf
- Patient pagers in the out-patients department, UHW
- The UHB became the first hospital in the UK to be awarded the RNIBs Visibility Better Accreditation in the Radiology Department. Dental Clinical Board has gained the Action on Hearing Loss Louder than Words Accreditation Charter Mark. The University Dental Hospital is the only hospital in the UK to have this accreditation
- In most cases, the new Welsh Language standards can be reached or we are already compliant.

Mouth care

- Annual Health and Care Standards audits indicates that uptake of mouth care assessment tool is variable across UHB. Medicine CB and Children & Women CB report highest compliance with assessment tool.
- Mouth care assessment incorporated into HCA training programmes

Continence

- Current continence education has been reviewed and Catheter e learning now available via ESR available to UHB/ care staff.
- Minimal concerns are raised in relation to continence care with most actioned and resolved immediately
- More wards are reporting 100% patient satisfaction than at any time before in relation to getting enough sleep and rest. However 8 wards are scoring 40% or less which brings our overall average down and reduced it for the third consecutive year.

Learning disabilities bundle

- Over 90 Learning Disabilities champions have been trained and 120 resource packs were distributed.

End of life care

- We have recruited 2 MacMillan Advance Care Planning (ACP) facilitators and are working to promote greater awareness and use of ACP. A second MacMillan End of Life GP facilitator has been appointed to support primary and community care colleagues. We have participated in the National Audit into care at End of Life (NACEL) which looks at care given to patients and those close to them in the last days of life.

Areas for focus for 2019-2020

- Continue with work to fully implement the Welsh Language Standards
- Develop the next four year Strategic Equality Plan ready for implementation from April 2020
- Progress developments within our IT systems to record communication preferences and flagging as a priority.
- Undertake in depth patient surveys on wards that report lowest satisfaction rates for sleep and rest. Measure level of sound at night with decibel readers.
- Roll out of Learning Disabilities bundle into paediatrics.

Aim 5 - Timely care

Main achievements:

Referral to treatment

- Only 40 patients waited more than 8 weeks for a diagnostic test in 2018-19 – a 95% reduction on last year which is a huge improvement.

- 327 people waited over 36 weeks from their referral to the time of their treatment. This is 58% fewer patients than the previous year.

Cancer target

- Achievement of the urgent suspected cancer 62 day target was a challenge for the Health Board with performance at 84%. 16,007 patients were referred which is over 2400 more than last year. Of the 1109 patients diagnosed with cancer we treated 928 patients within 62 days. The endoscopy service has reduced the diagnostic pathway from over 2 weeks to one day.

Unscheduled care targets

- Last year 1066 people waited in the Emergency Unit for more than 12 hours. This year it was reduced to 689.
- The number of patients treated within 4 hours in our Emergency Department (ED) has increased by 3% during 2018-19 despite more than 5000 additional attendances.
- Ambulance handover times have reduced by 12%.

Mental health

- Over 90% of primary mental health assessments for Children and Adolescents are now provided within 28 days, a significant improvement over the past 12 months.

Delayed transfers of care

- DTOCs continue to reduce and C&V have the second lowest number in Wales. There has been a 12% decrease from April 2018 to April 2019.
- There are well developed relationships with evidence of Local Authority colleagues working collaboratively to reduce delayed discharges.

Primary care

- We are actively supporting the introduction of a multidisciplinary approach in place of a traditional medical model in the GP out of hour's services. This includes advanced nurse practitioners, clinical practitioners (paramedics), and paediatric advanced nurses. All GP practices will have mental health liaison workers working within them by March 2019.
- Community mental health services are working with 3rd sector organisations to streamline their services to make sure that users can access the right treatment in a timely way.

Areas for focus for 2019-2020

- Eradicate the wait for diagnostic tests.
- Eradicate the number of people waiting over 12 hours in the Emergency Unit.
- Further reduce delayed transfers of care.
- Establish Mental Health Liaison Workers in all GP practices in Central and Eastern Vale.

Aim 6 - Individual care

An update against part of this domain will be covered in detail in a report to the committee scheduled for June 2019 on implementation of the Patient Experience Framework.

Main achievements:

Care closer to home

- Get Me Home plus discharge to assess model has been implemented on three wards.
- Residential re-ablement facilities are available in both Cardiff and Vale Local Authority areas.

- Availability of Step Down accommodation facilities has increased across both Cardiff and Vale communities.
- A comprehensive multi agency Get Me Home training plan is in place with over 200 attending safe discharge planning training.

Psychological care

- New posts have been created in the OCD team, adult eating disorders team, "Therapy Hub" (which delivers group interventions), Traumatic Stress Service [TSS] which have led to reduced waiting times (except for TSS which has an increasing referral rate).
- All clinical boards undertook an audit of mental capacity assessments.
- The UHB participated in the review of the all-Wales Consent e-learning course.
- Regular face to face training on Consent takes place.

Dementia

- ICF programmes are underway to complete the actions in the Dementia Strategy 2018-2028.
- There is continued roll out of the 'Read about Me' person-centred tool for people with dementia.
- 76.7% of frontline staff have completed dementia training at the 'informed' level.
- There is continued roll out of 'John's campaign'.

Areas for focus for 2019-2020

- Get Me Home Action plan to be progressed
- Increase residential re-ablement facilities
- Roll out of GMH plus model across UHB
- A new Primary Care Liaison Service will be based in Psychology & Psychotherapy Directorate and will work closely with other staff who deliver therapy interventions.
- Bid for more Welsh Government Funding for psychological therapies.
- Clinical Boards to undertake further audit on Mental Capacity Act Compliance
- Continue to provide training on Consent
- Delivery of Year 2 of the Dementia Strategy 2018-2028
- Continued roll out of the 'Read about Me' person-centred tool for people with dementia
- Ensure Clinical Boards are meeting the now mandatory Dementia training targets (>85% trained)
- Continued roll out of John's campaign
- Implement Year 3 of Patient Experience Framework

RECOMMENDATION:

The Quality, Safety and Experience (QSE) Committee is asked to:

- **CONSIDER** progress with implementation of year two of the Quality, Safety and Improvement framework.
- **NOTE** the main high level achievements for 2018/2019 and areas for focus for 2019-20.

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

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

REPORT TITLE:	**PATIENT EXPERIENCE FRAMEWORK 2017 – 2020 - PROGRESS UPDATE 2018-19**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**18th June 2019**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	Assistant Director of Patient Experience Angela.hughes5@wales.nhs.uk								

PURPOSE OF REPORT:

SITUATION:

The purpose of this report is to present the Committee with a high level update on year one implementation of the refreshed Patient Experience Framework 2017 -2020.

ASSURANCE is provided by:

- The range of achievements during 2018-2019
- Identification of particular areas for focus during 2019-2020

REPORT:

ASSESSMENT:

The Framework was approved by the Committee in April 2017. Since that time, the Patient Experience Team has been working with Clinical Boards and specialist leads within the organization, to support implementation.

The Framework supports, and is integral to the delivery of our Integrated Medium Term Plan and embraces the philosophy of Caring For People, Keeping People Well; supporting the broad organisational objectives of our overall UHB strategy – Shaping Our Future Wellbeing Strategy – that is, to deliver outcomes that matter to people and avoid waste, variation and harm. The key measurement is to provide an insight into what does it feel like to be a patient/ carer using our services

The framework will operate in conjunction with the Health Board strategy and the Quality, Safety and Improvement Framework.

Our priorities are aligned with some of the key domains within the Health and Care Standards framework 2015, the framework ensures that we hear and actively listen to the voices of our service users. The implementation of the framework ensures that we can demonstrate our response to their feedback.

It is applicable across all health care settings in primary and secondary care. We work with the third sector organisations and we value their support with many of our patient experience activities.

The framework is part of our quality assurance system.

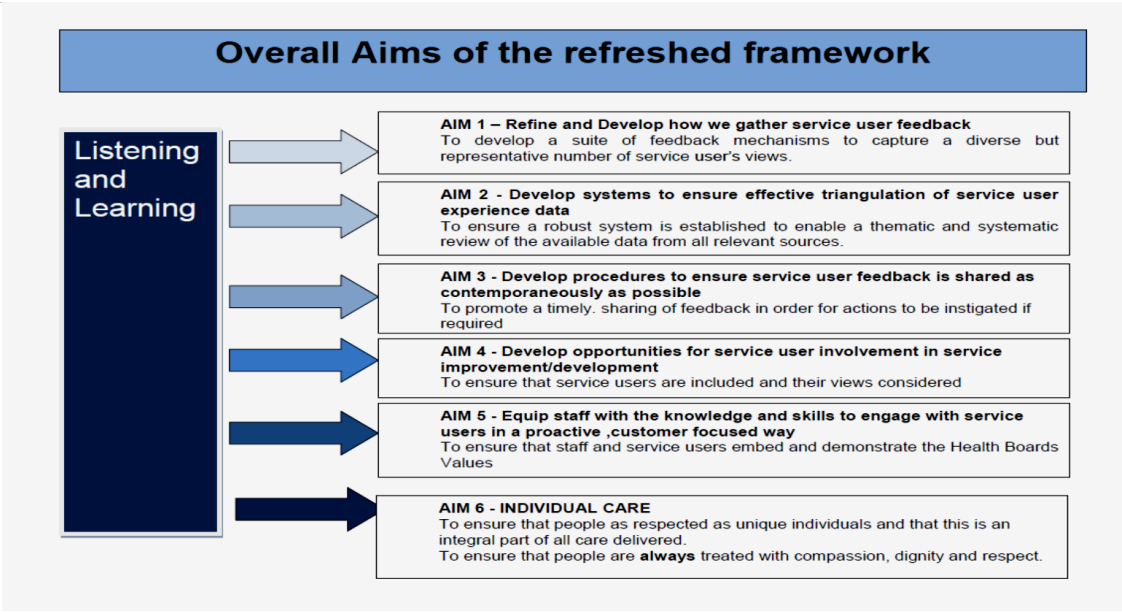
The Clinical Board submissions for each annual Health and Care standards report demonstrates the embedded maturity of the framework.

Our Annual Quality Statement provides an account of how we are progressing with the implementatic of the framework over the next three years.

The Framework is also aligned with the UHB Quality, Safety and Improvement Framework 2017 - 2020.

In order to capture service user feedback it is recognised that there is no single method that can provide the assurance that Health Boards require and that a number of methods are required for triangulation to verify findings and make improvements. To support this approach the All Wales Framework for Assuring Service User Experience describes four quadrants which group together a wide range of feedback.

Real Time **Short Surveys -** used to obtain views on key patient experience indicators whilst patients, carers and service users are in our care (such as in hospital) or very shortly afterwards (such as on discharge or immediately after an out-patient appointment)	**Retrospective** **Surveys -** post discharge or any clinical encounter in any setting to gain in-depth feedback of service user experience. They can also incorporate quality of life measures and Patient Reported Outcome/Experience Measures (PROM/PREM)
Proactive / Reactive Provide opportunities for all service users/families/carers to provide feedback. Includes feedback cards, permanent and temporary online surveys and emerging methods such as text, QR codes and social media.	**Balancing** Concerns and complaints Compliments Patient stories Focus groups Third party surveys such as Community Health Council and voluntary organisations



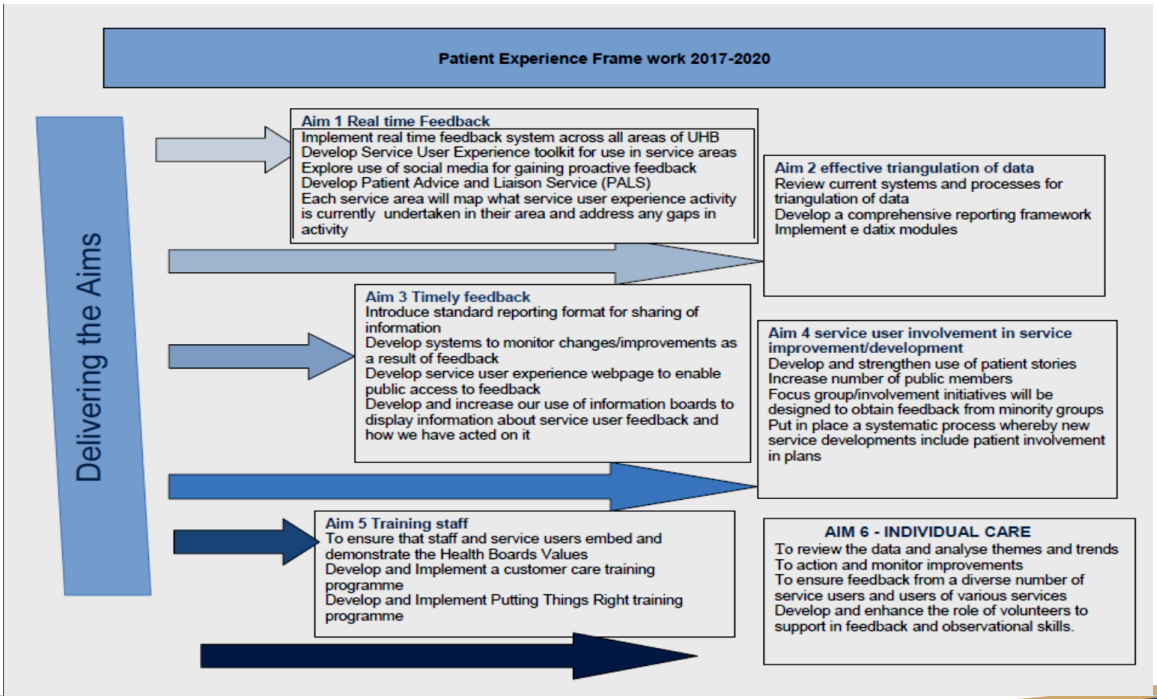
Key Achievements in each domain – more detailed reports on individual elements will be provided to the QSE committee via annual reports. These include:

A Putting Things Right annual report to outline activity regarding Concerns-Complaints and Claims, including Ombudsman activity will be shared with the September committee.

Carers annual report – to advise of the work in relation to the transitional funding will be share with the September committee.

One of the fundamental aims for 2018/19 was to evidence increased activity in each of the quadrants As evidenced in the integrated report to the Board we are able to share activity in each quadrant.

In the framework we have a 3 year plan to deliver the aims.



Main achievements in relation to the Driver Diagram 2018/19.

Aim 1 Real time feedback – there has been a lot of focus in developing this activity.

Over 1,000 surveys are completed each month.

Timely reports to Clinical Boards with themes and trends which are discussed at their QSE meetings.

The UHB has also developed two new surveys which have been administered across both inpatient and outpatient areas. These surveys have been designed to ascertain feedback supporting the Health Board strategy, providing information that we could learn from and importantly act upon;

Examples of additional questions include;

1. If able have staff encouraged you to get out of bed and move around?
2. If able, have staff encouraged you to get dressed?
3. If able, have you had the opportunity to be involved in activities?

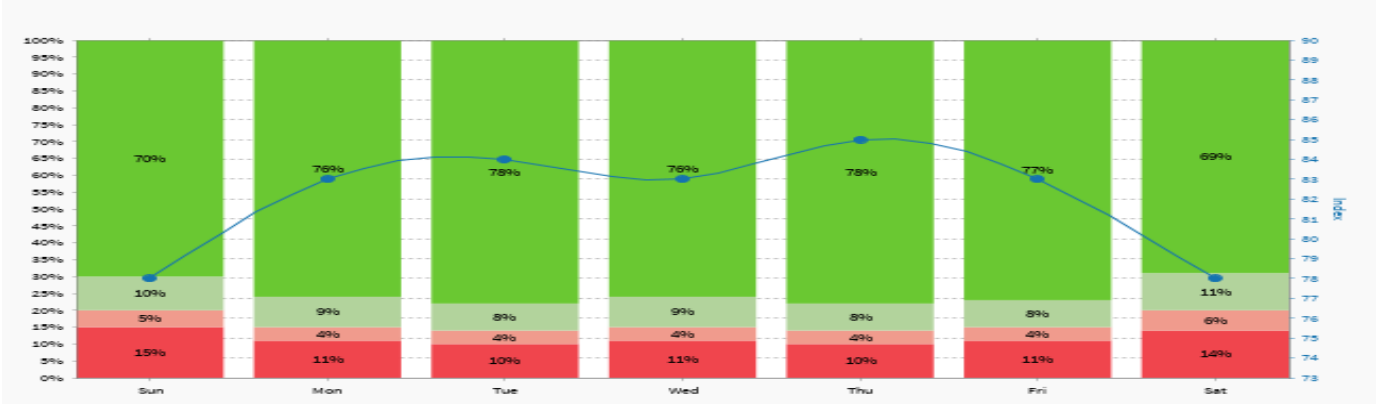
Questions 1 and 2 align to the 'get up, get dressed, get moving' campaign; promoting independence and preventing deconditioning, while the information from question 3 will be used to inform the Volunteering agenda, including opportunities for befriender, activity and musician volunteer support.

The Happy or Not machines have been used across the UHB sites and in primary care to elicit over 100,000 responses in the last year.

It is evident that on Saturdays and Sundays, patients and visitors are more negative.

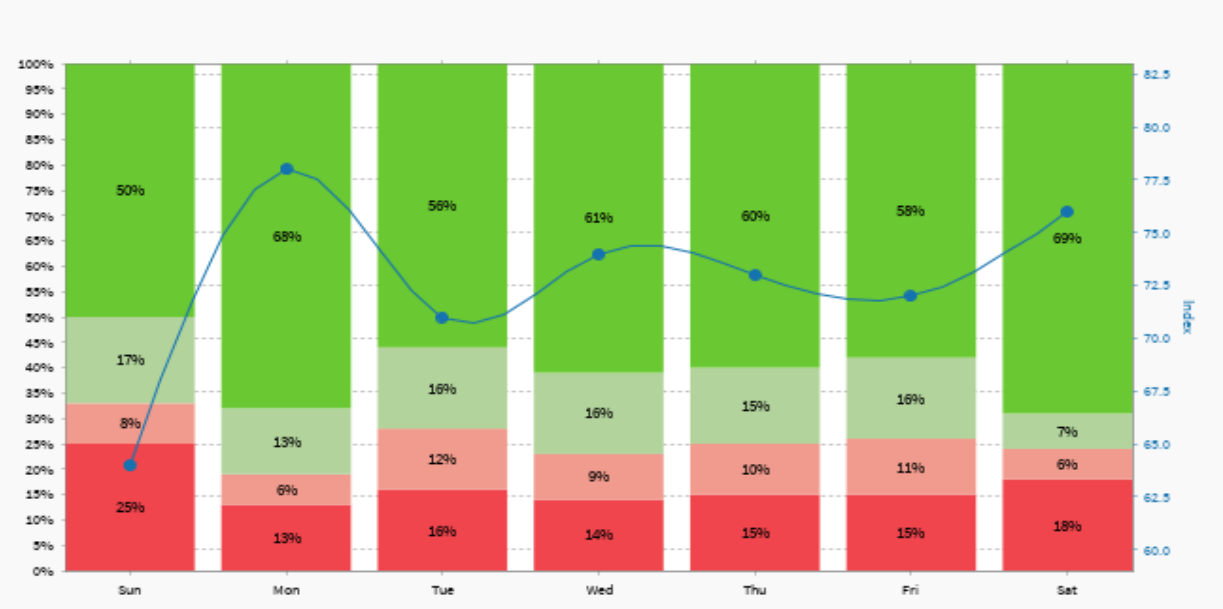
Would you recommend this hospital to family and Friends?

[redacted]

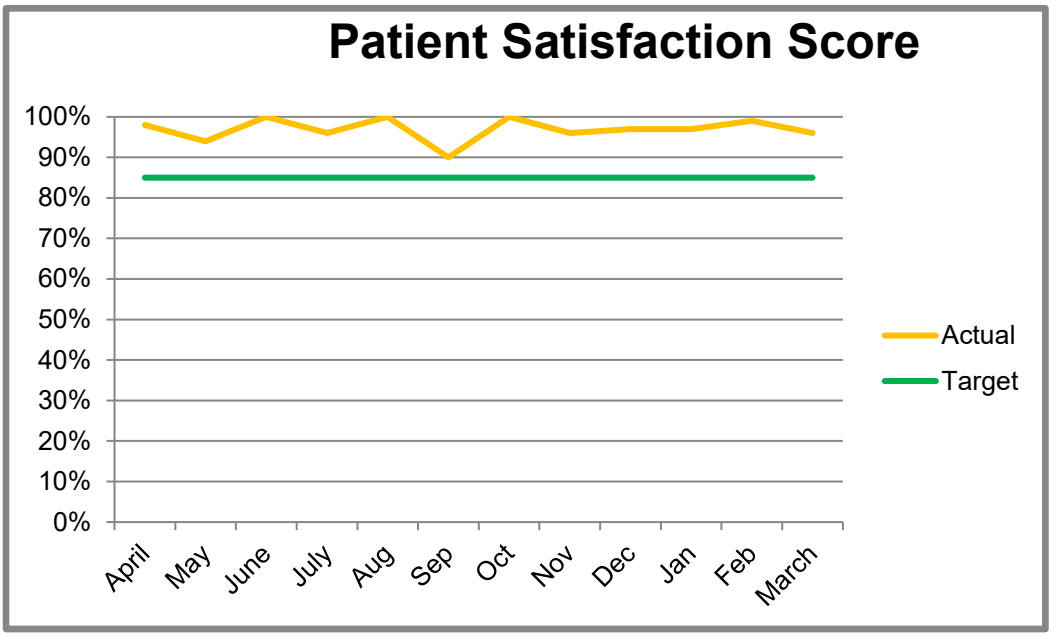


When other questions are reviewed this remains a pattern.

How was your visit today?



In order to address this point and explore the reasons we will undertake a specific weekend survey.

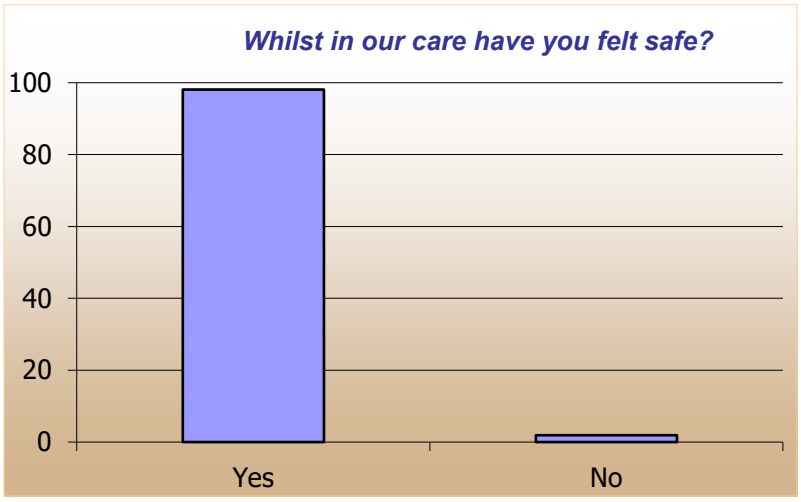


The Run chart above tracks patient satisfaction across the year which has been consistently high throughout 2018-19.

This kiosk is based in the UHW concourse area and has received in total 869 responses since December 2018 from relatives and patients and continues to be completed

consistently each month by over 100 patients providing real time information. 88% of people would recommend this hospital to family and friends, with 58% of people rating the care as 10/10.

Overall patients report feeling safe in our care



We have undertaken survey activity in GP Practices, Dental Practices and with the Acute Response Team.

Reports have led to service improvement – increased use of way finding volunteers, reminders to staff to inform patients and apologise for any clinic delays. The team is currently exploring ways of more interactive way finding which would be suitable for all patients and in particular those with sensory loss.

The ward feedback kiosks were introduced to the wards in June 2017 and were a means of gathering real time feedback from patients, relatives, friends, carers and staff. The survey tools loaded on the kiosks, were available in both English and Welsh. During each survey period, the kiosk remained on its designated ward for 1 week.

Most patients feel safe in our care and involved in decisions about their care.

Concerns – development of the PALS (Patient Advisory Liaison Team)

The PALS team have worked very effectively with the Clinical Boards to resolve concerns via an early resolution route. They continue to have dedicated sessions based in the Patient Information centres.

30 working day response time to formal concerns has been maintained over the past year and the aim for 2019/20 will be to achieve in excess of 80% consistently.

Welsh Government commissioned the Once for Wales Concerns Management System project in response to a number of recommendations made by Mr Keith Evans in the report “The Gift of Complaints” and this project is hosted by the Welsh Risk Pool.

The project team was tasked to coordinate a review in relation to the National Complaint Data Submissions which health bodies are required to submit to Welsh Government. A series of workshops, meetings and reviews of local data systems were conducted.

Following consultation with the Welsh Government Healthcare Quality Team, the final version of the definitions and supporting information, highlighted a number of inconsistencies in how previous definitions were interpreted across organisations. The most significant of these relates to the definitions of 'formal' and 'informal' complaints. The use of these terms has been discontinued and the interpretation of 'Complaints managed through the Putting Things Right regulations' has been established. This means that the data submitted by organisations will be accurate and consistent across Wales. However, the change in definition and data capture means that data presented to Board meetings during the year will be different and it is important that any variance is carefully explained.

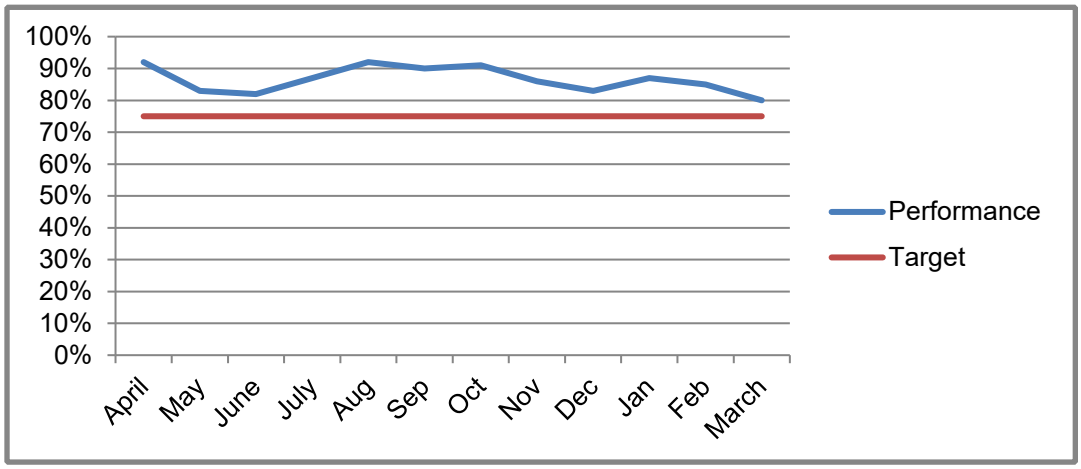
Further detail on the changes in these definitions will be incorporated in the next report to Board.The Committee should be advised however that, these definitions need to be applied retrospectively and the impact of this has been outlined below

In 2018/19 we received 2759 concerns.

921 were managed under early resolution representing 33% of all concerns and 57% were responded to in 2 working days.

1812 complaints were managed through the Putting Things Right Regulations i.e. within 30 working days

Below is the 30 working day response time when applied retrospectively - the average response time over the year is 87%



Aim 2 Effective Triangulation of Data

We have implemented E datix modules for Concerns-Complaints and Ombudsman cases which enables more effective analysis of the data.

The Patient Experience team work more collaboratively and we share intelligence to focus

resources.

E.g. if an area has a poor satisfaction score we review the information and work with the Clinical Board to see if we need to focus some of our volunteers activity or develop a bespoke survey. We have found that using the kiosk with a bespoke survey has enabled us to quickly analyse issues in an area.

Aim 3 Timely Feedback

We have developed the on line surveys, we provide reports in real time to clinical areas wherever possible as outlined in Aim1.

Aim 4 Service User involvements in Service Improvement/development

We have started to engage with groups who do not necessarily raise concerns or provide feedback via surveys. We have a **Learning Disability Questionnaires** which has been administered weekly since August 2018. Three reports were completed and shared with the Lead Nurse for Surgery; these provide data from January to early May 2019. The numbers administered are relatively low; however the qualitative comments are diverse.

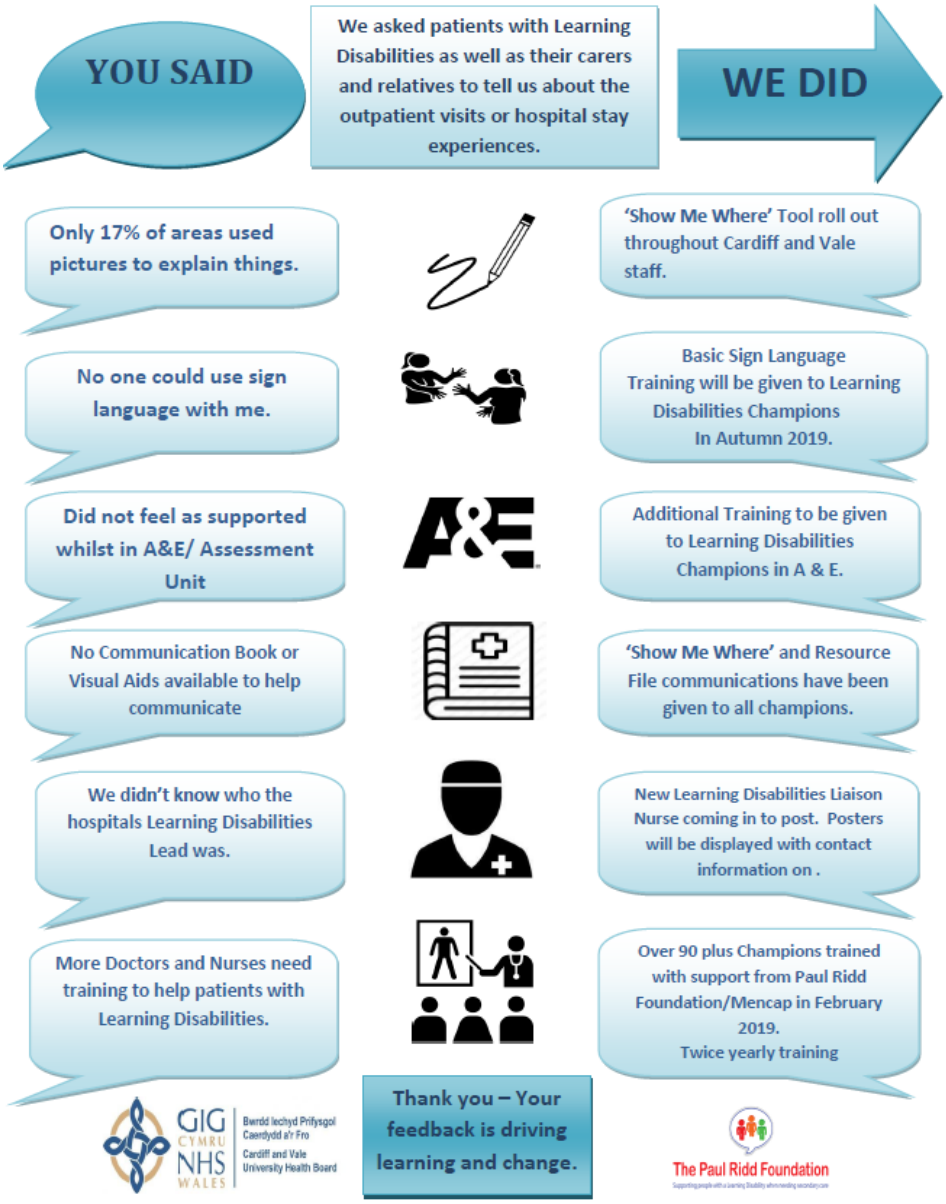
Patients in their survey outlined the importance of time and communication to help them understand the choices about their health care.

Andy Jones, Lead Nurse in the Surgical Clinical Board has been recognised nationally for the work he has been doing in training Learning Disability champions. In February, 92 champions were trained.

The training, which is supported by MENCAP and the Ridd Foundation, provides staff with the knowledge and skills to specially tailor the care which they provide to adequately meet the needs of this vulnerable patient group and their carers/families. For instance, some with a learning disability may need extra time to process the information you give them, especially regarding medical issues. They may also have limited communication skills and not be able to verbalise their symptoms and their needs in the same way as other patients.

The central tenet of the training is simple: to see and treat the person, not the disability.

The ongoing survey work enables us to measure the impact of the increased awareness and see the training in action. From the surveys a poster was produced by Andy Jones to share the feedback and actions taken.



In February 2018 we met with people who are deaf or hard of hearing and a focussed piece of work supported by our Executive Lead Ruth Walker and the Chair, is to improve accessibility to our services for these service users. This will improve their experience of using our services. As part of the framework we will continue to try to engage with people who use our services and listen to their experiences, It was clear that we needed multi-channel communication.

There has been significant work undertaken in Medical Records to identify people on our system who require either a BSL interpreter or a technological solution. We are booking interpreters promptly, recording preferences for named interpreters etc.

BSL Training

We have over the next year 2019 planned training sessions for staff. Feedback has been very positive. The poster acknowledges the support of the charity.

1) BSL Equality Training
2) BSL Taster sessions

BSL Charter

On June 19th 2019 the Health Board will sign the BDA charter with the deaf community. This is a public commitment to the pledges'. We will be the first Health Board in Wales to sign the charter.

Actions to date

- An immediate action was to establish an E mail dedicated to deaf people pe@wales.nhs.uk
- All Wales Task and Finish group to improve access for people who are deaf / hard of hearing to raise concerns – a video has been made in BSL, Audio and subtitled. This has been completed and will be shared across Wales.
- From April 2019 in the concerns team we have a sign video number in use for people who are deaf / hard of hearing to contact us directly.
- We have made improvements in our medical records department to book interpreters.
- We are thankful to the Charity's kind support undertaking a programme of Deaf awareness training and Basic BSL training for over 500 staff.
- We are increasingly using technology – in primary and secondary care we have a project called DAISY (digital access interpretation services) in 3 GP practices, which is part of the Bevan Exemplar program.

Aim 5 Training Staff

As a team we are proactive in promoting the Health Board Values and living our values. Regular training is provided regarding the Putting Things Right Regulations to support and maintain the quality of investigations and the 30 working day response times.

Further work needs to be undertaken to promote living our values the impact of the lasting First Impression. This work is linked with the "Hello my name is" campaign as patients quite rightly expect all staff to introduce themselves.

Aim 6 Individual Care

The diverse methods of gathering feedback are constantly being reviewed to question do they tell us what it feels like to be a patient/ carer using our services.

One of our areas of focus in 2019/20 will be the analysis of patient stories.

Patient Stories involves collecting stories from patients' personal experiences to understand how they perceived the health care they have received. Patients talk about what they felt, saw, heard, the emotions that were evoked and how this may have affected their decisions and actions during

their journey. These insights are an important component in understanding how we can improve different aspects of service delivery and care in our hospitals and in our community-based health care programs.

Many patients advise that hospital and being ill can be a lonely place and much of the work of the volunteers are undertaking actions to address loneliness and isolation. The volunteer-led Knit and Natter Group meet weekly in the Information and Support Centre, UHL. Patients, visitors and the local community attend.The RVS provide a trolley service at UHW.

There is a Mobile library service run by volunteers at UHL and Hafan Y Coed and a Cwtch Book facility at the Information and Support Centre at UHL.We have a comprehensive program of activity volunteers available across all UHB sites with diverse roles such as crafts, reading, singing and befriending.

Digital Reminiscence therapy equipment is available in a variety of clinical areas. e.g. C7 and SRC. The feedback is extremely positive from patients, visitors and staff.

Audio books, DVDs, DVD players purchased from charitable funds have been used by Patient Experience as required on a variety of wards.

Harmoni Cymru and Ukulele nights play to the patients across many of the UHB sites.

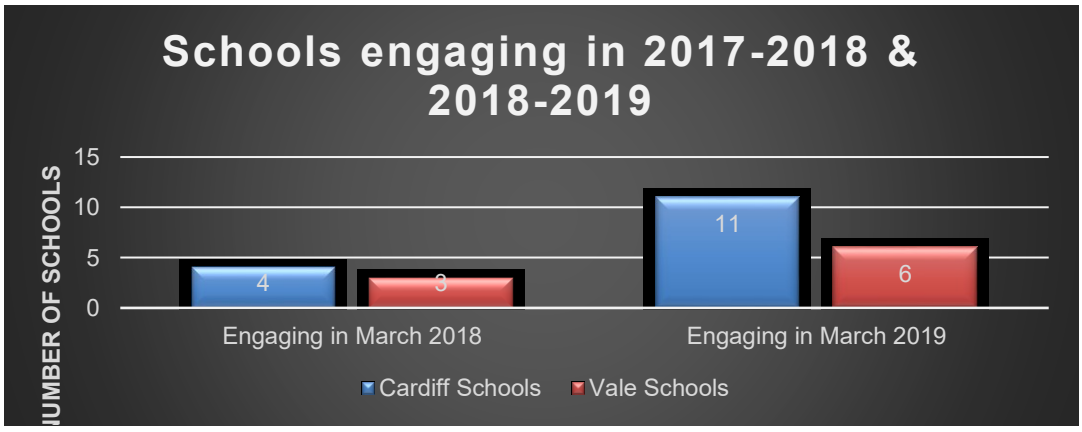
The link below is from the celebration of our volunteers in volunteers' week and tells their stories.

Stories from volunteer's week

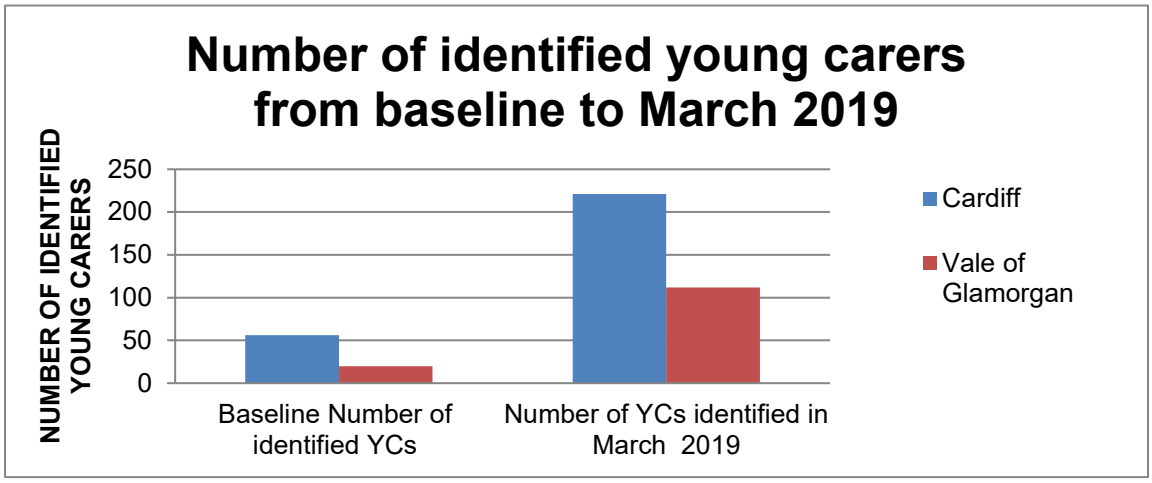
As an organization we were able to secure 2 year funding from PEARS foundation to concentrate upon the recruitment and development of young volunteers, as an appendix please find attached the first quarterly report.

Individual care incorporates our recognition of carers in primary, secondary care and in education. One of the key areas for focus in 2018/19 was regarding carers.

The Young Carers in Schools Programme has seen an increase in engagement and achievement. Schools have been committed to supporting young carers and ensuring their staff have awareness and an understanding of the support young carers require.



The below graph demonstrates the increase in numbers of identified young carers.



Other Key achievements

- The UHB has maintained very good patient satisfaction scores throughout out 2018-2019.
- There has been an increased % of concerns managed informally and a sustained improvement in the formal response times.
- We have developed activity in all of the Patient Experience quadrants.
- The diverse work with carers in secondary care via the roll out of the John's Campaign, through GP practices and in schools.
- The focussed work undertaken with our deaf community.

Areas for focus across the Framework in 2018/2019:

- Recognition of carers – continues roll out of the principles of the John's Campaign, further develop work in schools to support young carers.
- Inviting the non-engaging schools from Cardiff and the Vale of Glamorgan to engage with the Young Carers in Schools project.
- Continue to raise the profile of the Young Carers in Schools Programme at events in Cardiff and the Vale of Glamorgan.
- Thematic analysis of patient stories – develop the 2 minute patient story library.
- Bespoke surveys re sleep quality, loneliness and surveys linked to our strategy will be undertaken.
- Recruitment of young volunteers and specifically Activity Volunteers.
- Sustained improvement in response times to concerns.
- Focus upon improving access to services for those who are deaf or have hearing loss - a further paper on this point will be shared at a future QSE meeting.
- Train in excess of 500 staff in basic BSL.

RECOMMENDATION:

The Quality, Safety and Experience (QSE) Committee is asked to:

- **CONSIDER** progress with implementation of year two of the Patient Experience framework.
- **NOTE** the main high level achievements for 2018/2019 and areas for focus for 2019-20.

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								

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

REPORT TITLE:	**ESSURE – PATIENT NOTIFCATION EXCERCISE**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**18.06.19**	
STATUS:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	**Assistant Director Patient Safety and Quality**								

PURPOSE OF REPORT:

SITUATION:

The pupose of the report is to provde an overview of a patient notfication exercise that was undertaken when it became apparent that the outcomes of some patients who had undergone the ESSURE procedure (hysteroscopic sterilisation), were unclear.

REPORT:

BACKGROUND:

Essure is a device used for female sterilization. It is a metal coil which when placed into each fallopian tube induces fibrosis and blockage.

The Essure Procedure was offered as an outpatient procedure under Local Anaesthetic to offer sterilisation as an alternative to a procedure undertaken in Theatres under General Anaesthetic. The procedures were undertaken as a day case and patients would be discharged the same day. Patients would be followed up 3 months post procedure and a Hysterosapingogram (HSG) or an ultrasound scan would be performed to confirm whether the procedure was successful. HSGs were undertaken through the department of Radiology or alternatively a Consultant Gynaecologist utilised the Cardiff University system to undertake a 3D ultrasound scan. It became apparent that due to a lack of clear documentation, it was unclear as to whether the HSG/ultrasound scan had been undertaken and the associated outcome/success of the procedure. Therefore all patients who had received an ESSURE Procedure were reviewed to ascertain the outcome

ASSESSMENT:
Patient notes were reviewed (paper and electronic). They were then categorised as follows:

Category	Number of women	Action taken
A - Patients who had a confirmed successful procedure and it was documented that they had been informed	22	No action was required

B - Patients who had a confirmed successful procedure but there was no evidence that they had been informed.	17	A letter of confirmation was sent to each patient
C - Patients who had a departmental scan performed but the outcome was not confirmed and therefore needed further investigation.	3	The patients were contacted and offered further investigation.
D - Patients who did not appear to have had any follow up scan/HSG (i.e. there was no evidence that they had had this).	19	Patients contacted to explain the situation and invite them for further scans/HSGs.
E - Patients who had an unsuccessful procedure and had been informed	3	No Action Required (These patients already had subsequent sterilisation under GA)
F - Patients who had an unsuccessful procedure and there was no evidence that they had been informed.	3	These patients were contacted to explain the situation and invite them for further treatment

Letters were sent to all patients where indicated. For patients who did not respond to letters sent, an attempt to contact via the telephone and further letters was also made by both the Radiology department and the Gynaecology department. All letters were copied to the patient's GP.

Those patients who responded to contact from the department were offered confirmatory scans and informed of the outcome. A small number of patients had already undergone other procedures such as hysterectomy or laproscopic sterilization, which meant that follow up imaging was not necessary.

At the conclusion of the exercise:1 patient underwent a laparoscopic sterilisation

- 12 patients underwent HSGs and it was confirmed that the procedure had been successful.
- 8 patients had either a follow up appointment or an appointment for a follow up scan and did not attend. They have all been followed up in writing.
- 1 patient became pregnant and is in a Putting Things Right process.
- 3 patients had not responded to any of the multiple communications from the UHB. Checks were made with the patient's GPs to ensure that the contact details were correct in case any patients had moved address. All communications stated that until confirmed that the procedure is successful, it was recommended that they use alternative contraception as there is potential that the procedure may not be successful.

The original lady who presented went on to give birth.

The Committee should be advised that the UHB no longer offers ESSURE as an option for female sterilisation.

RECOMMENDATION:

The Committee is asked to **NOTE** the contents of the report and the outcome of the patient notification exercise.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	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		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:	**INFECTED BLOOD INQUIRY**						
MEETING:	Quality Safety and Experience Committee				**MEETING DATE:**	**18.06.19**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**
LEAD EXECUTIVE:	Executive Nurse Director						
REPORT AUTHOR (TITLE):	**Head of Patient Safety and Quality Assurance**						

PURPOSE OF REPORT:

SITUATION

The purpose of this paper is to update the Committee in relation to UHB activity undertaken to support and engage with the Infected Blood Inquiry.

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REPORT:

BACKGROUND

On 2 July 2018, the Independent Public Inquiry into Infected Blood and Blood Products (the Infected Blood Inquiry) was launched. The inquiry will examine the circumstances in which men, women and children treated by the NHS in the UK were given infected blood and blood products, in particular since 1970.

The UHB responded to the Inquiry on September 12th 2018 and submitted evidence in lines with the terms of reference.

This is of particular significance to Cardiff because the Health Board is the Comprehensive Care Centre in Wales and Professor Arthur Bloom, a former employee and lead clinician in the Haemophilia Centre during the 1970s until his death in 1992, was the Chair of the UK Haemophilia Centre Doctors' Organisation (UKHCDO) - an association of medical practitioners who work within Haemophilia centers in the UK and have an interest in the care of people with Haemophilia and other inherited bleeding disorders. The UKHCDO were influential in providing guidance and advice around the management and treatment of inherited bleeding disorders.

ASSESSMENT AND ASSURANCE

Since responding to the Inquiry on 12th September 2018, the UHB has continued to work with Haemophilia Wales, Welsh Blood Service, Public Health Wales, Velindre NHS Trust and other Health Boards across Wales.

Evidence submitted to the Inquiry to date, relates largely to the care of patients within the Haemophilia Centre, as well as a small number of patients who contracted a blood borne virus as a result of a blood transfusion. The patient cohort from the Hemophilia Center include 150

affected patients and their families. The Inquiry will identify which of the documents submitted by the UHB will used to inform the Inquiry. Once identified the UHB will be given limited period to review these documents for redaction prior to them being made available as evidence.

The current priority has been to ensure that affected patients and families have timely access to their medical records; this is largely restricted to haemophilia patients in the first instance, however several individuals who do not have an inherited bleeding disorder but have had blood transfusions within the significant time frames have also requested and been provided with their medical records.

Following the launch of the Inquiry in July 2019 the health board has worked closely with Hemophilia Wales to ensure that it could be as responsive as possible in the provision of medical records and in supporting individuals to understand the information in their records.

Prior to the launch of the Inquiry, it was agreed in a meeting at Welsh Blood Services attended by all health boards that NHS Wales would have a collaborative approach to ensure that there was a streamlined process for patients to access their medical records. Cardiff agreed to host an email account to receive requests for medical records and then to forwarded these requests to the relevant health boards to process a subject access request. A flyer was designed and provided to Haemophilia Wales advertising the contact details and these were distributed at the launch of the inquiry.

On 5th July 2018, Dr Andrew Goodall was issued with a letter by the Chair of the Inquiry instructing NHS Wales in relation to the retention/non-destruction of documents relating to the Independent Public Inquiry into Infected blood and Blood products. Given, that we have a potentially significant number of patients who will have been transfused with blood products that we cannot easily identify, it has been agreed that the routine destruction of historical medical records would cease. In last three quarters of 2018/19 43,875 of acute medical records that would have been destroyed have now being retained. Additional medical records storage has been sourced through a third party to accommodate these records.

By May 2019, 81 individuals had approached the health board to request their records and as a result 84 Subject Access Requests (SAR) have been facilitated. The majority of SARs have been implemented within the 28 days statutory timeframe but in some cases it has taken longer to be able to identify all volumes of the patient records. Every effort has been made to provide all volumes of records, in some cases this has meant individuals have been provided with up to 17 volumes of records. All medical records are reviewed and redacted prior to preparing and scanning. Individuals have in most cases been provided with electronic copies of records but the health board has responded when individuals have preferred paper copies. In some cases individuals have viewed the records in supportive environments where there has been a health professional present to answer questions and to help to navigate the records.

In 3 cases it has been evident that medical records were destroyed in line with the Data Protection Act and in a further 2 cases it has not been possible to provide complete sets of medical records referencing all episodes of care although records of all blood products administered to patients have been available and provided. Where the UHB has been unable to provide the complete records, the Chief Executive has written to the individuals or their relatives to apologise and to assure them that where we cannot evidence that the records have been destroyed all efforts to trace the remaining records will continue for the duration of the Inquiry.

There is provision within the Inquiries Act to grant Core Participation Status to individuals and organisations who have:

- played a direct and significant role in relation to the matters to which the Inquiry relates
- Have a significant interest in an important aspect of the matters to which the inquiry relates
- May be subject to explicit or significant criticism during the inquiry proceedings or in the report or in any interim report.

On 10th May 2019, the UHB applied for Core Participant Status. Because of its status as a comprehensive Care Centre and because Professor Bloom undertook the role of Chair of the UK Hemophilia Centre Doctors Organisation it is felt that the health board is likely to be able to contribute significantly to the Inquiry. The Solicitor to the Inquiry has requested further information to support the application.

All individuals who have been infected or affected have been able to develop written witness statements that will be considered by the inquiry. In July 2019 four days of hearings will be held in Cardiff. The majority of the infected or affected Welsh individuals who have been called to give oral evidence will do so during this week. The Cardiff hearings follow eight weeks of hearings in venues across the UK. It is understood that there will be further opportunities for infected and affected individuals to give oral evidence later in the Inquiry. The health board have submitted an expression of interest to attend these hearings as they will prove valuable in understanding the experiences of patients who have received care. A proportionate and supportive approach to attendance by the Haemophilia Centre clinicians and Social Workers will also be determined.

It is anticipated that in early 2020 further hearings will be scheduled to hear evidence from other witnesses and this could possibly include past and present members of staff. There has been communication with staff from across the health board via the Clinical Boards advising them of the support that is available through The Employee and Wellbeing Service, this is in recognition of the likelihood that in a large organisation there is a possibility that there are staff members who have been directly affected by the issues raised by the Inquiry as well as those who have provided care to infected and affected individuals.

RECOMMENDATION:
The Committee are asked to:
NOTE The approach taken to respond to the Infected Blood Inquiry

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	

3. All take responsibility for improving our health and wellbeing	x	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	
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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.

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Report Title:	**HTA INSPECTION AND THE RESPONSE TO INDEPENDENT REVIEW OF THE MORTUARY AND CELLULAR PATHOLOGY SERVICES AND RCA INTO TISSUE TRACEABILITY**								
Meeting:	**Quality, Safety and Patient Experience Committee**						**Meeting Date:**	**18 June 19**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Executive Director Therapies and Health Science**								
Report Author (Title):	**CD&T Clinical Board Director, Director of Operations and Director of Quality, Safety and Patient Experience**								

SITUATION

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

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

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

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

BACKGROUND

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

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

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

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

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

ASSESSMENT

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

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

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

The Clinical Board and Service delivered the required actions against each of the non-conformances in the timescales that were set out by the HTA. The HTA confirmed in a letter dated 13th February 2019 that all 26 non-conformances have been reviewed and have been confirmed as closed.

Independent Review of the Mortuary and Cellular Pathology services and RCA into tissue traceability:
In reviewing both these reports the service and Clinical Board developed an action plan to reflect progress against recommendations made. The action plan is included in appendix 1.

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

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

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

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

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

Of the 35 recommendations the progress against associated actions is as follows:
1. Completed – 33
2. In progress - 2

Within the external review report there were 21 recommendations made. The recommendations can be grouped in to themes as follows:
1. Governance
2. Leadership
3. Designated individual (DI)
4. Culture
5. WIFM

Of the 21 recommendations the progress against associated actions is as follows:
1. Completed – 19
2. In progress – 2

The remaining 'in progress' actions are in final stages of completion and include transition to the new DI, (subject to HTA approval of the individual), final approval of the SLA with WIFM, and completion of the database development for tissue management.

The Clinical Board is fully committed to on-going sustainability of the remedial actions delivered to ensure continued regulatory compliance in this service. As part of this work, the Clinical Board have developed the Regulatory Compliance Dashboard which is used to drive improvement through the Clinical Board Regulatory Compliance Group. This mechanism is used to ensure appropriate Clinical Board management oversight of all regulated and accredited services within the Clinical Board.

However, in order to transform diagnostic services the Clinical Board recognises that a new focus is needed to drive quality, safety, patient experience, outcomes and costs. The Clinical Board is therefore proposing the development of a Quality Led Governance framework which will provide

- Delivery of safe, effective and high quality healthcare
- Improvement of the patient experience of diagnostic services
- Improvement in the health of individual patients and patient populations.
- Development of new performance and quality indicators
- Delivery and maintenance of regulatory compliance and accreditation of services (a state of being 'Always Inspection Ready')
- Reduction in governance risks
- Reduction in the per capita costs of diagnostic services.

The essential elements within this framework include

- Building capability, by improving leadership, management, professional and service culture, and developing the skills and behaviours required to assure quality and sustain improvement
- Ensuring processes and structures are fit for purpose
- A strong focus on continuous learning and improvement.
- A risk management process to identify, understand, monitor and address current and future risks
- A proactive rather than reactive approach, recognising that the costs of reacting to poor inspections can outweigh the costs of maintaining a sustainable Quality Management System
- The capability to measure the quality of diagnostic and therapeutic services. This is central to the development of sustainable improvement to the quality and cost effectiveness of these services.

This scheme is within the IMTP for 19/20 and a business case for the required resources will be presented to BCAG in June 2019. Without investment in quality resource, sustainability of the improvements made to date will be challenging.

ASSURANCE is provided by:

- The actions developed and progressed

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

- Closure of the HTA inspection findings
- The action plans
- The intended monitoring mechanism through CD&T governance structures
- The proposed Quality Led Governance approach

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	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	

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		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.								

Appendix 1 - POST HTA REVIEW ACTION PLAN

	Recommendation	Action	Timescale	Action owner	Progress
1	The DI post holder should have a substantive contract with the UHB with remuneration to reflect the time and responsibility of the role.	The move from a temporary DI to a sustainable solution will need careful consideration. Appointing an individual with sole responsibility for the role on a substantive basis may present challenges. This is due to the fact that in the view of the HTA the DI has the ability to step down from the role at any point. How this is managed contractually will need to be developed in conjunction with HR.	April 2019	HWOD DoO	Notice received from interim DI that he will cease as DI from 1st April 2019. A new DI has been identified and the transition is in progress. This is subject to HTA approval of the proposed individual.
2	At least monthly meetings with the licence holder (LH) to provide support to the DI and assurance for the LH.	Minimum monthly meetings in place which are minuted	Ongoing requirement	DI LH	Complete
3	The new Terms of Reference developed for the HTA Licence 12163 compliance group should include mechanisms to directly escalate concerns in terms of the DI to the LH or vice versa.	Revise TOR for HTA Compliance Group	22-6-18	DI	Complete
4	Robust checks and sign off processes should be put in place in respect of the development of Standard Operating Procedures (SOPs)	All SOPs have been reviewed and signed off by the DI. SOPs are recorded on Q-pulse and are acknowledged electronically	18-5-18	DI SM DQSPE	Complete
5	Work needs to take place within the Directorate to ensure clarity in respect of roles and responsibilities In addition as part of the management and appraisal process any gaps in terms of either manager's or staff's ability to undertake their roles needs	This action will be completed as part of the OD intervention covering a number of recommendations. The detailed planning of the OD is included within the programme plan for the Mortuary and Cellular Pathology. The informal elements of OD have begun with	1/9/18	HWOD DoO	Complete

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

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

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

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

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

Key

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

RCA ACTION PLAN

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

	review new, revised regulation, accreditation and professional standards. This list is not exhaustive, and perform a gap analysis should be undertaken to identify the resources or investment required to ensure compliance.	This will be monitored through the Regulatory Compliance Group			
2	The UHB must put in place a leadership and governance structure around HTA regulatory compliance that provides the Executive Team with robust assurance that compliance with contemporaneous standards is regularly and consistently monitored.	HTA Compliance Group established CB Regulatory Compliance Group established	1-6-18	DI DoO DQSPE CBD	Complete
3	Key personnel appear to be unaware of the HTA consultation process before the changes to the Codes of Practice.	Standing agenda item for the HTA Compliance Group This will be monitored through the Regulatory Compliance Group	8-11-17	DI SM LD	Complete
4	Inadequate dissemination of changes in Code of Practice for working on human tissue	Standing agenda item for the HTA Compliance Group	8-11-17	DI SM LD	Complete
5	The organisation should identify clear lines of accountability and authority in relation to the unification of the Cellular Pathology, Mortuary and Post Mortem governance (including HTA compliance) and staff need to be supported in those roles.	Organisational chart completed and circulated and staff discussed		DI SM LD	Complete
6	Dedicated and protected time allocation did not appear to be available to allow role(s) to be successfully completed, there did not appear to be adequate support or independence to facilitate escalation as and when required. Therefore key roles, e.g. both the Traceability Lead and Cellular Pathology Quality Manager must have a salary that is commensurate of the skills required and have sufficient protected time (whole time equivalent) to complete the legal duties required of the post holder	Through the restructuring dedicated roles for these in place and tested		SM LD DoO	Complete
7	All establishments under the HT Act 2004 must complete a compliance update. The information provides the HTA with a	Forms part of the agenda of the HTA Compliance Group	8-11-17	DI SM	Complete

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

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

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

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

24	The mortuary storage areas need to be mapped with secure access that is reviewed on a regular basis. Within the storage areas there needs to be clear segregation between specimens retained under PACE, Coronial authority, CPIA or as part of a hospital consent post mortem.	PM tissue has been clearly segregated	12/2/18	DI SM LD Cardiff Uni	Complete
25	All requests for additional work should be captured in a clear and consistent method, using a standardised format to facilitate interpretation with regard to transcription, audit and disposal.	To be defined in SOP	6/7/18	LD	Complete
26	Timelines for additional testing should be defined in the procedure, one case within the 42 investigated [X,17.0000467.H] had additional testing performed after the Coroner had concluded the inquest.	To be defined in SOP	6/7/18	LD	Complete
27	The authority to dispose of specimens following completion of the case i.e. Coroner authority ended, Police case/appeal process ended, and family wishes to dispose is by the managing Pathologist. No disposal forms must be changed, amended or added to after this approval has been granted. There is evidence of specimens being added to the disposal inventory by laboratory staff after the Pathologist has approved the disposal, [X,14.0000076.F].	All staff communicated to regarding practice expectations, SOP to be re-circulated within 2 weeks	21/6/18	SM	Complete
28	The definitive disposal date and should be agreed by all parties, there is evidence of the Pathologist requesting specimens be retrieved from the disposal bin after they have been deposited, see statements Appendix_I.	completed	complete	SM	Complete
29	Specimen type, volume, number need to be recorded on the original worksheet to facilitate cross-reference to the disposal records. There is evidence of specimens being 'missed' on a disposal run and being disposed of on subsequent disposal runs.	Updated form in place	complete	LD	Complete

30	Specimens sent away for additional work, such as urine and samples for toxicology, should be covered by a Technical Agreement or SLA, with the third party to ensure the specimen is used in totality or returned.	SOP has been revised	complete	DI SM	Complete
31	Cases where that post mortem was undertaken outside of CVUHB and specimens referred to C&V for further analysis require a separate review. The evidence from these cases, within the 42 post mortem cases reviewed, showed the documentation to be ambiguous as to the type and volume of specimen transferred.	To be defined in SOP	6/7/18	LD SM DI	Complete
32	Disposal – there should be a far more proactive approach to the disposal of holdings	SOP for disposal has been revised HTA Compliance Officer now in place to ensure proactive timely disposal of tissue		DI SM LD DoO	Complete
33	The current IT systems and recording methodology (i.e. the use of four separate systems) is not fit for purpose. CVUHB should update the four separate systems with one application to mitigate the risk of multiple transcription areas and greatly assist in the traceability of holdings	A market review of the available systems for tissue traceability has been undertaken, and no system is available which is fit for purpose. The Clinical Board has recruited an individual to develop a bespoke solution.	May 2019	CBD DoO	In progress
34	The Clinical Diagnostic and Therapeutic Clinical Board, Cellular Pathology Management Team and the Designated Individual should review the directorate and departmental quality management system (QMS). The review should examine document control, record keeping, stakeholder information and communication, training and development, standard operating procedures, self-inspection, premises and equipment. This list is not exhaustive. The Investigation Team	Metrics have been modified and simplified. 'Temperature gauge' indicator gives quick visible measure of compliance. DQSPE has access to metrics via Q-pulse and regularly reviews and acknowledges.	Started but ongoing action	DQPSE DI LD SM LMQM	In progress

	reviewed multiple examples of areas where the QMS identified non-compliance or opportunities for improvement	The Regulatory Compliance Group will monitor QMS effectiveness			
35	Non-conformities and incident management should be reviewed, and a good reporting culture developed Evidence reviewed revealed - a) an inconsistent and low volume reporting culture b) limited experience in root cause analysis tools, identification of robust corrective and preventive actions, change and risk management, process for periodic review c) a limited self-inspection programme that does not meet the regulatory and accreditation requirement d) a self-inspection programme that has no independent review	Root cause analysis training to be rolled out Audit schedule to be risk assessed to ensure timely self-inspection undertaken. Audit and self-inspection will be performed by independent auditors. DQSPE will actively support audit within the service. Metrics include audit performance. Metrics reviewed by DQSPE, reviewed at Clinical Board and Regulatory Compliance group.	Ongoing actions in place 31/8/18	LMQM DQSPE SM LD	On-going

Protective Marking OFFICIAL

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Date 13 February 2019

Mr Clive Morgan
Deputy Director of Therapies & Health Science
University Hospital Wales
Cardiff
Email: clive.morgan3@wales.nhs.uk

Dear Clive

Closure of the Corrective and Preventative Action (CAPA) for University Hospital Wales (UHW), Cardiff, Licence no. 12163

Thank you for the submission of the requested audits for body and tissue traceability and disposal of tissues, to provide the HTA with assurance that audit findings are clearly and accurately recorded including any actions that are required. I can confirm that the HTA are satisfied with the evidence you have submitted to close the remaining CAPA for the shortfall against standard T2(a).

The audits submitted outline the scope, findings (non-conformances), root causes, recommendations and corrective and preventative actions (CAPAs). It is noted that the corrective and preventative action closure dates for the findings in the audits were after the submission date of 31 January 2019. Although the audits have identified some issues, during our conversation on 8 February 2019, you were able to provide the necessary assurances and that the CAPAs would be completed by the closure dates stated in the audit reports. The audit schedule and audits will be reviewed as part of your next site visit inspection.

Thank you for your commitment in addressing the shortfalls and working with the HTA.

Kind regards

Lisa Carter
Interim Head of Regulation

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

Ionising Radiation Risk Management Policy

Policy Statement

To ensure that the Cardiff and Vale University Health Board (UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will manage our of use ionising radiation in a safe manner and in such a way as to protect the health and well-being of patients, staff and members of the public.

Policy Commitment

We will:

- Provide a robust framework for the management and use of ionising radiation
- Ensure that management of the use of ionising radiation is safe and compliant with current legislation, standards and guidance in order to protect the UHB, patients, staff and members of the public
- Ensure that managers and staff are aware of their roles in the safe use of ionising radiation
- Keep radiation doses and dose rates as low as reasonably practicable (ALARP)
- Restrict the use of ionising radiation to practices that are justified and ensure that each intentional exposure of a human subject is individually justified
- Optimise exposure to ionising radiation in order to reduce radiation dose, provided that this is consistent with any desired clinical or related outcome
- Keep radiation doses to staff and members of the public within statutory dose limits
- Manage radiation equipment in accordance with accepted best practice
- Entitle duty holders associated with the exposure of human subjects to ionising radiation
- Demonstrate compliance through record keeping and audit
- Appoint Radiation Protection Adviser(s), Medical Physics Expert(s), Radioactive Waste Adviser(s) and Radiation Protection Supervisors

Supporting Procedures and Written Control Documents

This Policy is supported by two procedures:

- Exposure of Patients to Ionising Radiation Procedure
- Exposure of Staff and Members of the Public to Ionising Radiation Procedure

They describe the following with regard to the safe use of ionising radiation:

- Procurement and use of radiation equipment, particularly for medical applications
- Management of the use of ionising radiation with emphasis on the safety of those who are affected or may be affected by its use
- Demonstration of compliance with regulatory requirements and dealing with instances of non-compliance
- Duties associated with the safe use of ionising radiation

Other supporting documents include:

- Health and Safety Policy
- Medical Equipment Management Policy
- Risk Management Policy
- Radioactive Substances Risk Management Policy
- Radioactive Substances Risk Management Procedure

Scope

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

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this policy/supporting procedure. *Note: if an EqIA has not been completed indicate why*
Health Impact Assessment	A Health Impact Assessment (HIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this policy/supporting procedure. *Note: if a HIA has not been completed indicate why*
Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Radiation Protection Group

Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*
2			

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

Exposure of Patients to Ionising Radiation Procedure

Introduction and Aim

The Cardiff and Vale University Health Board (UHB) uses ionising radiation for a variety of clinical and other applications and this use presents a potential hazard to a range of people including patients, staff and members of the public.

The UHB has an Ionising Radiation Risk Management Policy whose aim is to ensure that we manage the use of ionising radiation in such a way as to minimise adverse effects on people, provided that this is consistent with any desired clinical or related outcome.

This Procedure supports the Policy and translates its aim into practical implementation measures as regards the safety of patients.

Objectives

We will achieve our aim by:

- Providing a robust framework for the management and safe use of ionising radiation
- Ensuring that management of the use of ionising radiation is safe and compliant with current legislation, standards and guidance in order to protect the UHB, patients staff and members of the public
- Ensuring that managers and staff are aware of their roles in the safe use of ionising radiation
- Keeping radiation doses and dose rates as low as reasonably practicable (ALARP)
- Restricting the use of ionising radiation to practices that are justified and ensure that each intentional exposure of a human subject is individually justified
- Optimising exposure to ionising radiation in order to reduce radiation dose, provided that this is consistent with any desired clinical or related outcome
- Keeping radiation doses to staff and members of the public within statutory dose limits
- Managing radiation equipment in accordance with accepted best practice
- Entitling duty holders associated with the exposure of human subjects to ionising radiation
- Demonstrating compliance through record keeping and audit
- Appointing Radiation Protection Adviser(s), Medical Physics Expert(s), Radioactive Waste Adviser(s) and Radiation Protection Supervisors

Scope

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

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this policy/supporting procedure. *Note: if an EqIA has not been completed indicate why*
Health Impact Assessment	A Health Impact Assessment (HIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this policy/supporting procedure. *Note: if a HIA has not been completed indicate why*
Documents to read alongside this Procedure	• Ionising Radiation Risk Management Policy • Exposure of Staff and Members of the Public to Ionising Radiation Procedure • Health and Safety Policy • Medical Equipment Management Policy • Risk Management Policy • Radioactive Substances Risk Management Policy • Radioactive Substances Risk Management Procedure
Approved by	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	

Disclaimer

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

Summary of reviews/amendments

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

Contents

Appendices

1 Definition of terms

Absorbed dose
The fundamental type of radiation dose defined as the energy deposited by ionising radiation in unit mass of irradiated material.

Alpha rays (alpha radiation)
Particulate ionising radiation in the form of helium-4 nuclei (a combination of two protons and two neutrons) emitted by nuclei during radioactive decay.

Beta rays (beta radiation)
Particulate ionising radiation in the form of electrons or positrons emitted by nuclei during radioactive decay.

Deterministic effect
An effect of ionising radiation on living tissue in which the severity of the effect increases with radiation dose above a threshold dose (below which the effect does not occur).

Diagnostic Reference Level (DRL)
Value of radiation dose, or administered activity in nuclear medicine, for typical diagnostic examinations in groups of standard-sized patients for broadly defined types of radiation equipment.

Dose constraint
A restriction on the prospective radiation dose to an individual that may result from a given radiation source.

Effective dose
The sum of the product of equivalent dose and tissue weighting factor taken over all irradiated tissues and organs.

Electron
A negatively charged particle that is one of the constituents of the atom.

Equivalent dose
The product of absorbed dose and radiation weighting factor for a particular irradiated tissue or organ.

Gamma rays (gamma radiation)
Ionising radiation in the form of photons emitted by nuclei during radioactive decay.

Gy
The gray, which is the unit of absorbed dose (equal to 1 joule of energy per kg).

Ionising radiation
Radiation that is sufficiently energetic to cause ionisation through the release of inner electrons in atoms of high atomic number.

Neutron
An uncharged particle that is one of the constituents of the atomic nucleus.

Particle
A unit of radiation that has mass e.g. electron, beta particle, proton, alpha particle and neutron.

Photon
A unit (quantum) of electromagnetic radiation such as infra-red, visible, ultra-violet, x and gamma radiation.

Proton
A positively charged particle that is one of the constituents of the atomic nucleus.

Radiation
A stream of energy, usually in the form of photons or particles, emitted from a source, moving through a material and interacting with it to deposit energy in the material.

Radiation dose
A measure of the energy deposited by ionising radiation in a material and its potential harmful effects.

Radiation employer
An employer who in the course of a trade, business or other undertaking carries out, or engages others to carry out, work with ionising radiation.

Radiation weighting factor
A quantity that indicates the relative harmfulness of different types of ionising radiation to living tissue.

Radioactive decay or disintegration
The transformation of one nuclide (a radionuclide) into another with the emission of ionising radiation.

Radioactive substance (material)
Substance (material) that contains one or more radionuclides.

Radioactive waste
Any material that is either radioactive in its own right or is contaminated by radioactive substances and for which no further use is envisaged.

Radioactivity
The phenomenon associated with radioactive decay or disintegration.

Radiopharmaceutical
A radioactive medicinal product that is administered to human subjects for medical diagnosis or treatment or a related purpose such as medical research.

Radiosensitivity
The sensitivity or susceptibility of different tissues and organs to the harmful effects of radiation.

Stochastic effect
An effect of ionising radiation on living tissue in which the probability of the effect occurring increases linearly with radiation dose without a threshold.

Sv
The sievert, which is the unit of equivalent dose and effective dose.

Tissue weighting factor
A quantity that indicates the relative sensitivity or susceptibility of different tissues and organs to the harmful effects of ionising radiation.

Tissue reaction
This is the same as a deterministic effect.

X-rays (x-radiation)
Ionising radiation in the form of photons emitted by electron interactions in atoms, possibly as a consequence of radioactive decay.

X-ray tube
An evacuated chamber in which electrons are accelerated towards a target to produce x-rays.

2 Use and harmful effects of ionising radiation

Ionising radiation takes the form of either high energy photons (such as x-rays and gamma rays) or high energy particles (such as alpha rays, beta rays, electrons, protons and neutrons). It is produced by electrical radiation generators (such as x-ray tubes) and by radioactive substances. Ionising

radiation has a wide range of beneficial applications but it also has the potential to cause harm.

The UHB uses ionising radiation at Barry Hospital, Cardiff Royal Infirmary, Rookwood Hospital, St David's Hospital, University Hospital Llandough (UHL), the University Hospital of Wales (UHW) (including the Children's Hospital and the Dental Hospital) and at community medical and dental sites in the following practices:

- Manufacture of radioactive products (including radiopharmaceuticals and radioactive sources)
- Application of radioactive tracers (for medical and biological techniques)
- Medical diagnosis
- Medical treatment
- Occupational health screening
- Health screening
- Medical and biomedical research and development
- Medico-legal procedures
- Non-medical imaging using medical radiological equipment
- Teaching and training
- Ionising radiation metrology
- Transport of radioactive material

All these practices are justified [1-3] i.e. they produce sufficient benefit to individuals exposed to ionising radiation or to society in general to offset the detriment that they cause. Justification is one of the basic tenets of radiation protection, the others being optimisation and dose limitation [4].

The majority of the above practices are associated with radiology (diagnostic and interventional) and nuclear medicine (diagnostic and therapeutic). In radiology, human subjects are exposed to x-rays from an external source (x-ray tube). Radiology is practised widely throughout the UHB. Nuclear medicine, on the other hand, involves the administration of radioactive substances (in the form of radioactive medicinal products or radiopharmaceuticals) to humans such that the subjects are irradiated internally by beta and gamma rays. Nuclear medicine is practised only at UHW and UHL.

The potential of ionising radiation to cause harm is usually expressed in terms of radiation dose, which is a measure of the energy deposited by radiation and its impact on living tissue [4]. The basic quantity is absorbed dose, which is an expression of the energy deposited by ionising radiation per unit mass of the material which it irradiates; its unit is the gray (Gy). Absorbed dose is used to quantify the energy deposited by ionising radiation in tissues and organs.

The same absorbed dose delivered to living tissue by different types of ionising radiation causes biological damage to different extent. This variation is expressed by the radiation weighting factor, which is unity (one) for x, beta and gamma radiation (since they are equally harmful) and greater for alpha radiation and neutrons (because they are relatively more harmful for the same absorbed dose). The equivalent dose is given by the absorbed dose multiplied by the radiation weighting factor. It is indicator of harm to a particular tissue or organ due to ionising radiation irrespective of the type (and energy) of the radiation; its unit is the sievert (Sv).

In addition, some living tissues and organs are more sensitive or susceptible to the harmful effects of ionising radiation. This variation is expressed by the tissue weighting factor, which is relatively larger for those tissues and organs which are most radiosensitive (i.e. most susceptible to the harmful effects of radiation). The effective dose is the sum of the equivalent dose multiplied by the tissue weighting factor for all irradiated tissues and organs. It is an indicator of harm to the whole body from either total or partial exposure to radiation regardless of the number of tissues and organs exposed; it is also expressed in Sv.

There are two broad types of harmful effect of ionising radiation: deterministic effects (also called tissue reactions) and stochastic effects [4]. Deterministic effects occur in the irradiated individual and are characterised by a threshold absorbed dose (below which the effect does not occur) and the fact that the severity of the effect increases with absorbed dose (above the threshold). An example would be erythema (reddening) of the skin with a threshold of 2-5 Gy and progression to blistering and ulceration as absorbed dose increases.

For stochastic effects, the probability of the effect occurring increases in proportion to effective dose; there is no threshold. Stochastic effects may occur in irradiated individuals and in future generations. The most important stochastic effect is the induction of cancer in an irradiated individual. For a general population, the risk of fatal cancer is about 5% per Sv, although the risk varies with age and is greater for children than for adults [4].

Irradiation of the embryo and foetus may cause both deterministic and stochastic effects [4].

3 Regulation of ionising radiation

The use of ionising radiation is governed by legislation that is designed to control its adverse effects on people and the environment. This involves keeping radiation doses as low as reasonably practicable (ALARP). The

legislation is supported by codes of practice and guidance and compliance is assessed through a programme of inspections by statutory external agencies.

The exposure of patients to ionising radiation is governed by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 and a subsequent amendment to the regulations [5,6]. These are made under the European Communities Act 1972 [7] but are enforced as if made under the Health and Safety at Work Act 1974 [8]. The regulations are supported by official and professional body guidance [9,10]. They apply to the deliberate exposure of human subjects to ionising radiation as follows:

- To patients as part of their medical diagnosis or treatment
- To individuals as part of health screening programmes
- To patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes
- To carers and comforters
- To asymptomatic individuals
- To individuals undergoing non-medical imaging using medical radiological equipment

For the purposes of this Procedure, those subject to exposures in these categories are collectively called ‘patients’. Practices that involve the deliberate exposure of humans under circumstances other than the above do not fall within the scope of IR(ME)R 2017. Such practices are permitted only if their justification is confirmed by the most recent version of the national Justification Register [1-3,11].

The regulations are enforced by Healthcare Inspectorate Wales (HIW), which reports on its activities [12]. In England, similar reports are published by the Care Quality Commission (previously Healthcare Commission) [13-14].

In nuclear medicine, radiopharmaceuticals may be administered to humans only by a person who holds a licence from Health Ministers or someone acting under the authority of such a person. In addition, a separate licence is required by the employer at each site where such administrations take place [15]. Radiopharmaceuticals are prepared in a specialised radiopharmacy at UHW under a regime [9,16-18] that is regulated by the Medicines and Healthcare products Regulatory Agency (MHRA).

The Ionising Radiations Regulations (IRR) 2017 [19] address all aspects of work with ionising radiation. They are made under the Health and Safety at Work Act 1974 [8] and are supported by an Approved Code of Practice (ACOP) and official guidance [20] as well as professional body guidance [9]. IRR 2017 deal with the radiation protection of workers and the members of the public who are exposed as a result of work with ionising radiation. They are not concerned directly with the radiation protection of patients. The

regulations specify the responsibilities of a radiation employer; these include making risk assessments, appointing a Radiation Protection Adviser (RPA) and one or more Radiation Protection Supervisors (RPSs) and writing Local Rules. IRR 2017 are enforced by the Health and Safety Executive (HSE).

Radioactive material is kept on UHB premises in accord with the stipulations of the Environmental Permitting Regulations (EPR) 2016 and subsequent amendment [21-22] and under conditions that are specified in Environmental Permits issued by Natural Resources Wales (NRW). The same applies to the accumulation and disposal of radioactive waste. The permits are site-specific for UHW and UHL. In addition, there is a requirement [23-24] to appoint a suitable Radioactive Waste Adviser(s) (RWA). Radioactive materials are transported in a manner [9,25-26] that is consistent with the requirements of the Office for Nuclear Regulation, which includes the appointment of a Dangerous Goods Safety Adviser (DGSA). Regulations governing the keeping and transportation of radioactive substances and the management of radioactive waste do not have a direct impact on the radiation safety of patients.

4 General arrangements for the protection of patients against the harmful effects of ionising radiation

For the deliberate irradiation of patients, the goal of radiation protection is to achieve the desired clinical outcome while restricting radiation exposure as much as possible i.e. keeping radiation doses ALARP. The mechanisms for achieving this goal are the justification of individual exposures and the optimisation of processes. For diagnostic and interventional procedures this means minimising the risk of stochastic effects and avoiding deterministic effects. In radiotherapy, it means controlling the exposure of healthy tissue so as not to induce unacceptable side effects. IR(ME)R [5-6] provide a regulatory framework within which the UHB works to achieve these goals.

The exposure of patients to ionising radiation is mainly carried out in four areas within the UHB: Cardiothoracic (part of the Specialised Services Clinical Board); Radiology and Medical Physics (both part of the Clinical Diagnostics and Therapeutics Clinical Board) and the University Dental Hospital (part of the Dental Clinical Board).

The Employer as defined in the regulations is the UHB and the Chief Executive takes overall responsibility for compliance with legislation on behalf of the UHB. The Chief Executive has delegated the task of ensuring compliance with radiation safety legislation to the Executive Director of Therapies and Health Science (DoTH). The DoTH has further delegated this task to individuals throughout the UHB's line management structure. This includes the identification and entitlement of various duty holders and the

appointment of Medical Physics Experts to provide expert advice regarding the medical exposure of patients.

The UHB has established a Radiation Protection Group (RPG) that reports to the Quality, Safety and Patient Experience Committee and onwards to the Executive Board. The RPG discusses all aspects of radiation safety including the exposure of patients and its work includes what would otherwise be done by a Medical Exposures Committee [9].

5 Specific arrangements for the regulation of medical exposures to ionising radiation

The UHB should provide standard operating procedures (SOPs) for all aspects the medical exposure of patients to ionising radiation. These include the following employer's procedures:

- Entitlement of duty holders (referrers, practitioners and operators)
- Identification of patients
- Establishing whether females of child bearing age (12-55 years) are pregnant and, in the case of nuclear medicine, breast feeding
- Evaluation of each radiation exposure
- Role of duty holder (particularly the practitioner and operator) in exposures associated with research
- Assessment of patient radiation dose and, in nuclear medicine, administered activity
- Development and use of Diagnostic Reference Levels (DRLs) for diagnostic investigations, including review and action when they are consistently exceeded
- Issue of written instructions to nuclear medicine patients regarding radiation safety after the administration of a radiopharmaceutical
- Ensuring that the likelihood and magnitude of accidental or unintended radiation doses to patients are reduced and that any such occurrences are relayed to the referrer, practitioner and individual exposed
- Development and application of Quality Assurance (QA) programmes, including those for SOPs and equipment
- Providing the patient with information relating to the risks and benefits associated with the radiation dose from an exposure
- Establishing appropriate dose constraints and guidance for carers and comforters

Those procedures that apply throughout the UHB, especially at corporate level, are addressed in this document. More detailed procedures are tailored to the work of individual services. The content of these procedures may vary considerably from one service to another, reflecting the diversity of the UHB's clinical and research work.

The UHB as employer should pay special attention to the following:

- Exposures that have no direct health benefit to the exposed individuals including setting dose constraints for research
- Medical exposure of children because of their relatively high radiosensitivity compared with adults
- Medical exposure for health screening, which can involve large numbers of symptomless individuals
- Medical exposures involving high radiation dose to patients because of the increased stochastic risk and the possibility of tissue reactions
- Medical exposures of females in whom pregnancy cannot be excluded, in particular if pelvic or abdominal anatomic regions are involved, taking into account the exposure of both the expectant mother and the unborn child, the urgency of the exposure and the relatively high radiosensitivity of the foetus
- Radiopharmaceutical administrations in nuclear medicine to females who are breast feeding, taking into account the exposure of both the female and the child and the urgency of the exposure

The UHB should perform other duties imposed upon the employer; these include ensuring that:

- Referral criteria, such as those developed by the Royal College of Radiologists for diagnostic investigations [27], are made available to referrers, together with the appropriate radiation doses
- Research involving radiation exposure has been approved by the appropriate Ethics Committee
- Doctors and dentists who administer radiopharmaceuticals in nuclear medicine hold appropriate licences issued by officials of the Administration of Radioactive Substances Advisory Committee (ARSAC) on behalf of health ministers
- In nuclear medicine, the role of practitioner is undertaken by an ARSAC licence holder
- Duty holders are identified for each exposure, with particular attention to the use of portable radiation equipment and exposures conducted in multi-disciplinary settings (such as an operating theatre or a catheterisation laboratory)
- Adequate training, including that for new techniques, and continuous professional development (CPD) is provided for practitioners and operators
- Records of training are kept and made available for inspection by HIW
- Duty holders (referrers, practitioners and operators) carry out the duties assigned to them in Section 6 of this Procedure
- The radiation exposure of individual patients is justified and authorised and different types of exposure are optimised

- Practitioners and operators comply with SOPs
- Written protocols are provided for each type of standard radiological practice for each item of equipment
- The expertise of Medical Physics Experts (MPEs) as specific operators is used as appropriate, depending upon the hazards and radiation doses associated with the particular type of exposure
- Appropriate clinical audit is carried out
- An inventory is kept of equipment used for medical exposure
- Incidents involving radiation doses to patients much greater than intended [28] are reported to HIW

6 Duties

To ensure the implementation of its Ionising Radiation Risk Management Policy as regards the exposure of patients, the UHB assigns the duties described here.

The duties of the Executive Director of Therapies and Health Science include:

- Ensuring that the UHB provides suitable management arrangements, including sufficient resources and competent persons, to comply with legislation and guidance governing the safe use of ionising radiation
- Providing assurance to the UHB Board that the use of ionising radiation is managed in compliance with the UHB's policies and procedures
- Informing the UHB Board about issues related to the use of ionising radiation
- Ensuring that Clinical Board Directors have arrangements in place for the entitlement of referrers, practitioners and operators for services provided within their Clinical Boards
- Appointing suitably qualified and experienced MPEs in writing
- Maintaining a list of appointed MPEs including their scope of practice
- Delegating duties to other managers as appropriate
- Ensuring that the UHB holds licences for the sites at which radiopharmaceuticals are administered

The duties of Clinical Board Directors include:

- Providing assurance to the Executive Director of Therapies and Health Science that the use of ionising radiation is managed in compliance with policies and procedures and regulatory requirements
- Ensuring that Directorate Clinical Directors have arrangements in place for the entitlement of referrers, practitioners and operators for services provided by their Directorates
- Communicating and liaising with the Chair of the Radiation Protection Group, Practitioners, MPEs, Clinical Directors and other managers about issues related to the use of ionising radiation

- Reporting confirmed incidents of exposure much greater than intended to HIW in a timely manner
- Disseminating information about reported incidents within the UHB as appropriate
- Delegating duties to other managers as appropriate

The duties of Directorate Clinical Directors include:

- Ensuring that members of staff are aware of their roles and duties as regards medical exposures
- Entitling registered healthcare professionals as referrers, defining their scope of practice (with due regard to their qualifications and training) and making referral guidelines available to them
- Entitling registered healthcare professionals as practitioners and defining their scope of practice (e.g. in terms of type of medical exposure)
- Entitling operators and defining their scope of practice (e.g. in terms of operator tasks, including making and recording a clinical evaluation of each exposure)
- Withdrawing entitlement for persistent non-compliance with policies and procedures
- Maintaining a list of referrers, practitioners and operators
- Ensuring that practitioners and operators are qualified, adequately trained, receive update training as appropriate and participate in continuous professional development
- Maintaining training records and making such records available for inspection
- Providing SOPs and exposure protocols for their services and reviewing these documents at appropriate intervals
- Ensuring that a record is kept of all medical exposures including the names of the referrer, practitioner and operator(s) and an estimate of radiation dose for each individual exposure
- Providing procedures to ensure that a clinical evaluation is made and recorded for each exposure and that the record (report) is received by the referrer in a timely manner
- Ensuring that medical exposures and associated procedures are subject to suitable clinical and other types of audit
- Investigating suspected incidents of accidental, unnecessary or unintended exposure in association with the appropriate MPE and reporting confirmed incidents of exposure much greater than intended to the Clinical Board Head of Operations and Delivery
- Keeping records of incidents for the appropriate time
- Delegating duties to duty holders and other managers as appropriate

In nuclear medicine:

- Ensuring that practitioners hold ARSAC licences for the administrations of radiopharmaceuticals that they wish to undertake

The duties of the Chair of the UHB Radiation Protection Group include:

- Providing advice on the implementation of relevant UHB policies and procedures
- Auditing compliance with relevant UHB policies and procedures
- Reviewing relevant UHB policies and procedures at least every three years and ensuring that they are amended and updated as necessary
- Reviewing reports from Medical Physics Experts and taking action as necessary
- Liaising with members of the Radiation Protection Group and others as necessary

The duties of the Medical Physics Expert (MPE) include:

- Being involved as appropriate in clinical exposures with external radiation beams
- Working closely with practitioners as regards the justification of medical exposures
- Working closely with operators, maintenance engineers and others as regards the optimisation and practical aspects of medical exposures
- Measuring radiation dose and providing calibrated systems for radiation dose measurement
- Estimating radiation dose and assessing radiation risk to patients and, where appropriate, embryo or foetus, in cases of both intended and unintended exposure
- Providing advice to patients as regards radiation risk including female patients who are or may be pregnant
- Providing advice and assessing the radiation dose implications of introducing new equipment and techniques
- Setting and reviewing diagnostic reference levels (DRLs) for clinical exposures and dose constraints and target doses for research exposures
- Monitoring and reviewing patient radiation doses and developing dose reduction strategies
- Evaluating image quality in relation to patient dose
- Providing a quality assurance programme for equipment and liaising with other operators as regards routine equipment quality control
- Reviewing and communicating the outcome of equipment quality assurance
- Advising on equipment management including the specification, selection and purchase of clinical and related radiation equipment and the maintenance of an equipment inventory
- Advising on the application and quality assurance of clinical software
- Performing acceptance testing and participating in commissioning new equipment including communicating with equipment supplier applications specialists

- Advising on the suspension of the use of existing equipment
- Reviewing equipment replacement policies and processes
- Developing and performing suitable audits for medical exposures and participating in multi-disciplinary clinical audit programmes
- Investigating incidents including making patient radiation dose assessments
- Advising on the radiation protection of carers and comforters in association with the RPA
- Participating in inspections by statutory authorities
- Contributing to the development, implementation and quality assurance of employer's procedures, SOPs and exposure protocols
- Providing training
- Participating in multi-disciplinary clinical audit and review
- Liaising with the RPA as regards the design and construction of clinical and related radiation facilities
- Liaising with the RPA and agreeing on the demarcation of duties associated with radiation safety and compliance with legislation
- Communicating with practitioners, operators, managers and other employees as appropriate

In nuclear medicine

- Being available for diagnostic investigations and standard radionuclide therapies
- Being present and closely involved with all therapeutic administrations of radiopharmaceuticals that are non-standard or being undertaken for the first time
- Supporting applications for ARSAC licences by the UHB and by doctors and dentists
- Providing advice as regards radiation risk to infants in the case of female patients who are breast feeding
- Working closely with practitioners and others as regards the development and implementation of protocols for the diagnostic and therapeutic administration of radiopharmaceuticals
- Providing radiation protection advice to patients leaving hospital after radiopharmaceutical administration and to those who care for or come into contact with such patients, in liaison with the RPA
- Measuring radioactivity and providing calibrated systems for radioactivity measurement
- Liaising with the RWA and DGSA as regards the storage and transportation of radioactive substances and the accumulation and disposal of radioactive waste

The duties of the Radiation Protection Adviser (RPA) include:

- Liaising with MPEs and agreeing on the demarcation of duties associated with radiation safety and compliance with legislation

- Liaising with MPEs as regards the design and construction of clinical and related radiation facilities

In nuclear medicine:

- Providing radiation protection advice to patients leaving hospital after radiopharmaceutical administration and to those who care for or come into contact with such patients, in liaison with MPEs

The duties of the Referrer include:

- Providing the practitioner with accurate and legible information to permit unambiguous identification of the patient and a decision on justification (i.e. whether a net benefit is associated with the exposure)
- Ensuring that referrals or medical exposure are made within his/her scope of practice, in accordance with referral guidelines and after discussion with the practitioner where appropriate
- Ensuring that in the case of referrals made for clinical purposes, the required information has not already been provided by previous diagnostic investigations
- Assessing and acting upon reports and clinical evaluations in an appropriate and timely manner
- Identifying exposures that are requested for research purposes
- Ensuring that in the case of referrals made for research purposes, the research protocol has received ethics approval and that outcomes are included in the data analysis

The duties of the Practitioner include:

- Justifying individual exposures taking account of information supplied by the referrer, the specific objectives of the exposure, the characteristics of the patient, the benefit of the exposure vs. the nature and risk of potential detriment and the usefulness of alternative techniques
- Paying special attention to the justification of exposures on children and females in whom pregnancy cannot be excluded, with due regard to the urgency of the exposure and the possible irradiation of an unborn child
- Paying special attention to the justification of exposures to carers and comforters and those who derive no direct health benefit from the exposure
- Authorising individual exposures (by physical or electronic signature) and delegating authorisation to operators under written Delegated Authorisation Guidelines (DAGs) as appropriate
- Liaising with referrers regarding referrals that may not be justified i.e. ones for which there is insufficient net benefit
- Returning referrals when there is insufficient or incorrect information to unambiguously identify the patient
- Ensuring that radiation doses for research exposures are consistent with dose constraints (where there is no health benefit to the individual)

or target doses (where there is such a benefit) as specified in the research protocol
- Co-operating with operators, MPEs and others as regards practical aspects of exposures to keep radiation doses ALARP, consistent with the intended purpose
- Discussing incidents of accidental, unnecessary or unintended exposure with patients
- Engaging in continuous professional development and keeping a personal record of such activity

In nuclear medicine:
- Obtaining an ARSAC licence for clinical and research administrations of radiopharmaceuticals
- Paying special attention to the justification of an exposure to a female who is breast feeding, taking account of possible radiation dose to the infant
- Prescribing administered activities and routes of administration for diagnostic and research investigations that are in accord with ARSAC recommendations
- Making an individual assessment of each patient referred for radionuclide therapy and prescribing an administered activity and route of administration that takes account of professional guidance

The duties of the Operator include:
- Selecting equipment and methods to keep doses ALARP, consistent with the intended diagnostic, therapeutic or other purpose
- Paying special attention to quality assurance, assessment of radiation dose and adherence to DRLs
- Paying special attention to the restriction of radiation dose and the optimisation of exposures for children and females in whom pregnancy cannot be excluded
- Paying special attention to the optimisation of exposures made for health screening purposes and those that impart a relatively high radiation dose
- Co-operating with practitioners, MPEs and others as regards practical aspects of exposures
- Authorising individual exposures (by physical or electronic signature) under written Delegated Authorisation Guidelines (DAGs) from the practitioner
- Making and recording a clinical evaluation of each exposure including diagnostic findings and therapeutic implications as appropriate within the scope of practice
- Engaging in continuous professional development and keeping a personal record of such activity

In nuclear medicine
- Taking care to administer an appropriate activity through the correct route of administration

- Paying special attention to the optimisation of an exposure to a female who is breast feeding, taking account of possible radiation dose to the infant

The duties of the Head of Ionising radiation (Medical Physics) include:

- Recommending suitably qualified and experienced members of staff and other persons to the Executive Director of Therapies and Health Sciences for appointment as MPEs to the UHB
- Delegating duties to members of staff as appropriate

In nuclear medicine:

- Supporting applications for ARSAC licences by the UHB and by doctors and dentists

The duties individual members of staff include:

- Following SOPs and protocols for medical exposure
- Reporting suspected incidents of accidental, unnecessary or unintended patient exposure to the Clinical Director through the line management structure

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24. Environment Agencies Guidance on Suitability of Radioactive Waste Advisers. Environment Agencies 2011.

25. The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009. Statutory Instrument 2009 No. 1348.

26. Accord Européen relatif au Transport International des Marchandises Dangereuses par Route (ADR) (European Agreement Concerning the International Carriage of Dangerous Goods by Road). United Nations Economic Commission for Europe (UNECE) 2017.

27. iRefer - Making the Best use of Clinical Radiology. Royal College of Radiologists 2016 (version 7.0.2).

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Appendix 1

Role profile for Medical Physics Expert (MPE)

Qualifications:

- MSc in Medical Physics
- Registered Clinical Scientist (HCPC)
- Recognised MPE (RPA 2000)

Competences:

- Measurement of radiation dose and dose rates
- Calculation of radiation dose to individual patients or groups (e.g. research study participants)
- Calculation of radiation dose to embryo and foetus
- Use, quality assurance and calibration of equipment and devices for radiation dose measurement

In nuclear medicine

- Measurement of radioactivity
- Use, quality assurance and calibration of equipment and devices for radioactivity measurement

Duties:

- Being involved as appropriate in clinical exposures with external radiation beams
- Working closely with practitioners as regards the justification of medical exposures
- Working closely with operators, maintenance engineers and others as regards the optimisation and practical aspects of medical exposures
- Measuring radiation dose and providing calibrated systems for radiation dose measurement
- Estimating radiation dose and assessing radiation risk to patients and, where appropriate, embryo or foetus, in cases of both intended and unintended exposure
- Providing advice to patients as regards radiation risk including female patients who are or may be pregnant
- Providing advice and assessing the radiation dose implications of introducing new equipment and techniques
- Setting and reviewing diagnostic reference levels (DRLs) for clinical exposures and dose constraints and target doses for research exposures
- Monitoring and reviewing patient radiation doses and developing dose reduction strategies
- Evaluating image quality in relation to patient dose
- Providing a quality assurance programme for equipment and liaising with other operators as regards routine equipment quality control
- Reviewing and communicating the outcome of equipment quality assurance
- Advising on equipment management including the specification, selection and purchase of clinical and related radiation equipment and the maintenance of an equipment inventory
- Advising on the application and quality assurance of clinical software
- Performing acceptance testing and participating in commissioning new equipment including communicating with equipment supplier applications specialists
- Advising on the suspension of the use of existing equipment
- Reviewing equipment replacement policies and processes
- Developing and performing suitable audits for medical exposures and participating in multi-disciplinary clinical audit programmes
- Investigating incidents including making patient radiation dose assessments
- Advising on the radiation protection of carers and comforters in association with the RPA
- Participating in inspections by statutory authorities
- Contributing to the development, implementation and quality assurance of employer’s procedures, SOPs and exposure protocols
- Providing training
- Participating in multi-disciplinary clinical audit and review

- Liaising with the RPA as regards the design and construction of clinical and related radiation facilities
- Liaising with the RPA and agreeing on the demarcation of duties associated with radiation safety and compliance with legislation
- Communicating with practitioners, operators, managers and other employees as appropriate

In nuclear medicine

- Being available for diagnostic investigations and standard radionuclide therapies
- Being present and closely involved with all therapeutic administrations of radiopharmaceuticals that are non-standard or being undertaken for the first time
- Providing advice as regards radiation risk to infants in the case of female patients who are breast feeding
- Working closely with practitioners and others as regards the development and implementation of protocols for the diagnostic and therapeutic administration of radiopharmaceuticals
- Providing radiation protection advice to patients leaving hospital after radiopharmaceutical administration and to those who care for or come into contact with such patients, in liaison with the RPA
- Measuring radioactivity and providing calibrated systems for radioactivity measurement
- Liaising with the RWA and DGSA as regards the storage and transportation of radioactive substances and the accumulation and disposal of radioactive waste

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

Exposure of Staff and Members of the Public to Ionising Radiation Procedure

Introduction and Aim

The Cardiff and Vale University Health Board (UHB) uses ionising radiation for a variety of clinical and other applications and this use presents a potential hazard to a range of people including patients, staff and members of the public.

The UHB has an Ionising Radiation Risk Management Policy whose aim is to ensure that we manage the use of ionising radiation in such a way as to minimise adverse effects on people, provided that this is consistent with any desired clinical or related outcome.

This Procedure supports the Policy and translates its aim into practical implementation measures as regards the potential adverse effects of ionising radiation on staff and members of the public.

Objectives

We will achieve our aim by:

- Providing a robust framework for the management and safe use of ionising radiation
- Ensuring that managers and staff are aware of their roles in the safe use of ionising radiation
- Keeping radiation doses and dose rates as low as reasonably practicable (ALARP)
- Restricting the use of ionising radiation to practices that are justified and ensure that each intentional exposure of a human subject is individually justified
- Optimising exposure to ionising radiation in order to reduce radiation dose, provided that this is consistent with any desired clinical or related outcome
- Keeping radiation doses to staff and members of the public within statutory dose limits
- Managing radiation equipment in accordance with accepted best practice
- Ensuring that the use of ionising radiation is compliant with current legislation, standards and guidance
- Demonstrating compliance through record keeping and audit
- Entitling duty holders associated with the exposure of human subjects to ionising radiation
- Appointing Radiation Protection Adviser(s), Radioactive Waste Adviser(s), Medical Physics Expert(s) and Radiation Protection Supervisors

Scope This procedure applies to all of our staff in all locations including those with honorary contracts.	
Equality Impact Assessment	*An Equality Impact Assessment has/has not been completed. (please delete as necessary) Where it has not been completed indicate why e.g. 'This is because a procedure has been written to support the implementation the …….. Policy. The Equality Impact Assessment completed for the policy found here to be a negative/positive/no impact.*
Health Impact Assessment	*A Health Impact Assessment (HIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this policy/supporting procedure.* *Note: if a HIA has not been completed indicate why*
Documents to read alongside this Procedure	• Ionising Radiation Risk Management Policy • Exposure of Patients to Ionising Radiation Procedure • Radioactive Substances Risk Management Policy • Radioactive Substances Risk Management Procedure • Health and Safety Policy • Medical Equipment Management Policy • Risk Management Policy
Approved by	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	Consultant Clinical Scientist (Medical Physics) – Head of Ionising Radiation

Disclaimer

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

Summary of reviews/amendments

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

Contents

Appendices

1 Definition of terms

Absorbed dose
The fundamental type of radiation dose defined as the energy deposited by ionising radiation in unit mass of irradiated material.

Alpha rays (alpha radiation)
Particulate ionising radiation in the form of helium-4 nuclei (a combination of two protons and two neutrons) emitted by nuclei during radioactive decay.

Beta rays (beta radiation)
Particulate ionising radiation in the form of electrons or positrons emitted by nuclei during radioactive decay.

Deterministic effect
An effect of ionising radiation on living tissue in which the severity of the effect increases with radiation dose above a threshold dose (below which the effect does not occur).

Diagnostic Reference Level (DRL)
Value of radiation dose, or administered activity in nuclear medicine, for typical diagnostic examinations in groups of standard-sized patients for broadly defined types of radiation equipment.

Dose constraint
A restriction on the prospective radiation dose to an individual that may result from a defined source of exposure.

Effective dose
The sum of the product of equivalent dose and tissue weighting factor taken over all irradiated tissues and organs.

Electron
A negatively charged particle that is one of the constituents of the atom.

Equivalent dose
The product of absorbed dose and radiation weighting factor for a particular irradiated tissue or organ.

Gamma rays (gamma radiation)
Ionising radiation in the form of photons emitted by nuclei during radioactive decay.

Gy
The gray, which is the unit of absorbed dose (equal to 1 joule of energy per kg).

Ionising radiation
Radiation that is sufficiently energetic to cause ionisation through the release of inner electrons in atoms of high atomic number.

Neutron
An uncharged particle that is one of the constituents of the atomic nucleus.

Particle
A unit of radiation that has mass e.g. electron, beta particle, proton, alpha particle and neutron.

Photon
A unit (quantum) of electromagnetic radiation such as infra-red, visible, ultra-violet, x and gamma radiation.

Proton
A positively charged particle that is one of the constituents of the atomic nucleus.

Radiation
A stream of energy, usually in the form of photons or particles, emitted from a source, moving through a material and interacting with it to deposit energy in the material.

Radiation dose
A measure of the energy deposited by ionising radiation in a material and its potential harmful effects.

Radiation employer
An employer who in the course of a trade, business or other undertaking carries out, or intends to carry out, work with ionising radiation.

Radiation weighting factor
A quantity that indicates the relative harmfulness of different types of ionising radiation to living tissue.

Radioactive decay or disintegration
The transformation of one nuclide (a radionuclide) into another with the emission of ionising radiation.

Radioactive substance (material)
Substance (material) that contains one or more radionuclides.

Radioactive waste
Any material that is either radioactive in its own right or is contaminated by radioactive substances and for which no further use is envisaged.

Radioactivity
The phenomenon associated with radioactive decay or disintegration.

Radiopharmaceutical
A radioactive medicinal product that is administered to human subjects for medical diagnosis or treatment or a related purpose such as medical research.

Radiosensitivity
The sensitivity or susceptibility of different tissues and organs to the harmful effects of radiation.

Stochastic effect
An effect of ionising radiation on living tissue in which the probability of the effect occurring increases linearly with radiation dose without a threshold.

Sv
The sievert, which is the unit of equivalent dose and effective dose.

Tissue weighting factor
A quantity that indicates the relative sensitivity or susceptibility of different tissues and organs to the harmful effects of ionising radiation.

Tissue reaction
This is the same as a deterministic effect.

X-rays (x-radiation)
Ionising radiation in the form of photons emitted by electron interactions in atoms, possibly as a consequence of radioactive decay.

X-ray tube
An evacuated chamber in which electrons are accelerated towards a target to produce x-rays.

2 Use and harmful effects of ionising radiation

Ionising radiation takes the form of either high energy photons (such as x-rays and gamma rays) or high energy particles (such as alpha rays, beta rays, electrons, protons and neutrons). It is produced by electrical radiation generators (such as x-ray tubes) and by radioactive substances. Ionising

radiation has a wide range of beneficial applications but it also has the potential to cause harm.

The UHB uses ionising radiation at Barry Hospital, Cardiff Royal Infirmary, Rookwood Hospital, St David's Hospital, University Hospital Llandough (UHL), the University Hospital of Wales (UHW) (including the Children's Hospital and the Dental Hospital) and at community medical and dental sites in the following practices:

- Manufacture of radioactive products (including radiopharmaceuticals and radioactive sources)
- Application of radioactive tracers (for medical and biological techniques)
- Medical diagnosis
- Medical treatment
- Occupational health screening
- Health screening
- Medical and biomedical research and development
- Medico-legal procedures
- Non-medical imaging using medical radiological equipment
- Teaching and training
- Ionising radiation metrology
- Transport of radioactive material

All these practices are justified [1-3] i.e. they produce sufficient benefit to individuals exposed to ionising radiation or to society in general to offset the detriment that they cause. Justification is one of the basic tenets of radiation protection, the others being optimisation and dose limitation [4].

The majority of the above practices are associated with radiology (diagnostic and interventional) and nuclear medicine (diagnostic and therapeutic). In radiology, human subjects are exposed to x-rays from an external source (x-ray tube). Radiology is practised widely throughout the UHB. Nuclear medicine, on the other hand, involves the administration of radioactive substances (in the form of radioactive medicinal products or radiopharmaceuticals) to humans such that the subjects are irradiated internally by beta and gamma rays. Nuclear medicine is practised only at UHW and UHL.

The potential of ionising radiation to cause harm is usually expressed in terms of radiation dose, which is a measure of the energy deposited by radiation and its impact on living tissue [4]. The basic quantity is absorbed dose, which is an expression of the energy deposited by ionising radiation per unit mass of the material which it irradiates; its unit is the gray (Gy). Absorbed dose is used to quantify the energy deposited by ionising radiation in tissues and organs.

The same absorbed dose delivered to living tissue by different types of ionising radiation causes biological damage to different extent. This variation is expressed by the radiation weighting factor, which is unity (one) for x, beta and gamma radiation (since they are equally harmful) and greater for alpha radiation and neutrons (because they are relatively more harmful for the same absorbed dose). The equivalent dose is given by the absorbed dose multiplied by the radiation weighting factor. It is indicator of harm to a particular tissue or organ due to ionising radiation irrespective of the type (and energy) of the radiation; its unit is the sievert (Sv).

In addition, some living tissues and organs are more sensitive or susceptible to the harmful effects of ionising radiation. This variation is expressed by the tissue weighting factor, which is relatively larger for those tissues and organs which are most radiosensitive (i.e. most susceptible to the harmful effects of radiation). The effective dose is the sum of the equivalent dose multiplied by the tissue weighting factor for all irradiated tissues and organs. It is an indicator of harm to the whole body from either total or partial exposure to radiation regardless of the number of tissues and organs exposed; it is also expressed in Sv.

There are two broad types of harmful effect of ionising radiation: deterministic effects (also called tissue reactions) and stochastic effects [4]. Deterministic effects occur in the irradiated individual and are characterised by a threshold absorbed dose (below which the effect does not occur) and the fact that the severity of the effect increases with absorbed dose (above the threshold). An example would be erythema (reddening) of the skin with a threshold of 2-5 Gy and progression to blistering and ulceration as absorbed dose increases.

For stochastic effects, the probability of the effect occurring increases in proportion to effective dose; there is no threshold. Stochastic effects may occur in irradiated individuals and in future generations. The most important stochastic effect is the induction of cancer in an irradiated individual. For a general population, the risk of fatal cancer is about 5% per Sv, although the risk varies with age and is greater for children than for adults [4].

Irradiation of the embryo and foetus may cause both deterministic and stochastic effects [4].

An inevitable consequence of the clinical use of ionising radiation is the exposure of members of staff as well as those receiving treatment or diagnostic investigations. Members of staff are also exposed as a result of non-clinical work with ionising radiation. To some extent, the use of ionising radiation also leads to the exposure of members of the public. In this context, members of the public include all those who are not subject to medical exposure or are not regarded as staff (e.g. visitors). The radiation doses

received by individual members of staff are much lower than those received by those receiving clinical investigation or treatment; the doses received by individual members of the public are lower still.

3 Regulation of ionising radiation

The use of ionising radiation is governed by legislation that is designed to control its adverse effects on people and the environment. This involves keeping radiation doses as low as reasonably practicable (ALARP). The legislation is supported by codes of practice and guidance and compliance is assessed through a programme of inspections by statutory external agencies.

The exposure of patients to ionising radiation is governed by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 and a subsequent amendment to the regulations [5,6]. These are made under the European Communities Act 1972 [7] but are enforced as if made under the Health and Safety at Work Act 1974 [8]. The regulations are supported by official and professional body guidance [9,10]. They apply to the deliberate exposure of human subjects to ionising radiation as follows:

- To patients as part of their medical diagnosis or treatment
- To individuals as part of health screening programmes
- To patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes
- To carers and comforters
- To asymptomatic individuals
- To individuals undergoing non-medical imaging using medical radiological equipment

For the purposes of this Procedure, those subject to exposures in these categories are collectively called ‘patients’. Practices that involve the deliberate exposure of humans under circumstances other than the above do not fall within the scope of IR(ME)R 2017. Such practices are permitted only if their justification is confirmed by the most recent version of the national Justification Register [1-3,11].

The regulations are enforced by Healthcare Inspectorate Wales (HIW), which reports on its activities [12]. In England, similar reports are published by the Care Quality Commission (previously Healthcare Commission) [13-14].

In nuclear medicine, radiopharmaceuticals may be administered to humans only by a person who holds a licence from Health Ministers or someone acting under the authority of such a person. In addition, a separate licence is required by the employer at each site where such administrations take place [15]. Radiopharmaceuticals are prepared in a specialised radiopharmacy at

UHW under a regime [9,16-18] that is regulated by the Medicines and Healthcare products Regulatory Agency (MHRA).

The Ionising Radiations Regulations (IRR) 2017 [19] address all aspects of work with ionising radiation. They are made under the Health and Safety at Work Act 1974 [8] and are supported by an Approved Code of Practice (ACOP) and official guidance [20] as well as professional body guidance [9]. IRR 2017 deal with the radiation protection of workers and the members of the public who are exposed as a result of work with ionising radiation. The regulations specify the responsibilities of a radiation employer; these include making risk assessments, appointing a Radiation Protection Adviser (RPA) and one or more Radiation Protection Supervisors (RPSs) and writing Local Rules. IRR 2017 are enforced by the Health and Safety Executive (HSE).

Radioactive material is kept on UHB premises in accord with the stipulations of the Environmental Permitting Regulations (EPR) 2016 [21-22] and under conditions that are specified in Environmental Permits issued by Natural Resources Wales (NRW). The same applies to the accumulation and disposal of radioactive waste. The permits are site-specific for UHW and UHL. In addition, there is a requirement [23-24] to appoint a suitable Radioactive Waste Adviser (RWA). Radioactive materials are transported in a manner [9,25-26] that is consistent with the requirements of the Office for Nuclear Regulation, which includes the appointment of a Dangerous Goods Safety Adviser (DGSA). Regulations governing the keeping and transportation of radioactive substances and the management of radioactive waste do not have a direct impact on the radiation safety of patients.

4 General arrangements for the protection of staff and members of the public against the harmful effects of ionising radiation

For staff and the public, the goals of radiation protection are to restrict exposure as much as possible, i.e. to keep radiation doses ALARP, and to ensure that dose limits are not exceeded. The mechanisms for achieving these goals are the justification of practices and the optimisation of processes, although additional limitation measures may be necessary under some circumstances. As regards the effects of ionising radiation, this means minimising the risk of stochastic effects and avoiding deterministic effects. IRR [19] provide a regulatory framework within which the UHB works to achieve these goals.

The exposure of patients to ionising radiation is mainly carried out in four areas within the UHB: Cardiothoracic (part of the Specialised Services Clinical Board); Radiology and Medical Physics (both part of the Clinical Diagnostics and Therapeutics Clinical Board) and the University Dental Hospital (part of the Dental Clinical Board). It follows that it is members of staff working in

these areas that are most likely to be exposed to ionising radiation and it is on premises occupied by these areas that the public is most likely to be exposed.

The Employer as defined in the regulations is the UHB and the Chief Executive takes overall responsibility for compliance with legislation on behalf of the UHB. The Chief Executive has delegated the task of ensuring compliance with radiation safety legislation to the Executive Director of Therapies and Health Science (DoTH). The DoTH has further delegated this task to individuals throughout the UHB's line management structure. This includes the identification and appointment of Radiation Protection Adviser(s) (Appendix 1) and Radiation Protection Supervisors (Appendix 2).

The UHB has established a Radiation Protection Group (RPG) that reports to the Quality, Safety and Patient Experience Committee and onwards to the Executive Board. The RPG discusses all aspects of radiation safety including the exposure of members of staff and members of the public [9] (Appendix 3).

5 Specific arrangements for the limitation of radiation dose to staff and the public

The UHB should put in place a range of procedures to limit radiation dose to members of staff and the public that arise as a result of its work with ionising radiation. Those procedures that apply throughout the UHB, especially at corporate level, are addressed in this document. More detailed procedures are tailored to the work of individual services. The content of these procedures may vary considerably from one service to another, reflecting the diversity of the UHB's clinical, research and other work.

Before undertaking any work with ionising radiation, the UHB should notify the HSE, register that work with the HSE or obtain the HSE's consent for that work as appropriate. In addition, it should carry out a suitable and sufficient radiation risk assessment in order to identify the measures need to restrict exposure to staff and the public.

While performing work with ionising radiation, the UHB should implement a range of measures to restrict exposure. These include:

- Writing standard operating procedures including Systems of Work for all aspects work with ionising radiation
- Identifying and designating controlled and supervised radiation areas
- Writing Local Rules for designated radiation areas
- Providing personal protective equipment
- Providing training for radiation workers and RPSs
- Making suitable arrangements for members of staff who are pregnant or breast-feeding

- Making suitable arrangements for outside workers

In general, Local Rules should be provided for all areas where ionising radiation is used. They should be regularly reviewed and available in the locations to which they refer. Controlled areas should be identified in the Local Rules and staff and visitors should only enter in accordance with Systems of Work. Outside workers are members of staff of other employers who carry out work in a UHB controlled area; they should be subject to special procedures as outlined in Local Rules.

In addition, the UHB should put in place a programme of personal and area radiation dose monitoring. Members of staff who regularly work with ionising radiation and who have to enter controlled areas should be monitored; the type and frequency of monitoring should be determined by means of a risk assessment. Members of staff who are regularly monitored must wear their dosimiters whenever they enter a controlled area. The dosimeter must be worn in the approved manner. Employees must return any dosimiters supplied to them in a timely manner at the end of each monitoring period.

Doses should be kept under regular review and investigation levels set to minimise the risk of exceeding a dose limit; the investigation levels should be stated in the Local Rules. Dose records must be kept for a minimum of two years. Annual summaries of radiation doses received by staff should be prepared, reviewed by the RPA and reported to the RPG.

Particular attention should be paid to those members of staff who receive relatively high doses and the possibility that they might need to be designated as classified persons. Special procedures, including annual medical investigations, should apply to such persons.

Incidents involving ionising radiation should be promptly and thoroughly investigated and, where appropriate, reported to external agencies; these include incidents involving radiation doses much greater than intended [27].

6 Duties

To ensure the implementation of its Ionising Radiation Risk Management Policy as regards the exposure of members of staff and the public, the UHB assigns the duties described here.

The duties of the Executive Director of Therapies and Health Science include:

- Ensuring that the UHB provides suitable management arrangements, including sufficient resources and competent persons, to comply with legislation and guidance governing the safe use of ionising radiation

- Providing assurance to the UHB Board that the use of ionising radiation is managed in compliance with the UHB's policies and procedures
- Informing the UHB Board about issues related to the use of ionising radiation
- Establishing a UHB Radiation Protection Group
- Appointing suitably qualified and experienced RPA(s) in writing
- Delegating duties to other managers as appropriate

The duties of Clinical Board Directors include:

- Providing assurance to the Executive Director of Therapies and Health Science that the use of ionising radiation is managed in compliance with policies and procedures and regulatory requirements
- Ensuring that Directorate Clinical Directors have arrangements in place for the appointment of RPSs and the writing and implementation of Local Rules and Systems of Work
- Communicating and liaising with the Chair of the Radiation Protection Group, RPAs, Clinical Directors and other managers about issues related to the use of ionising radiation
- Disseminating information about reported incidents within the UHB as appropriate
- Delegating duties to other managers as appropriate

The duties of Directorate Clinical Directors include:

- Ensuring that members of staff are aware of their roles and duties as regards radiation safety
- Appointing RPSs in writing and maintaining a list of such appointments
- Ensuring that RPSs and members of staff are adequately trained, receive update training as appropriate and participate in continuous professional development
- Maintaining training records and making such records available for inspection
- Providing SOPs, Systems of Work and Local Rules and ensuring that they are regularly reviewed and updated
- Ensuring that radiation risk assessments are undertaken in association with RPA and that such assessments are reviewed regularly
- Ensuring that radiation equipment is selected, installed, critically examined, commissioned, maintained and replaced in accordance with regulations and guidance
- Ensuring that a risk assessment is made of the working conditions of a members of staff who declares that she is pregnant and that any required changes to working conditions are implemented
- Investigating suspected radiation incidents in association with the RPA and reporting confirmed incidents to the Clinical Board Director and the Head of the Health, Safety and Environment Unit
- Keeping records of incidents for the appropriate time

- Delegating duties to duty holders and other managers as appropriate

In nuclear medicine:

- Ensuring that a risk assessment is made of the working conditions of a members of staff who declares that she is breast feeding and that any required changes to working conditions are implemented

The duties of the Chair of the UHB Radiation Protection Group include:

- Formulating and reviewing relevant UHB policies and procedures related to ionising radiation
- Providing advice on the implementation of relevant UHB policies and procedures
- Auditing compliance with relevant UHB policies and procedures
- Reviewing relevant UHB policies and procedures at least every three years and ensuring that they are amended and updated as necessary
- Reviewing reports from RPAs and taking action as necessary
- Liaising with members of the Radiation Protection Group and others as necessary

The duties of the Head of the Health, Safety and Environment Unit include:

- Acting as the UHB's primary contact with HSE as the regulator for compliance with IRR 2017
- Reporting incidents of regulatory non-compliance to HSE
- Ensuring that the Executive Director of Therapies and Health Science, the Chair of the UHB Radiation Protection Group and the relevant Clinical Director and Clinical Board Head of Operations and Delivery are aware of all reports made to external regulatory bodies
- Delegating duties to other managers as appropriate

The duties of the Radiation Protection Adviser (RPA) include:

- Implementing requirements as to controlled and supervised areas
- Examining plans for installations and the acceptance into service of new or modified sources of ionising radiation in relation to engineering controls, design features, safety features and warning devices provided to restrict exposure
- Regularly calibrating equipment provided for monitoring ionising radiation dose and dose rate and checking that such equipment is serviceable and correctly used
- Periodically examining and testing engineering controls, design features, safety features and warning devices and checking Systems of Work including any written arrangements provided to restrict exposure to ionising radiation
- Performing critical examinations of newly installed or repaired equipment or articles for work with ionising radiation
- Estimating radiation dose to members of staff and members of the public

- Participating in inspections by statutory authorities
- Providing radiation protection training
- Liaising with the MPE and agreeing on the demarcation of duties associated with radiation safety and compliance with legislation
- Liaising with MPEs as regards the design and construction of clinical and related radiation facilities
- Advising on radiation risk assessments and contingency plans
- Advising on the form and content of Local Rules for each designated controlled and supervised area
- Advising on the conduct of incident investigations and the content of subsequent reports
- Advising on dose assessment and recording, including personal and area monitoring
- Advising on the selection and use of appropriate personal protective equipment
- Advising on quality assurance programmes for radiation equipment
- Advising on arrangements for outside workers
- Advising on the designation of classified workers
- Advising on information and instructions for pregnant members of staff
- Advising on training for dealing with emergencies
- Advising on the radiation protection of comforters and carers in association with the MPE

In nuclear medicine:

- Liaising with the RWA and DGSA as regards the storage and transportation of radioactive substances and the accumulation and disposal of radioactive waste
- Advising on radiation protection advice to patients leaving hospital after radiopharmaceutical administration and to those who care for or come into contact with such patients, in liaison with MPEs
- Advising on the design of radiopharmacies and radionuclide laboratories and associated protocols
- Advising on information and instructions for breast-feeding members of staff

The duties of the Radiation Protection Supervisor (RPS) include:

- Exercising close supervision of work with ionising radiation to ensure that it is done in accordance with Local Rules and Systems of Work and in compliance with IRR 2017. To maintain an audit trail to demonstrate staff members' compliance.
- Ensuring that the radiation dose received by members of staff and other persons are appropriately monitored
- Notifying managers of any proposed changes in or additions to work with ionising radiation
- Notifying managers of any change of equipment usage or conditions, which might affect radiological safety

- Notifying managers of any monitoring instrument used to demonstrate compliance with regulations that has not been calibrated to accepted standards
- Notifying managers of any incident involving or suspected incident resulting in exposure much greater than intended
- Helping to ensure that controls for the restriction of exposure are used in accordance with Local Rules and Systems of Work
- Observing, from time to time, all procedures involving ionising radiation and issuing instructions necessary to maintain radiation doses ALARP
- Attending courses and receiving training as recommended by the RPA
- Promulgating Local Rules and Systems of Work to ensure that necessary safety information and guidance is given to staff, outside workers and any other persons who enter controlled or supervised radiation areas
- Performing additional tasks as agreed with managers

In nuclear medicine

- Notifying managers of any damage to a radioactive source or any spillage, loss or suspected loss of a radioactive substance

The duties of the Head of Ionising Radiation (Medical Physics) include:

- Recommending suitably qualified and experienced members of staff and other persons to the Executive Director of Therapies and Health Sciences for appointment as RPAs to the UHB
- Delegating duties to members of staff as appropriate

The duties of individual members of staff include:

- Following SOPs and Systems of Work and complying with Local Rules
- Wearing provided personal dosimeters at all times during occupational exposure to ionising radiation
- Making full and proper use of any personal protective equipment that has been provided
- Reporting any defects or suspected faults in radiation and protective equipment to the RPS and the Clinical Director through the line management structure
- Reporting suspected radiation incidents to the RPS and the Clinical Director through the line management structure
- Informing the RPS and line manager through the line management structure as soon as they know or suspect that they are pregnant

In nuclear medicine:

- Informing the RPS and the Clinical Director through the line management structure as soon as they start to breast feed

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26. Accord Européen relatif au Transport International des Marchandises Dangereuses par Route (ADR) (European Agreement Concerning the International Carriage of Dangerous Goods by Road). United Nations Economic Commission for Europe (UNECE) 2017.

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Appendix 1

Role profile for Radiation Protection Adviser (RPA)

Qualifications:

- MSc in Medical Physics or Radiation Sciences
- Registered Clinical Scientist (HCPC)
- RPA certification (RPA 2000)

Competences:

- Measurement of radiation dose and dose rates
- Calculation of radiation dose to individuals or groups
- Calculation of radiation dose to embryo and foetus
- Use, quality assurance and calibration of equipment and devices for radiation dose measurement

In nuclear medicine

- Measurement of radioactivity
- Use, quality assurance and calibration of equipment and devices for radioactivity measurement

Practical Duties:

- Implementing requirements as to controlled and supervised areas
- Examining plans for installations and the acceptance into service of new or modified sources of ionising radiation in relation to engineering controls, design features, safety features and warning devices provided to restrict exposure
- Regularly calibrating equipment provided for monitoring ionising radiation dose and dose rate and checking that such equipment is serviceable and correctly used
- Periodically examining and testing engineering controls, design features, safety features and warning devices and checking Systems of Work including any written arrangements provided to restrict exposure to ionising radiation
- Performing critical examinations of newly installed or repaired equipment or articles for work with ionising radiation
- Estimating radiation dose to members of staff and members of the public
- Participating in inspections by statutory authorities
- Providing radiation protection training
- Liaising with the MPE and agreeing on the demarcation of duties associated with radiation safety and compliance with legislation

In nuclear medicine

- Liaising with the RWA and DGSA as regards the storage and transportation of radioactive substances and the accumulation and disposal of radioactive waste

Advisory duties

- Radiation Risk assessments and contingency plans

- The form and content of Local Rules for each designated controlled and supervised area
- The conduct of incident investigations and the content of subsequent reports
- Dose assessment and recoding, including personal and area monitoring
- The selection and use of appropriate personal protective equipment
- Quality assurance programmes for radiation equipment
- Arrangements for outside workers
- Designation of classified workers
- Information and instructions for pregnant members of staff
- Training for emergencies
- Radiation protection of carers and comforters in association with the MPE

In nuclear medicine

- The design of radiopharmacies and radionuclide laboratories and associated protocols
- Radiation protection advice to patients leaving hospital after radiopharmaceutical administration and to those who care for or come into contact with such patients, in liaison with the MPE
- Information and instructions for breast-feeding members of staff

Appendix 2

Role profile for Radiation Protection Supervisor (RPS)

Competences:

- Knowledge and understanding of the requirements of Regulations and local rules relevant to the work with ionising radiation
- Identification of radiation hazards and assessment of radiation risks
- Assessment of working practices in relation to local rules and other instructions or guidance
- Communication of instructions and concerns
- Use of equipment and devices for radiation dose and dose rate measurement

In nuclear medicine

- Use of equipment and devices for the measurement of radioactive contamination

Duties:

- Exercising close supervision of work with ionising radiation to ensure that it is done in accordance with Local Rules and Systems of Work and in compliance with IRR 2017

- Ensuring that the radiation dose received by members of staff and other persons are appropriately monitored
- Notifying managers of any proposed changes in or additions to work with ionising radiation
- Notifying managers of any change of equipment usage or conditions, which might affect radiological safety
- Notifying managers of any monitoring instrument used to demonstrate compliance with regulations that has not been calibrated to accepted standards
- Notifying managers of any incident involving or suspected incident resulting in exposure much greater than intended
- Helping to ensure that controls for the restriction of exposure are used in accordance with Local Rules and Systems of Work
- Observing, from time to time, all procedures involving ionising radiation and issuing instructions necessary to maintain radiation doses ALARP
- Attending courses and receiving training as recommended by the RPA
- Promulgating Local Rules and Systems of Work to ensure that necessary safety information and guidance is given to staff, outside workers and any other persons who enter controlled or supervised radiation areas
- Performing additional tasks as agreed with managers

In nuclear medicine

- Notifying managers of any damage to a radioactive source or any spillage, loss or suspected loss of a radioactive substance

Appendix 3

Terms of Reference and Membership of the Radiation Protection Group

Aim:

- To provide the Cardiff and Vale University Local Health Board (UHB) with advice regarding all matters involving ionising and non-ionising radiation to enable UHB compliance with all relevant legislative requirements

Objectives:

- To review arrangements for the management of radiation protection within the UHB and to plan and implement effectively a corporate model based on best practice
- To ensure that there is a structured process for the review and implementation of new Regulations, Approved Codes of Practice and Guidance

- To ensure that policies and procedures related to radiation are reviewed and updated on a regular basis
- To identify and monitor all current activities and co-ordinate all developments related to the use of ionising and non-ionising radiation and the storage and disposal of radioactive substances in the UHB
- To review and monitor incidents and near misses and advise on the appropriate action required to be taken within a corporate framework
- To ensure that all aspects of personal risk from radiation exposure are monitored and addressed
- To ensure that the Group's activities integrate with the Divisional, Health and Safety, Risk Management and Patient Safety arrangements of the UHB
- To ensure close liaison with all relevant external agencies as appropriate
- To review, advise and assist with preparations for Health and Safety Executive, Healthcare Inspectorate Wales, Natural Resources Wales and Office for Nuclear Regulation inspections
- To ensure that effective two-way communication lines are established with senior management, departmental heads and staff within the UHB via designated channels
- To conform as appropriate with the Health and Care Standards in Wales

Reporting Arrangements:

- The RPG reports to the Executive Director of Therapies and Health Science

Frequency of Meetings:

- The Group shall meet on every three months

Membership:

- Chair
- Director of Operations, Clinical Diagnostics and Therapeutics Clinical Board
- Assistant Director of Therapies and Healthcare Sciences
- Radiation Protection Adviser(s)
- Radioactive Waste Advisor(s)
- Radiation Protection Adviser (Cardiff University)
- Laser Protection Adviser(s)
- Medical Physics Expert(s)
- Radiation Protection Supervisor(s) (Radiology, UHW & UHL)
- Representative from the Dental Services Clinical Board

- Representative from Patient Safety and Quality Team
- Representative from the Health, Safety and Environment Unit
- Staff Side Representative

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

Radioactive Substances Risk Management Policy

Policy Statement

To ensure the Cardiff and Vale University Health Board (UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will manage our use of radioactive substances and exposure to radon in a safe manner and in such a way as to minimise their impact on people and the environment.

Policy Commitment

The UHB will:

- Provide a robust framework and use best available techniques (BAT) to manage radioactive substances
- Ensure that radioactive substances management is safe and compliant with current legislation, standards and guidance in order to protect the UHB, patients, staff, members of the public and the environment
- Ensure that managers and staff are aware of their roles in the safe management of radioactive substances
- Keep radiation doses and dose rates as low as reasonably practicable (ALARP)
- Limit the amount of radioactive material kept on our premises by only procuring material for work that is justified
- Optimise radioactive substances management processes in order to reduce the amount of radioactive waste that we produce
- Where practicable and within terms of permit, reduce the amount of radioactive waste disposed to the environment by accumulating and storing it securely and allowing it to decay
- Dispose of radioactive waste in compliance with Environmental Permits issued by Natural Resources Wales and other statutory and regulatory requirements
- Ensure that arrangements for the transport of radioactive materials satisfy the requirements of the Office for Nuclear Regulation
- Monitor the concentration in air of naturally-occurring radioactive radon gas on its premises and take remedial action to limit exposure where necessary
- Demonstrate compliance through record keeping and audit
- Appoint Radioactive Waste Adviser(s), Dangerous Goods Safety Adviser(s), Radiation Protection Adviser(s) and Radiation Protection Supervisors

Supporting Procedures and Written Control Documents

This Policy is supported by two procedures:

- Radioactive Substances Risk Management Procedure
- Best Available Techniques for the Management of Radioactive Substances

They describe the following with regards to safe and effective management of radioactive substances:

- Duties associated with the management of radioactive substances
- Procurement and use of radioactive substances
- Transport of radioactive materials
- Management of radioactive waste including its generation, storage, disposal and recording
- Arrangements for monitoring and limiting exposure to airborne radon
- Demonstration of compliance with regulatory requirements and dealing with instances of non-compliance

Other supporting documents include:

- Ionising Radiation Risk Management Policy
- Exposure of Patients to Ionising Radiation Procedure
- Exposure of Staff and Members of the Public to Ionising Radiation Procedure
- Health and Safety Policy
- Waste Management Policy
- Waste Management Operational Procedures

Scope

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

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this policy/supporting procedure. *Note: if an EqIA has not been completed indicate why*

Health Impact Assessment	A Health Impact Assessment (HIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this policy/supporting procedure. *Note: if a HIA has not been completed indicate why*
Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*
2			
3			

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

Radioactive Substances Risk Management Procedure

Introduction and Aim

The Cardiff and Vale University Health Board (UHB) uses radioactive materials for a variety of clinical and other applications; this use results in the production of radioactive waste. The radiation emitted by radioactive substances (including radioactive waste) has the potential to present a hazard to people and to living organisms in the environment. In addition, individuals may be exposed to airborne naturally occurring radon gas on the UHB's premises.

The UHB has a Radioactive Substances Risk Management Policy whose aim is to ensure that we manage our use of radioactive substances and exposure to radon in a safe manner and in such a way as to minimise their impact on people and the environment.

This Procedure supports the Policy and translates its aim into practical implementation measures.

Objectives

The UHB will achieve its aim by:

- Providing a robust framework and using best available techniques (BAT) to manage radioactive substances
- Ensuring that radioactive substances management is safe and compliant with current legislation, standards and guidance in order to protect the UHB, patients, staff, members of the public and the environment
- Ensuring that managers and staff are aware of their roles in the safe management of radioactive substances
- Keeping radiation doses and dose rates as low as reasonably practicable (ALARP)
- Limiting the amount of radioactive substances kept on our premises by only procuring material for work that is justified
- Optimising radioactive substances management processes in order to reduce the amount of radioactive waste that is produced
- Where practicable and within terms of permit, reducing the amount of radioactive waste disposed to the environment by accumulating and storing it securely and allowing it to decay
- Disposing of radioactive waste in compliance with Environmental Permits issued by Natural Resources Wales and other statutory and regulatory requirements
- Ensuring that arrangements for the transport of radioactive materials satisfy the

requirements of the Office for Nuclear Regulation

- Monitoring the concentration in air of radioactive radon gas on its premises and taking remedial action to limit exposure where necessary
- Demonstrating compliance through record keeping and audit
- Appointing Radioactive Waste Adviser(s), Dangerous Goods Safety Adviser(s), Radiation Protection Adviser(s) and Radiation Protection Supervisors

Scope

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

Equality Impact Assessment	*An Equality Impact Assessment has/has not been completed. (please delete as necessary) Where it has not been completed indicate why e.g. 'This is because a procedure has been written to support the implementation the …….. Policy. The Equality Impact Assessment completed for the policy found here to be a negative/positive/no impact.*
Health Impact Assessment	*A Health Impact Assessment (HIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……../or incorporated within this policy/supporting procedure.* *Note: if a HIA has not been completed indicate why*
Documents to read alongside this Procedure	• Radioactive Substances Risk Management Policy • Best Available Techniques for the Management of Radioactive Substances • Ionising Radiation Risk Management Policy • Exposure of Patients to Ionising Radiation Procedure • Exposure of Staff and Members of the Public to Ionising Radiation Procedure • Health and Safety Policy • Waste Management Policy • Waste Management Operational Procedures
Approved by	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	

Disclaimer

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

Summary of reviews/amendments

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

Contents

Appendices

1 Definition of terms

Activity
The rate of decay or disintegration of a radionuclide (i.e. the number of nuclei decaying in unit time).

Alpha radiation
Particulate ionising radiation in the form of helium-4 nuclei (a combination of two protons and two neutrons) emitted by nuclei during radioactive decay.

Aqueous waste
Liquid radioactive waste in a continuous aqueous phase with any entrained solids, gases and non-aqueous liquids.

Atomic number
The number of protons in the nucleus of an atom of an element.

Becquerel (Bq)
The unit of activity (equal to one decay or disintegration per second).

Beta radiation
Particulate ionising radiation in the form of electrons or positrons emitted by nuclei during radioactive decay.

Flood-field source
A large area radioactive source that is used to test the uniformity of a gamma camera.

Gamma camera
A device that produces an image of the distribution of a radiopharmaceutical within an individual.

Gamma radiation
Ionising radiation in the form of photons emitted by nuclei during radioactive decay.

GBq
Giga becquerel (10^{12} Bq).

Half-life
The time taken for the activity of a radionuclide to decrease to half its original value.

Ionising radiation
Radiation that is sufficiently energetic to cause ionisation through the release of inner electrons in atoms of high atomic number.

kBq
Kilo becquerel (10^3 Bq).

Low Level Waste (LLW)
Solid radioactive waste, including any immediate packaging, with a maximum activity of 4 GBq per tonne (equivalent to 4 kBq per gram) of alpha emitting radionuclides and 12 GBq per tonne (equivalent to 12 kBq per gram) of all other radionuclides

MBq
Mega Becquerel (10^6 Bq).

Nuclide
A particular nuclear species in which all the atomic nuclei are identical (i.e. they contain the same number of protons and the same number of neutrons).

Open source
A radioactive source that is not in the form of a sealed source.

Organic liquid waste
Liquid radioactive waste, not being aqueous waste, containing one or more organic chemical compounds.

Photon
A unit (quantum) of electromagnetic radiation.

Radioactive decay or disintegration
The transformation of one nuclide (a radionuclide) into another with the emission of ionising radiation.

Radioactive source
An object that comprises or contains radioactive substances and is the origin of ionising radiation emitted by radionuclides.

Radioactive substance (material)
Substance (material) that contains one or more radionuclides.

Radioactive generator
A device that produces a short-lived radionuclide from a longer-lived parent radionuclide.

Radioactive waste
Any material that is either radioactive in its own right or is contaminated by radioactive substances and for which no further use is envisaged.

Radioactivity
The phenomenon associated with radioactive decay or disintegration.

Radionuclide
A radioactive nuclide.

Radon
A naturally occurring radioactive gas that is present in air.

Sealed source
A radioactive source whose structure is such as to prevent, under normal conditions of use, any dispersion of radioactive substances to the environment.

Very Low Level Waste (VLLW)
Solid radioactive waste in which each 0.1 m^3 total volume of waste contains a total activity less than 400 kBq and an activity of any single item less than 40 kBq.

X-radiation
Ionising radiation in the form of photons emitted by electron interactions in atoms, possibly as a consequence of radioactive decay.

2 Use and regulation of radioactive substances

Radioactive substances pose a hazard as a result of the ionising radiation that they emit. The UHB as an employer uses radioactive substances at the University Hospital of Wales (UHW) and at University Hospital Llandough (UHL).

The UHB uses or may use radioactive substances in the following practices:

- Manufacture of radioactive products (including radiopharmaceuticals and radioactive sources)
- Application of radioactive tracers (for medical and biological techniques)
- Medical diagnosis
- Medical treatment
- Occupational health screening
- Health screening
- Medical and biomedical research and development
- Medico-legal procedures
- Non-medical imaging using medical radiological equipment
- Teaching and training
- Ionising radiation metrology

- Transport of radioactive material

All these practices are justified [1-3] i.e. they produce sufficient benefit to individuals exposed to ionising radiation or to society in general to offset the detriment that they cause. Justification is one of the basic tenets of radiation protection [4].

The majority of the above practices are associated with nuclear medicine, which involves the administration of radioactive substances (in the form of radioactive medicinal products or radiopharmaceuticals) to humans, usually for medical diagnosis, medical treatment or medical or biomedical research. Nuclear medicine is practised at UHW and UHL.

Radiopharmaceuticals may be administered to humans only by a person who holds a licence from Health Ministers or someone acting under the authority of such a person; the premises on which the administration takes place must also be licensed [5-7]. The relevant regulations are enforced by the Medicines and Healthcare products Regulatory Agency (MHRA) [6-7].

Furthermore, exposures of humans to ionising radiation in nuclear medicine must be individually justified by an identified practitioner or an operator acting under written guidance from the practitioner [5-7]. This aspect is enforced by Healthcare Inspectorate Wales (HIW).

Radiopharmaceuticals are prepared in a specialised radiopharmacy at UHW under a regime [7-11] that is regulated by the MHRA. These products are transported to UHL (and other sites in south-east Wales) in a manner [7,12-13] that is consistent with the requirements of the Office for Nuclear Regulation (ONR), which includes the appointment of a Dangerous Goods Safety Adviser (DGSA).

Radioactive substances are used for biochemical radioimmunoassay (RIA) at UHW. They are also used at both UHW and UHL for the quality control and calibration of radiation equipment and for teaching and training in radiation sciences.

Radioactive sources are kept and used as sealed sources or open sources in accord with the stipulations of the Environmental Permitting Regulations (EPR) 2016 [14-15] and under conditions that are specified in separate Environmental Permits issued by Natural Resources Wales (NRW). These permits are also site-specific for UHW and UHL and EPR require the appointment of a Radioactive Waste Adviser (RWA).

Sealed sources are solid objects and typically they are used for equipment quality control or calibration. Open sources, on the other hand, are usually in liquid or gaseous form (although they may be solid). If treated inappropriately,

they may release radioactive substances to the environment causing radioactive contamination. Open sources are typically used for administration to patients as part of nuclear medicine tests or treatments.

By their very nature, radioactive substances and their applications are governed by general legislation and guidance [7,16-18] that apply to the use of ionising radiation, in particular the Ionising Radiations Regulations (IRR) 2017 [17]. This is enforced by the Health and Safety Executive (HSE) and requires the appointment of Radiation Protection Adviser(s) (RPA) and one or more Radiation Protection Supervisors (RPSs) and the writing of Local Rules.

3 General arrangements for the management of radioactive substances

The majority of the UHB's work with radioactive substances is done by Radiology and Medical Physics departments. The remainder is done by the Biochemistry department within the Laboratory Services Directorate. All departments are part of the Clinical Diagnostics and Therapeutics Clinical Board. The UHB's use of radioactive substances is subject to formal consent from the HSE. Their management is co-ordinated by Medical Physics in association with the RWA (Appendix 1), the RPA and the DGSA (Appendix 2).

The UHB procures radioactive materials for specific purposes. Most are purchased for clinical use in nuclear medicine as radiopharmaceuticals; in this case, the majority of the radionuclides have relatively short half-lives ranging from several seconds to several days. In some cases, the radionuclide that is procured (the parent) is not used directly and it is the daughter radionuclide that has clinical application. The most widely used example takes the form of a radioactive generator in which molybdenum-99, which decays to the clinically useful technetium-99m. Some clinical radionuclides and most radionuclides obtained for test and calibration purposes have relatively long half-lives ranging from weeks to years.

On receipt, radioactive materials are recorded and securely stored e.g. in a locked safe or a locked cupboard in a locked room. During storage, the materials are kept in shielded containers made of a suitable material of a suitable thickness and the store is labelled to indicate its contents. Records are kept of the removal of radioactive sources from the store and their return to the store. When a radioactive source is no longer required, its residual activity (following clinical or other use and/or radioactive decay) becomes radioactive waste.

It is inevitable that the use of open radioactive sources produces some radioactive contamination on surfaces and protective clothing. There are

routine monitoring programmes to detect such contamination and procedures for decontamination where necessary.

Risk assessments are made of all aspects of the use of radioactive substances [17-18]. In addition, there are contingency plans to deal with incidents such as a spillage of liquid radioactive material and the loss of a radioactive source. If the activities are sufficiently great, such incidents are reported to the HSE.

The UHB has established a Radiation Protection Group (RPG) that reports to the Quality, Safety and Patient Experience Committee and onwards to the Executive Board. The RPG discusses all aspects of radiation safety including the management of radioactive substances.

4 Transport of radioactive materials

In the course of its work, the UHB transports radioactive materials by road. This poses a potential hazard to staff, members of the public and the environment and in the governing regulations [12-13], radioactive materials are categorised as Class 7 dangerous goods. Since the regulations are made under the Health and Safety at Work Act 1974 [16], they are enforced by the Health and Safety Executive. In practice, however, compliance is assessed by the ONR.

Radiopharmaceuticals are transported from UHW to a number of other hospitals each working day for clinical nuclear medicine procedures. Sometimes radioactive waste is transported for storage and disposal at another site, radioactive patient samples (such as blood or tissue) are transported for analysis at another hospital and radioactive calibration and other sources are transported from one site to another. Patients to whom radioactive substances have been administered are not subject to the road transport regulations. It is also the case that the regulations do not apply to radioactive materials that are moved from one place to another within a single site (such as a hospital). The material is usually transported in a vehicle designated for this purpose, although a private car may be used under some circumstances; public passenger transport may not be used.

Radioactive materials are packaged in such a way as to minimise the external radiation hazard and the risk of damage to the contents or radioactive contamination. In order of increasing hazard, the packages used by the UHB are designated as exempt, excepted or Type A. Packages are labelled to indicate their contents and there are written procedures to ensure package security, minimise the risk of untoward events and mange incidents if they arise. Transport vehicles carry placards and a fire-proof cab notice to indicate the radioactive nature of the goods and what to do in the event of an accident.

Specific duties are assigned to the consignor (sender of the goods), the carrier (transporter), the vehicle driver and the consignee (recipient). Typically, the UHB is the consignor and the carrier and a member of its staff is the driver; the consignee may the UHB or another organisation. Shipments are accompanied by documents and records such that they are traceable to the consignor. Furthermore, there are training and quality assurance systems for the staff (vehicle drivers in particular), equipment and processes associated with the transport of the materials. There are also contingency plans that are tested periodically either in the field or as a 'desk-top' exercise.

5 Generation and regulation of radioactive waste

The use of radioactive substances by the UHB inevitably generates radioactive waste which, in general, may be solid, liquid or gaseous. In addition, the UHB receives radioactive waste from Cardiff University's Heath Park site.

Solid radioactive waste mainly takes the form of items (such as vials, syringes and test tubes) that contain residual radioactive substances and items (such as gloves, swabs, linen and clothing) that are contaminated by radioactive substances. These items are mainly produced as a result of:

- Radiopharmaceutical preparation
- Nuclear medicine tests and treatments
- RIA

Solid radioactive waste also includes sealed sources that have reached the end of their useful life.

The UHB produces solid radioactive waste as Low Level Waste (LLW) and Very Low Level Waste (VLLW).

The UHB produces aqueous liquid radioactive waste mainly in the form of:

- Unused radiopharmaceuticals, RIA ingredients and related products
- Gamma emitting nuclear medicine and RIA samples that have been measured
- Human excreta following nuclear medicine tests and treatments

Organic liquid waste is mainly produced as a result of the measurement of beta emitting samples in nuclear medicine using the method of liquid scintillation counting. This type of waste takes the form of liquid in a closed vial or other container.

The UHB does not produce gaseous radioactive waste. Radioactive gas (krypton-81m) is used in nuclear medicine for lung ventilation imaging but its half-life (13 seconds) is so short that no waste is produced.

The receipt, accumulation and disposal of radioactive waste are subject to the same legislation (EPR) [14-15] and regulatory framework as the keeping and use of radioactive substances. These aspects of radioactive waste management are incorporated into the same Natural Resources Wales environmental permit as applies for the keeping and use of open sources. In addition, there is a requirement [19-21] to appoint a suitable RWA.

6 General arrangements for the management of radioactive waste

The majority of the UHB's radioactive waste is generated by the work of the Radiology and Medical Physics departments; some waste is also generated by the work of the Laboratory Services Directorate. Other directorates may be involved with radioactive waste, especially those who deal with nuclear medicine in-patients and day cases.

The management of radioactive waste is co-ordinated by Medical Physics in association with Waste Management (Facilities Directorate). This includes the provision of a dedicated secure room that can be used as a radioactive waste store. It is located in Medical Physics at UHW. Radioactive waste is discussed by the RPG.

The UHB uses Best Available Techniques (BAT) for the Management of Radioactive Waste in order to minimise its impact on people and the environment. This includes keeping radiation doses and dose rates as low as reasonably practicable (ALARP) and optimising processes to reduce the amount of radioactive waste produced. There is a separate BAT procedure. The keeping of radioactive substances and the accumulation, storage and disposal of radioactive waste by the UHB should be in accordance with the conditions of the relevant Environmental Permits. Incidents involving non-compliance with Environmental Permits should be reported to NRW.

7 Accumulation, segregation and disposal of radioactive waste

Solid radioactive waste containing short-lived radionuclides (half-lives less than 7 hours) should be placed in a suitable container as it is produced. The container should not be the same as that used to keep long-lived waste and it should be labelled to indicate that it contains radioactive substances.

At the end of the period of waste accumulation, containers of short-lived solid waste should be sealed and placed in the dedicated radioactive waste store

or other suitable location. After a period of one week the radioactivity has decayed to such an extent that the waste may be classified as VLLW. It should be disposed of as contaminated non-radioactive waste after the removal of all labels indicting the presence of radioactivity.

Organic liquid waste and solid radioactive waste containing long-lived radionuclides (half-lives equal to or greater than 7 hours) should be placed in suitable separate containers as it is produced. Neither container should be the same as that used to keep short-lived solid waste and both should be labelled to indicate that they contain radioactive substances. A record should be made of the accumulation of waste in the containers.

After an accumulation period of no longer than three months, containers of organic liquid waste and long-lived solid waste should be sealed and transferred to the dedicated radioactive waste store together with the record of accumulated waste. The contents of the radioactive waste store should be kept securely at all times [22].

At the end of their period of storage, containers of organic liquid waste and long-lived solid waste should be suitably packaged and transferred to a contractor for removal and disposal by incineration (or possible burial at a designated land-fill site) as LLW. A record of the transfer should be made.

Small-sized sealed sources that are no longer required should be regarded as solid radioactive waste. They should be immediately disposed of as VLLW [23] or placed in the radioactive waste store and disposed of as LLW.

In general, large area sealed sources (gamma camera flood-field sources) and radionuclide generators that are no longer required should not be treated as radioactive waste by the UHB. By prior arrangement, they should be transferred as radioactive sources to the provider of a replacement source or generator at or near the time of delivery of the replacement. A record of such transfers should be made.

If transfer as radioactive sources is not possible, large area sealed sources and radionuclide generators that are no longer required should be taken to the dedicated radioactive waste store and disposed of as LLW or VLLW [23].

Individuals to whom radiopharmaceuticals have been administered will excrete some of the administered activity, mainly in urine. While they are on UHB premises, such individuals should be instructed to use designated toilets. These toilets should be identified by notices indicating that they may be used for this purpose.

The excreta are regarded as aqueous liquid waste which eventually reaches the sea via drains, sewers and sewage works. Much of the radioactivity in

this waste will decay before it is diluted in sea water. A record should be made of the estimated activity of aqueous waste disposed of in this manner.

Aqueous radioactive waste that is produced in clinical and laboratory settings should be disposed of by pouring down designated sinks or sluices and flushing with a copious amount of water. Such sinks and sluices should be identified by notices indicating that they may be used for this purpose.

The waste eventually reaches the sea via drains, sewers and sewage works and some of the radioactivity in this waste will decay before it is diluted in sea water. A record should be made of aqueous waste disposed of in this manner.

Since the UHB does not produce gaseous radioactive waste, it does not make any disposals of radioactive waste to air.

8 Exposure to radon

The element radon is a naturally occurring noble gas that only exists in radioactive form [24]. In common usage, the term radon means its most abundant isotope, radon-222, which decays with the emission of alpha radiation. Although its half-life is relatively short (3.8 days), it originates from uranium-238 in the natural environment. This radionuclide is much longer-lived, which means that radon is continuously produced.

Radon mixes with air and is therefore inhaled by all organisms including humans. It is colourless, odourless and tasteless and therefore its presence cannot be detected by human senses. Outdoors, the concentration of airborne radon is very small but it is possible for indoor concentrations to represent a radiation hazard. The main concern is the exposure of the lungs to alpha radiation and the associated risk of lung cancer. The air concentration of radon tends to be greatest in basements and other poorly ventilated areas. It also tends to be greater in winter than in summer, when buildings are better ventilated.

The concentration of radon in a specific room or location is usually measured with a passive detector, which is left in situ for a three-month period, and a risk assessment of radon exposure is made based on the results. If the annual average activity concentration of radon in air exceeds 300 Bq m^{-3}, remedial action should be taken [17-18]. The UHB's premises are not located in radon-affected areas and so it is unlikely that measures need to be taken to reduce radon concentration. However, radon concentration is monitored every ten years and risk assessments updated as appropriate.

9 Duties

Responsibility for implementing the Radioactive Substances Risk Management Policy and its supporting procedures lies with the UHB as radiation employer, with the Executive Director of Therapies and Health Science being the responsible officer. This responsibility is fulfilled by assigning the duties described here.

The duties of the Executive Director of Therapies and Health Science include:

- Taking overall responsibility for the management of radioactive substances on behalf of the UHB as the holder of Environmental Permits relating to radioactive substances and radioactive waste
- Providing assurance to the UHB Board that radioactive substances are managed in compliance with the UHB's policies and procedures and relevant Environmental Permits issued by Natural Resources Wales
- Ensuring that the UHB provides suitable management arrangements, including sufficient resources and competent persons, to comply with relevant Environmental Permits
- Providing assurance to the UHB Board that radioactive materials are transported in accordance with legislation and guidance
- Informing the UHB Board about issues related to radioactive substances management
- Appointing the UHB's RWA and RPA in writing
- Delegating duties to other managers as appropriate

The duties of Clinical Board Heads of Operations and Delivery include:

- Providing assurance to the Executive Director of Therapies and Health Science that radioactive substances are managed in compliance with policies and procedures and regulatory requirements
- Communicating and liaising with the RWA, RPA, Clinical Directors and other managers about issues related to radioactive substances and radioactive waste
- Appointing RPSs in writing
- Delegating duties to other managers as appropriate

The duties of the Chair of the UHB Radiation Protection Group (RPG) include:

- Reviewing relevant UHB policies and procedures at least every three years and ensuring that they are amended and updated as necessary
- Reviewing reports from the RWA, RPA and other members of the RPG and taking action as necessary

The duties of the Head of the Health, Safety and Environment Unit include:

- Acting as the UHB's primary contact with NRW as the regulator for the keeping of radioactive substances and the accumulation and disposal of radioactive waste

- Reporting incidents of regulatory non-compliance with respect to radioactive substances (including those associated with Environmental Permits) to the appropriate external regulatory body such as NRW, the Health and Safety Executive or the Office for Nuclear Regulation
- Ensuring that the Executive Director of Therapies and Health Science, the Chair of the UHB Radiation Protection Group and the relevant Clinical Director and Clinical Board Head of Operations and Delivery are aware of all reports made to external regulatory bodies
- Ensuring that the UHB's premises are monitored for radon every ten years, reviewing the results of such monitoring and updating radon risk assessments
- Liaising with the Head of Estates as regards remedial work to reduce the concentration of airborne radon
- Delegating duties to other managers as appropriate

The duties of the Radioactive Waste Adviser (RWA) include:

- Preparing applications for relevant Environmental Permits from NRW
- Liaising with NRW as regards radioactive waste management and matters such as site inspections and environmental permit variations
- Providing NRW with an annual inventory of the disposal of radioactive waste
- Performing, reviewing and updating environmental impact assessments for the discharge of aqueous liquid waste
- Promoting the use of BAT for the management of radioactive substances including radioactive waste
- Advising on the optimisation of processes to reduce the amount of radioactive waste produced
- Advising on the commissioning, calibration and quality assurance of contamination monitors and other equipment for the measurement of radioactivity
- Undertaking regular audits of compliance with relevant policies, procedures and Environmental Permits (to include the accumulation and disposal of solid and organic liquid waste and the disposal of aqueous liquid waste) and recommending remedial actions as necessary
- Providing quarterly reports to the Executive Director of Therapies and Health Science, the Chair of the Radiation Protection Group and relevant Clinical Board Heads of Operations and Delivery
- Providing advice to managers, Radiation Protection Supervisors and members of staff as regards compliance with relevant UHB policies and procedures and the stipulations of Environmental Permits

The duties of the Dangerous Goods Safety Adviser (DGSA) include:

- Giving direct advice on all aspects of the transport of radioactive materials

- Visiting sites to conduct safety audits and to review regulatory compliance as regards the transport of radioactive materials

The duties of the Radiation Protection Adviser (RPA) include:

- Providing advice on the safety of staff and the public as regards exposure to ionising radiation from radioactive substances and radioactive waste
- Providing advice on the safety of staff and members of the public as regards exposure to radon

The duties of the Head of Estates include:

- Co-operating with the Head of the Health, Safety and Environment Unit in performing monitoring for radon every ten years
- Undertaking any remedial work that is required to reduce the concentration of airborne radon at identified locations on the UHB's premises

The duties of Directorate Clinical Directors include:

- Ensuring that all aspects of the management of radioactive substances and radioactive waste (including procurement, storage, security, transport and disposal) comply with policies and procedures and regulatory requirements
- Ensuring that quality management system exists for all aspects of radioactive substances and radioactive waste
- Identifying and ensuring the appropriate training of individual members of staff as RPSs
- Ensuring that Local Rules and Standard Operating Procedures (SoPs) are written to implement the requirements of this UHB procedure
- Ensuring that relevant members of staff are adequately trained and have the resources to comply with the Local Rules and SoPs
- Maintaining records of staff training
- Putting in place measures to monitor staff compliance with SoPs
- Liaising with and seeking advice from the RWA, RPA and DGSA
- Making risk assessments and taking mitigating action as necessary
- Liaising with the Clinical Board Head of Operations and Delivery about the appointment of RPSs and issues related to the management of radioactive substances
- Reporting incidents of regulatory non-compliance (including those associated with Environmental Permits) to the Head of the Health, Safety and Environment Unit and informing the Executive Director of Therapies and Health Science, the Chair of the UHB Radiation Protection Group and the Clinical Board Head of Operations and Delivery
- Delegating duties to other managers as appropriate

The duties of the Head of Ionising Radiation (Medical Physics) include:

- Writing and updating relevant UHB policies and procedures
- Providing a secure dedicated room that may be used as a radioactive waste store
- Designating suitable members of staff as manager and RPS of the radioactive waste store
- Providing and maintaining a suitable computerised system (see Appendix 2) for recording radioactive substances and radioactive waste
- Retaining records of the disposal of radioactive waste until informed by NRW that records no longer need to be retained
- Ensuring that the transport of radioactive materials to and from the radiopharmacy at UHW complies with policies and procedures and regulatory requirements
- Liaising with the Executive Director of Therapies and Health Science as regards the appointment of RWA and RPA to the UHB
- Delegating duties to members of staff as appropriate
- Reporting incidents or potential incidents involving non-compliance with Environmental Permits and other concerns about radioactive substances management to the RWA and the Clinical Director
- Reporting incidents or potential incidents involving radioactive substances (other than those related to Environmental Permits) to the Clinical Director

The duties of the Head of Waste Management include:

- Procuring the services of an external contractor (see Appendix 3) for the disposal of long-lived solid and organic liquid radioactive waste
- Ensuring that the external contractor has appropriate Environmental Permits for the receipt, accumulation and disposal of radioactive waste
- Delegating duties to members of staff as appropriate

The duties of the manager of the radioactive waste store include:

- Receiving solid and organic liquid radioactive waste into the store from the UHB and Cardiff University on the Heath Park site
- Ensuring the security of the store and its contents
- Maintaining the record of radioactive substances and radioactive waste on the computerised system
- Arranging for the regular transfer of organic liquid waste and solid LLW to the external contractor in association with the Head of Waste Management
- Reporting incidents or potential incidents involving non-compliance with Environmental Permits and other concerns about radioactive waste management to the RWA and the Clinical Director

The duties of Radiation Protection Supervisors include:

- Ensuring compliance with arrangements for radiation safety and supervising the arrangements set out in the Local Rules
- Reporting incidents or potential incidents involving non-compliance with Environmental Permits and other concerns about radioactive substances management to the RWA and the Clinical Director
- Reporting other incidents to the Clinical Director
- Seeking advice from the RWA and RPA as required

The duties of individual members of staff include:

- Placing solid and organic liquid radioactive waste in the appropriate containers as it is produced
- Disposing of aqueous liquid radioactive waste via designated sinks
- Making a record of the production of organic liquid waste and long-lived solid waste and the disposal of aqueous liquid radioactive waste
- Disposing of short-lived solid radioactive waste as VLLW
- Transferring organic liquid waste and long-lived solid waste to the dedicated radioactive waste store
- Packaging and labelling radioactive materials for transport
- Preparing vehicles for the transport of radioactive materials
- Monitoring and recording radioactive contamination and taking remedial action as required
- Following SoPs and Local Rules pertinent to radioactive substances management
- Reporting incidents or potential incidents involving non-compliance with Environmental Permits and other concerns about radioactive substances management to the RPS

10 References

1. The Justification of Practices Involving Ionising Radiation Regulations 2004. Statutory Instrument 2004 No. 1769.

2. The Justification of Practices involving Ionising Radiation (Amendment) Regulations 2018. Statutory Instrument 2018 No. 430.

3. The Justification of Practices Involving Ionising Radiation Regulations 2004 (SI 2004 No. 1769): Guidance on their Application and Administration. Department for Environment, Food and Rural Affairs (DEFRA) 2008.

4. The 2007 Recommendations of the International Commission on Radiological Protection (ICRP Publication 103).

5. The Ionising Radiation (Medical Exposure) Regulations 2017. Statutory Instrument 2017 No. 1322.

6. Notes for Guidance on the Clinical Administration of Radiopharmaceuticals and Use of Sealed Radioactive Sources. Administration of Radioactive Substances Advisory Committee 2018.

7. Medical and Dental Guidance Notes: A Good Practice Guide on all Aspects of Ionising Radiation Protection in the Clinical Environment. Institute of Physics and Engineering in Medicine (IPEM) 2002.

8. The Medicines Act 1968.

9. The Human Medicines Regulations 2012. Statutory Instrument 2012 No. 1916.

10. Good Manufacturing Practice (GMP) Guidelines (EudraLex Volume 4). European Commission 2015.

11. Rules and Guidance for Pharmaceutical Manufacturers and Distributors. Medicines and Healthcare products Regulatory Agency (MHRA) 2017.

12. The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009. Statutory Instrument 2009 No. 1348.

13. Accord Européen relatif au Transport International des Marchandises Dangereuses par Route (ADR) (European Agreement Concerning the International Carriage of Dangerous Goods by Road). United Nations Economic Commission for Europe (UNECE) 2017.

14. The Environmental Permitting (England and Wales) Regulations 2016. Statutory Instrument 2016 No. 1154.

15. The Environmental Permitting (England and Wales) (Amendment) (No. 2) Regulations 2018. Statutory Instrument 2018 No. 428.

16. The Health and Safety at Work etc. Act 1974.

17. The Ionising Radiations Regulations 2017. Statutory Instrument 2017 No. 1075.

18. Work with Ionising Radiation: Ionising Radiations Regulations 2017 Approved Code of Practice and Guidance. Health and Safety Executive (HSE) 2018.

19. Environment Agencies Statement on Radioactive Waste Advisers. Environment Agencies 2011.

20. Environment Agencies Guidance on Suitability of Radioactive Waste Advisers. Environment Agencies 2011.

21. How to Comply with your EPR RSR Environmental Permit – Open Sources and Receipt, Accumulation and Disposal of Radioactive Waste on Non-nuclear Sites. Natural Resources Wales 2014.

22. Security Guidance for Sites and Sectors Working with Radioactive Sources. Association of Chief Police Officers 2003.

23. Guidance on the Scope of and Exemptions from the Radioactive Substances Legislation in the UK. Department for Environment, Food and Rural Affairs 2011.

24. Limitation of Human Exposure to Radon (RCE-15). Health Protection Agency 2010.

Appendix 1

Role Profile for Radioactive Waste Adviser (RWA)

Qualifications:

- MSc in Medical Physics
- Registered Clinical Scientist (HCPC)
- Certificated RWA (RPA 2000)

Competences:

- Measurement of environmental activity and dose rates
- Calculation of radiation dose to individuals or groups
- Use, quality assurance and calibration of radiation monitors

Duties

- Preparing applications for Environmental Permits
- Liaising with the regulator regards matters such as site inspections and environmental permit variations
- Providing the regulator with an annual inventory of the disposal of radioactive waste
- Performing, reviewing and updating environmental impact assessments for the discharge of aqueous liquid waste
- Promoting the use of Best Available Techniques (BAT) for the management of radioactive waste
- Advising on the optimisation of processes to reduce the amount of radioactive waste produced
- Advising on the commissioning, calibration and quality assurance of contamination monitors and other equipment for the measurement of radioactivity
- Undertaking regular audits of compliance with relevant policies, procedures and Environmental Permits (to include the accumulation and disposal of solid and organic liquid waste and the disposal of aqueous liquid waste) and recommending remedial actions as necessary
- Providing regular reports to management
- Providing advice to managers, Radiation Protection Supervisors and members of staff as regards compliance with policies and procedures and the stipulations of Environmental Permits

Appendix 2

Role Profile for Dangerous Goods Safety Adviser (DGSA)

Qualifications

- Vocational Training Certificate issued by the Scottish Qualifications Agency to act as a DGSA for road transport

Competences

- Detailed knowledge of legislation and guidance in relation to the transport of dangerous goods
- Ability to conduct and report on the findings of safety audits

Duties as regards the transport of radioactive substances

- Giving direct advice on legislation and related matters
- Visiting sites to review the existing standards of regulatory compliance
- Performing comprehensive safety audits
- Giving assistance with matters such as packaging, labelling, consignment procedures, documentation and vehicle marking
- Advising on the carriage, loading, unloading and handling of radioactive materials and associated safe working practices
- Developing procedures and emergency arrangements if required
- Providing safety training for staff if required

Appendix 3

Computerised system for recording radioactive substances and radioactive waste

System: IsoStock

Supplier: Gillett Partnership

Address: PO Box 4544
Sheffield
S17 9BP

Contact: Technical support
Tel: 0844 736 2660 option 2
Fax: 0844 736 2660
E-mail: support@gillett.co.uk

Appendix 4

External contractor for the disposal of organic liquid radioactive waste and long-lived solid LLW

Contractor: SRCL

Address: Indigo House
Sussex Avenue
Leeds
LS10 2LF

Contact: Customer support
Tel: 0333 240 4400
E-mail: support@srcl.com

Report Title:	**Committee Effectiveness Review – Results and Actions**							
Meeting:	Quality, Safety and Effectiveness Committee					**Meeting Date:**	18th June 2019	
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

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

It is also a requirement of Standing Orders that Committees of the Board undertake an annual review of their effectiveness. This is the first time that such a review has been undertaken.

The questions which were asked by Members of the Committee were agreed at the meeting of the Committee in April 2019. It was also agreed that Survey Monkey would be used as a tool to gather the feedback.

ASSESSMENT

Attached at appendix 1 are the results for the Committee Effectiveness review undertaken by Committee Members in addition to the Executive Director Lead for the Committee.

Attached at appendix 2 is a proposed action plan to improve the results which had either an 'adequate', 'needs improvement' or 'no' response to the questions asked.

RECOMMENDATION

The Committee is asked to:

- Note the results of the Committee Effectiveness Review for 2019.
- Approve the action plan for improvement to be completed by March 2020 in preparation for the next Effectiveness Review.

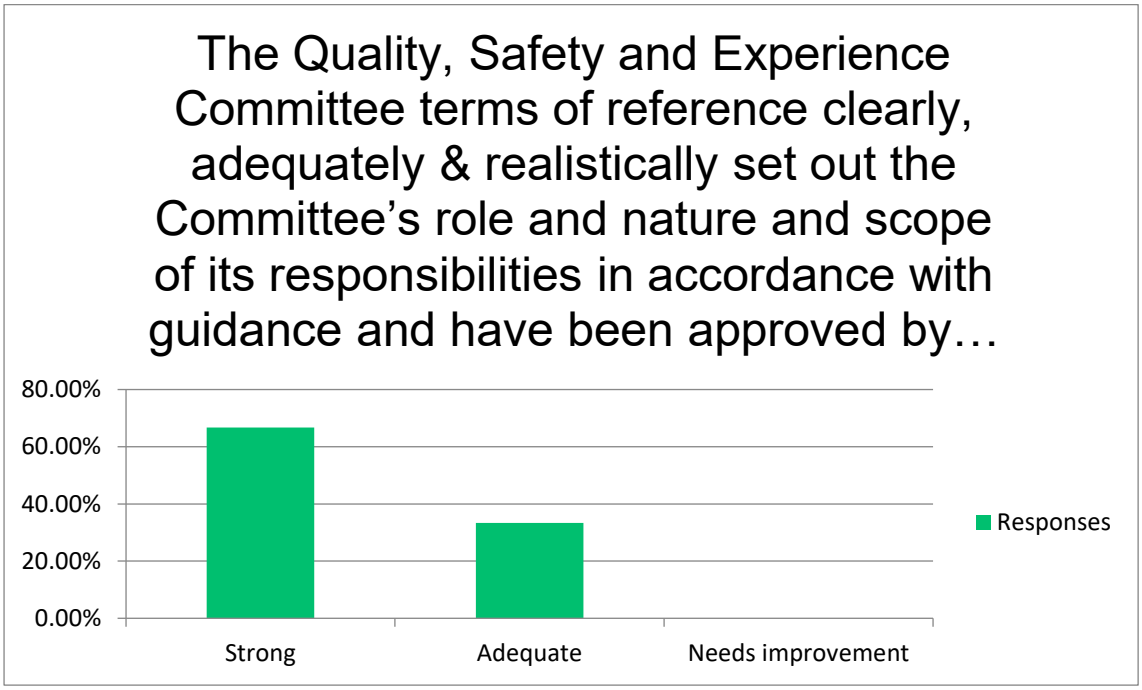
Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	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	

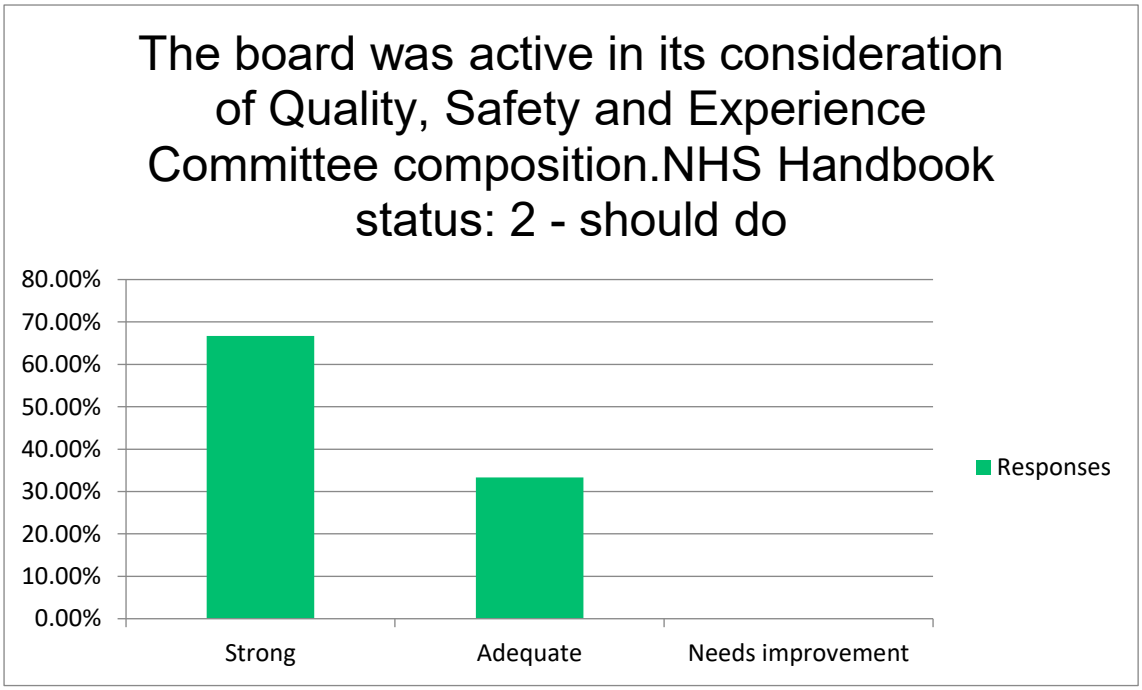
		sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides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

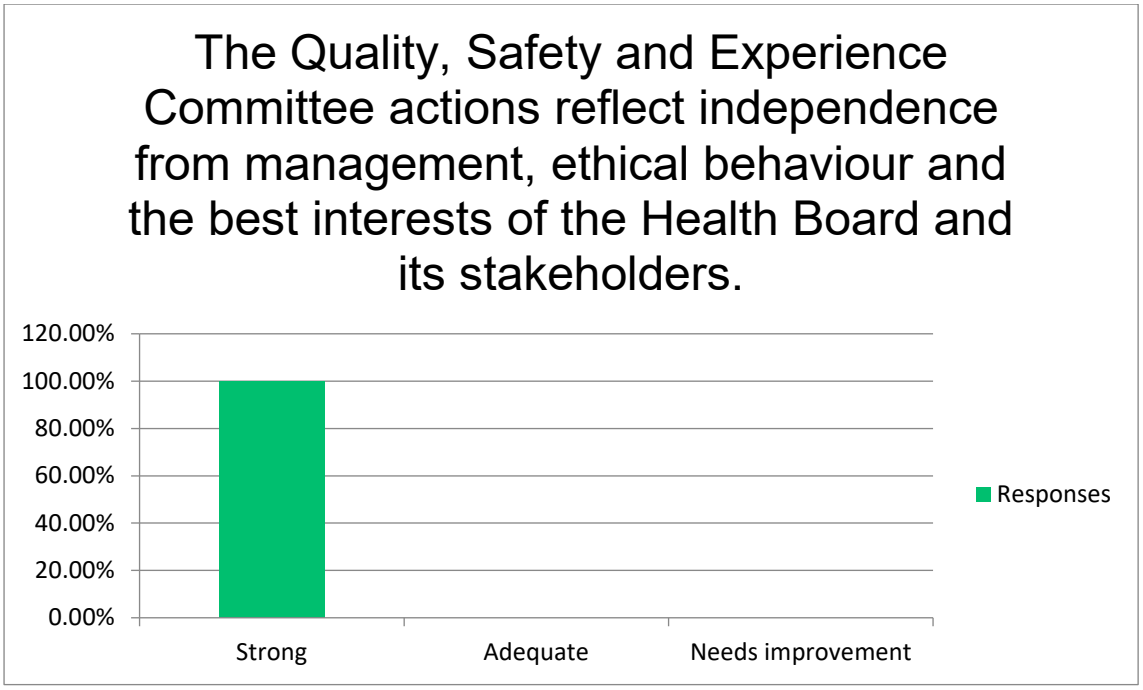
Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Quality, Safety and Effectiveness Committee – Results






The Quality, Safety and Experience Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.
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Strong
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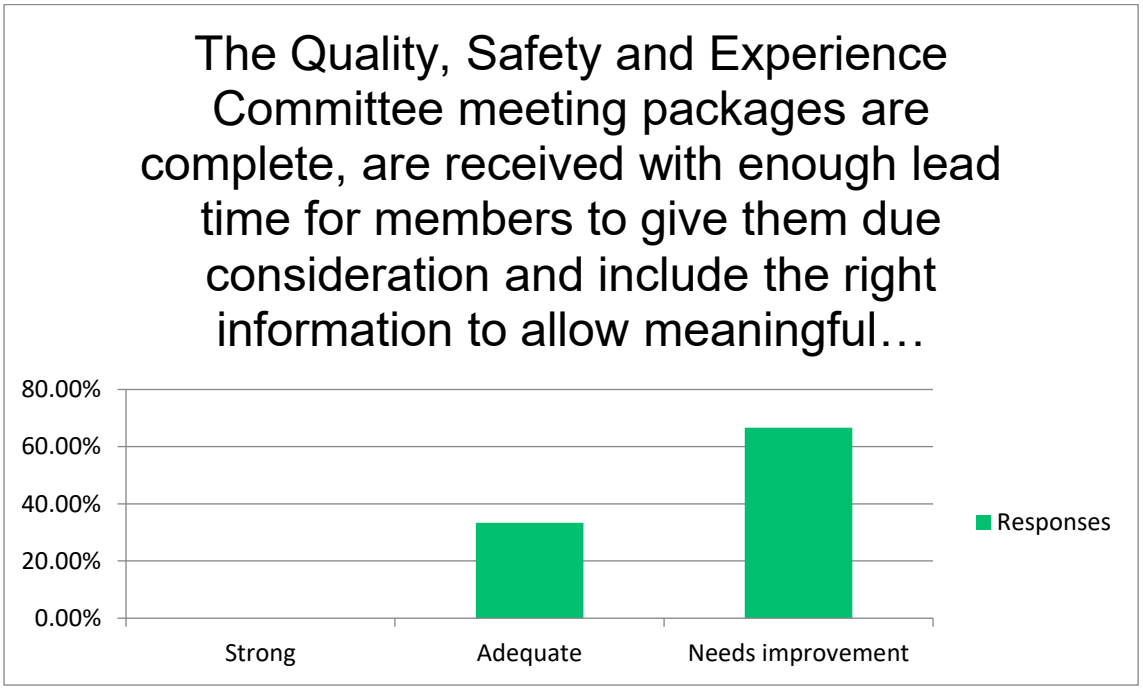
Needs improvement
Responses


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…
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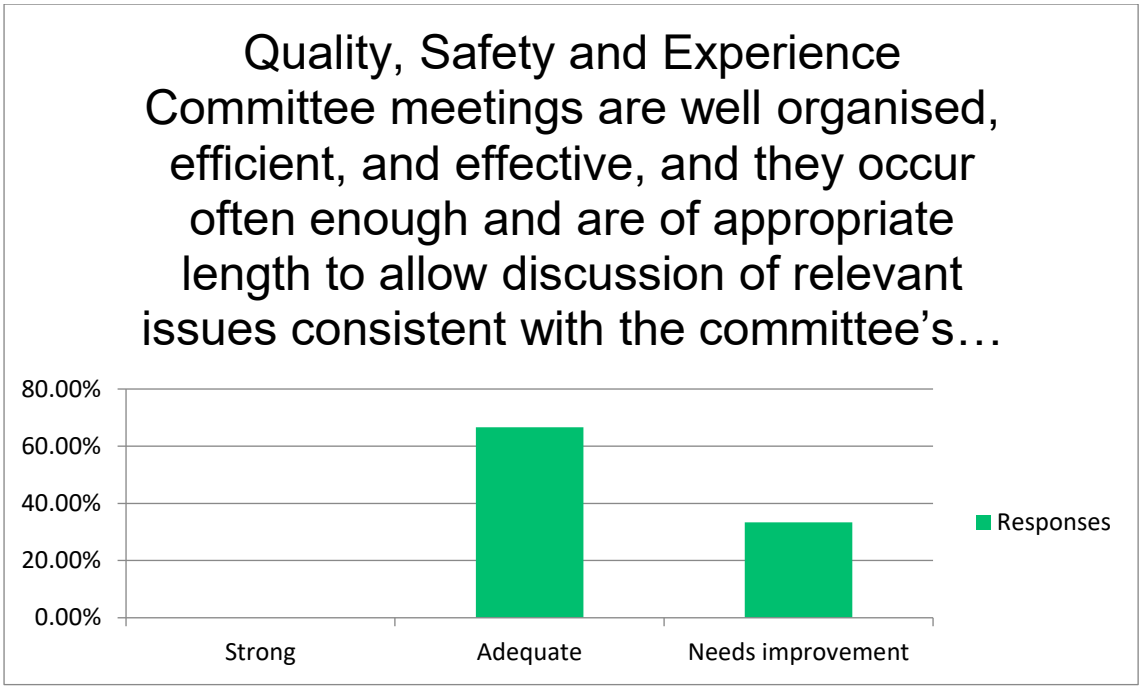
Quality, Safety and Experience Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's…
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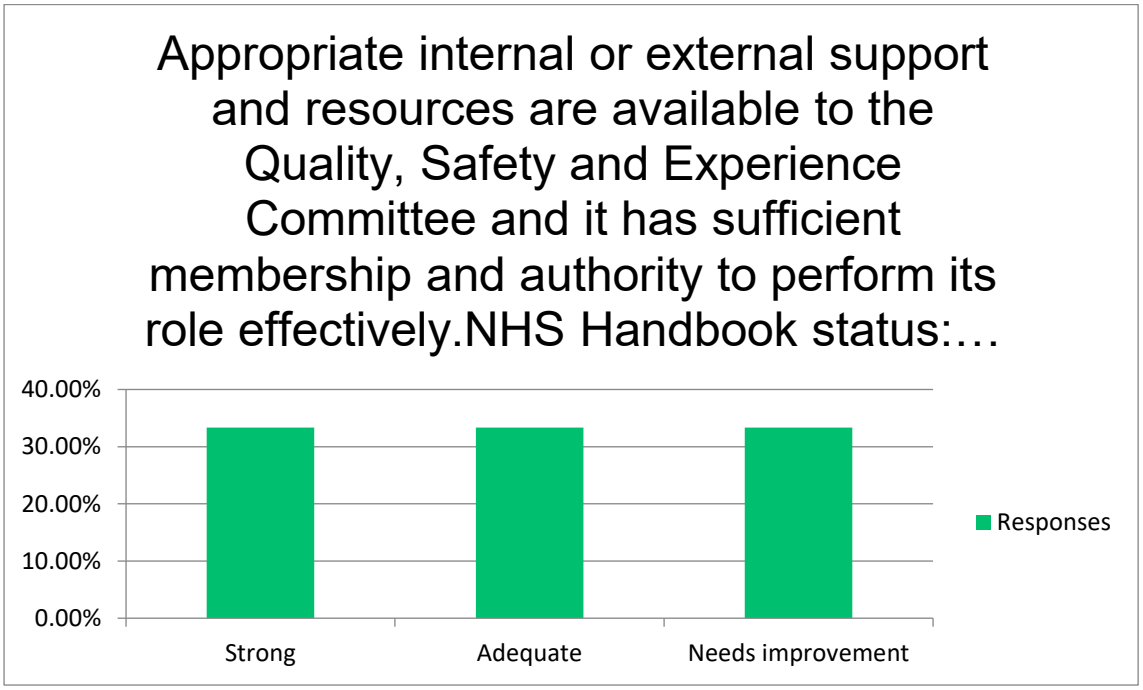
Appropriate internal or external support and resources are available to the Quality, Safety and Experience Committee and it has sufficient membership and authority to perform its role effectively.NHS Handbook status:…
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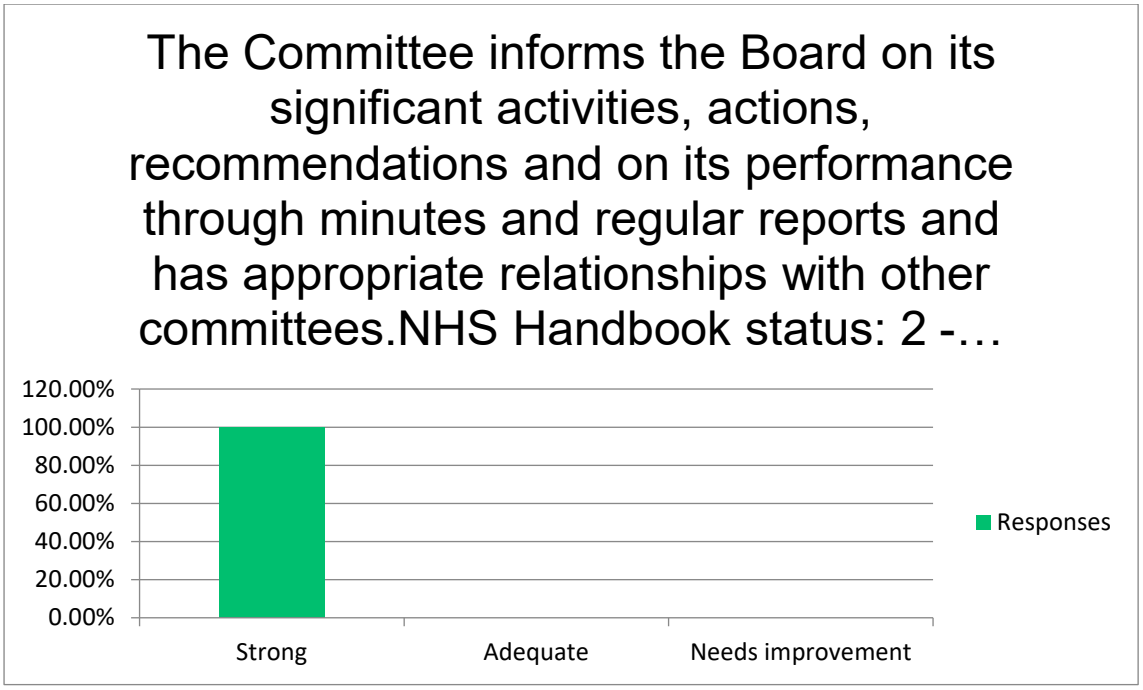
The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.NHS Handbook status: 2 -…
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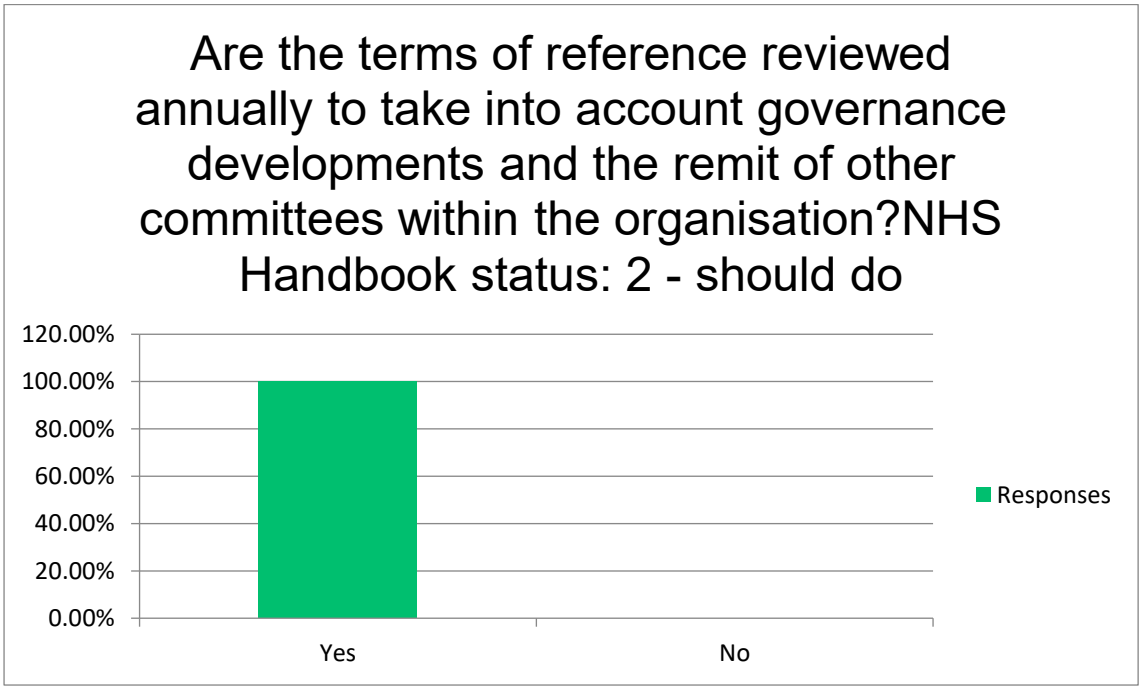
Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?NHS Handbook status: 2 - should do
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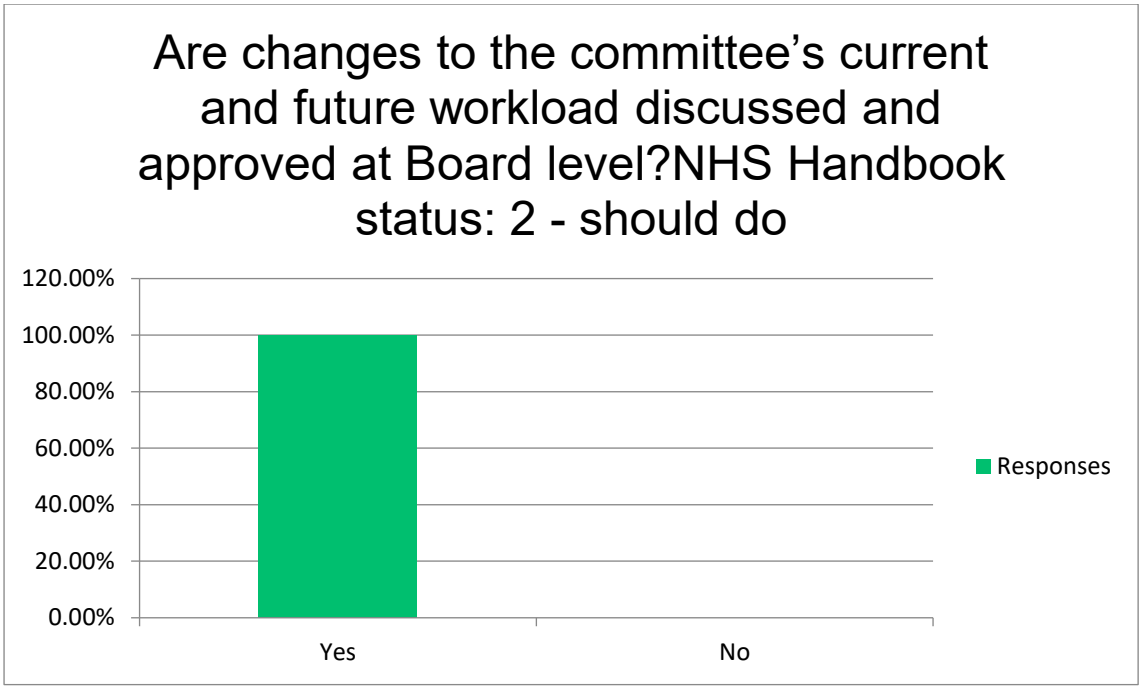
Are changes to the committee's current and future workload discussed and approved at Board level?NHS Handbook status: 2 - should do
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Yes
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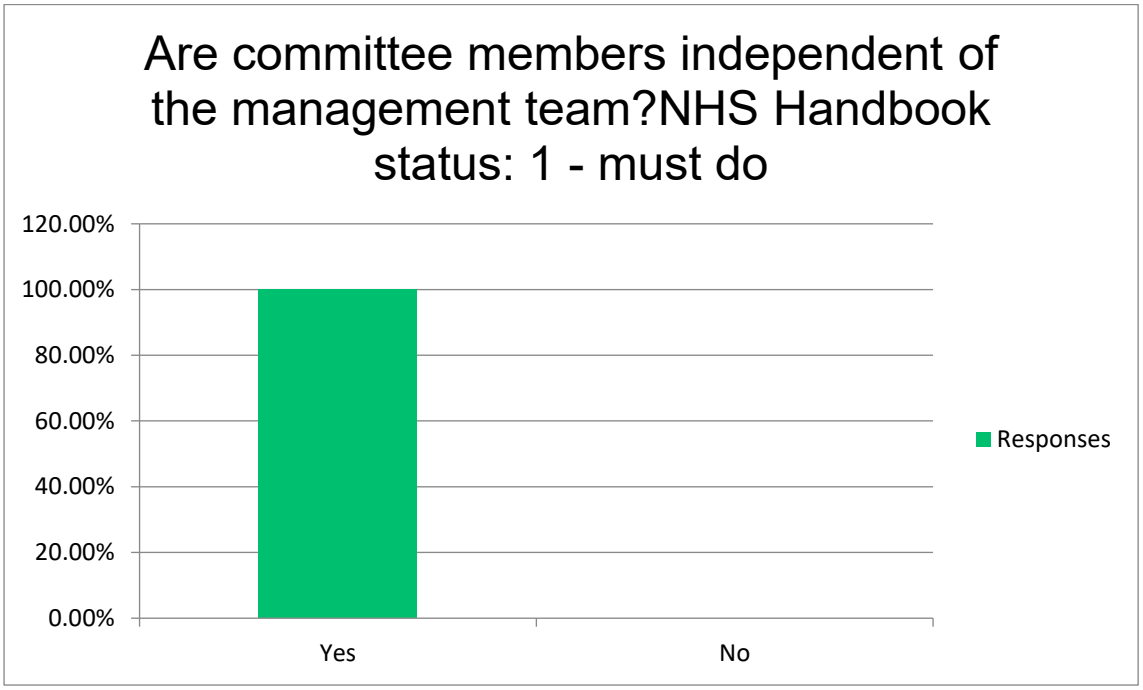
Responses


Are committee members independent of the management team?NHS Handbook status: 1 - must do
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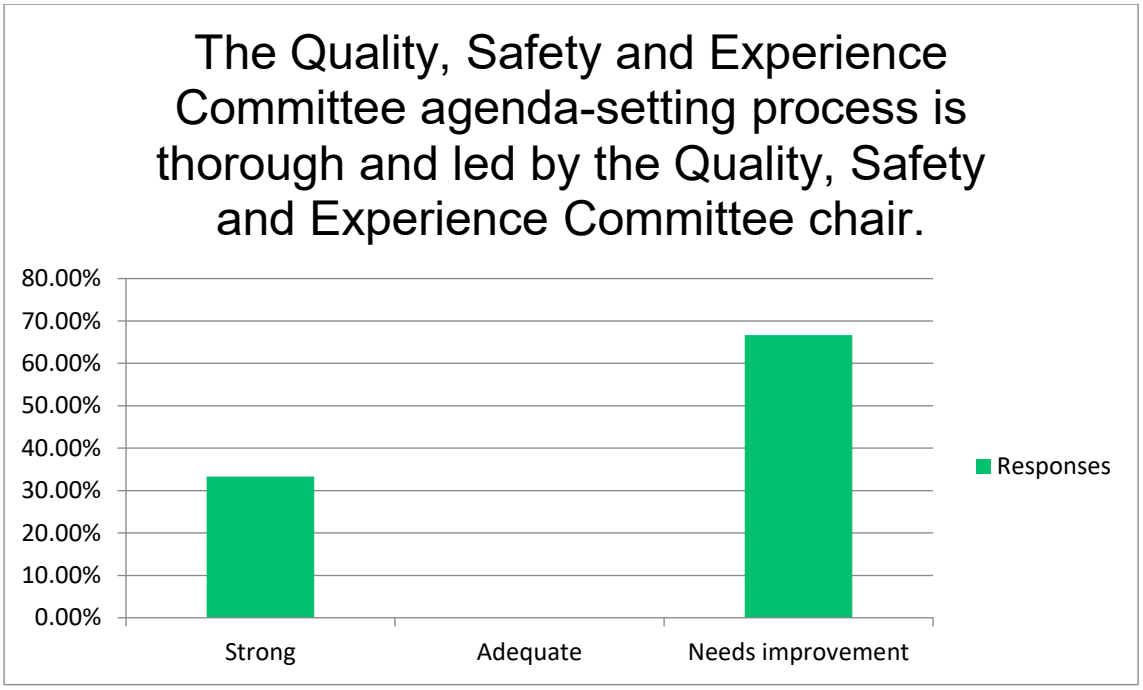
The Quality, Safety and Experience Committee agenda-setting process is thorough and led by the Quality, Safety and Experience Committee chair.
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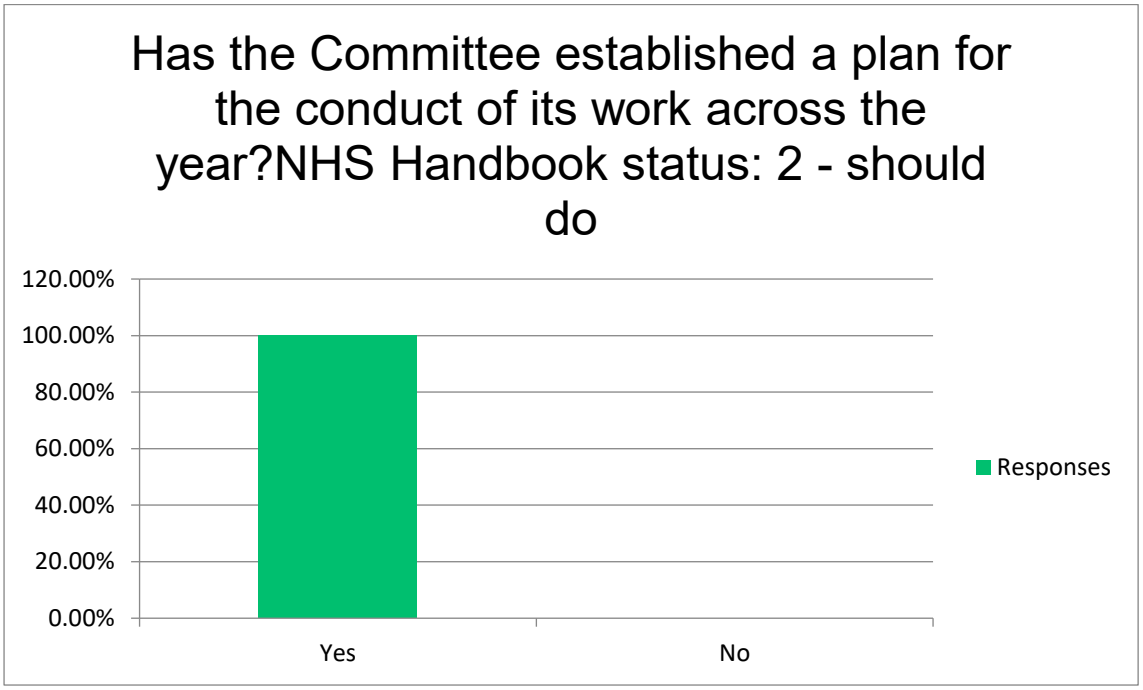
Has the Committee established a plan for the conduct of its work across the year?NHS Handbook status: 2 - should do
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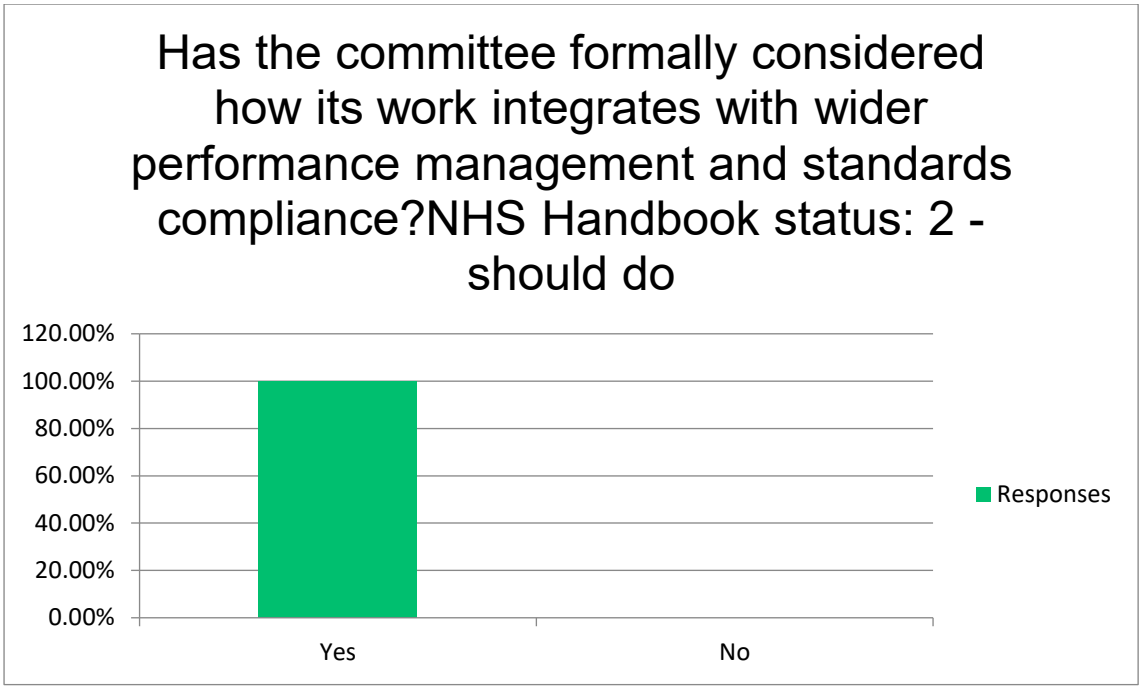
Has the committee formally considered how its work integrates with wider performance management and standards compliance?NHS Handbook status: 2 - should do
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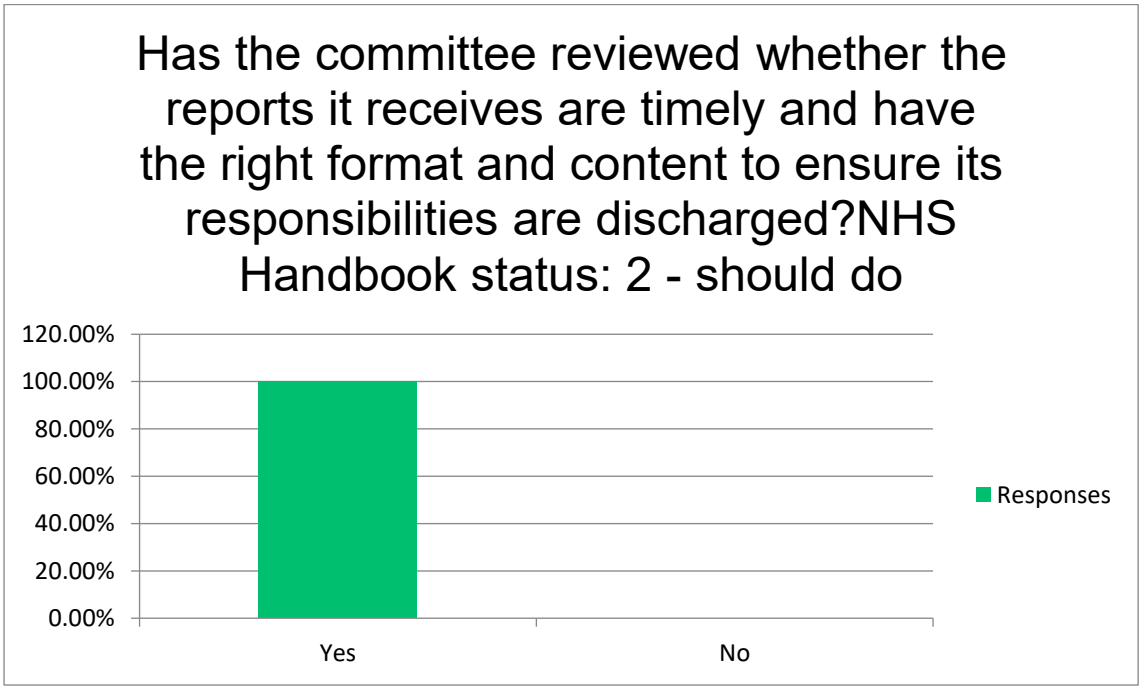
Has the committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?NHS Handbook status: 2 - should do
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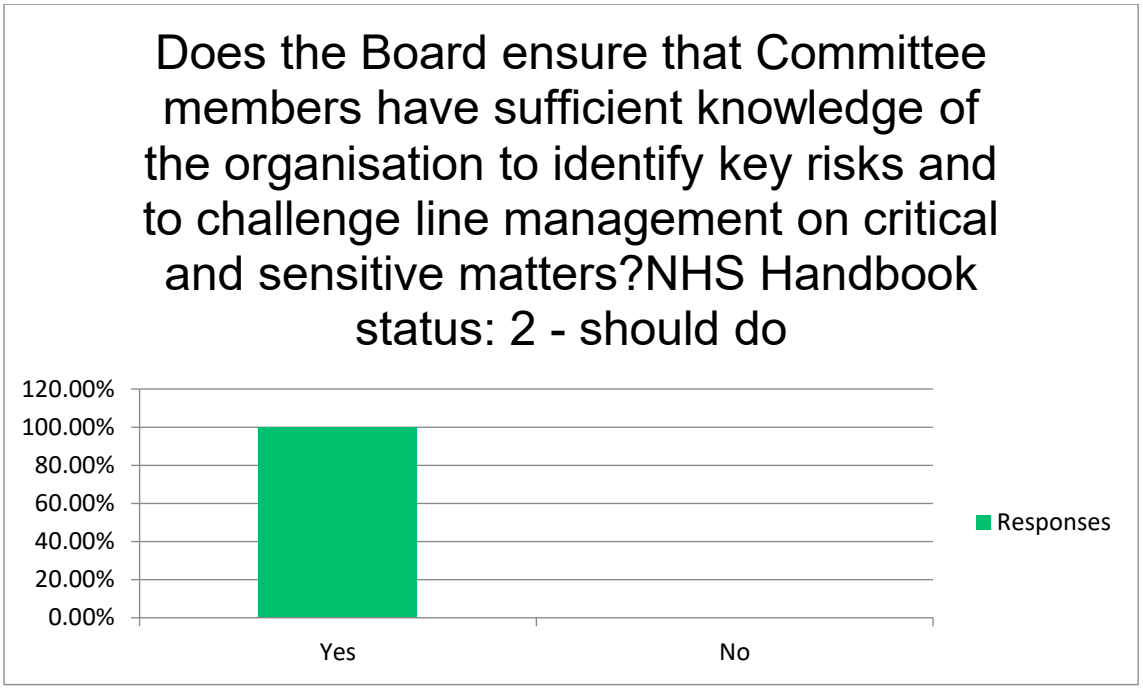
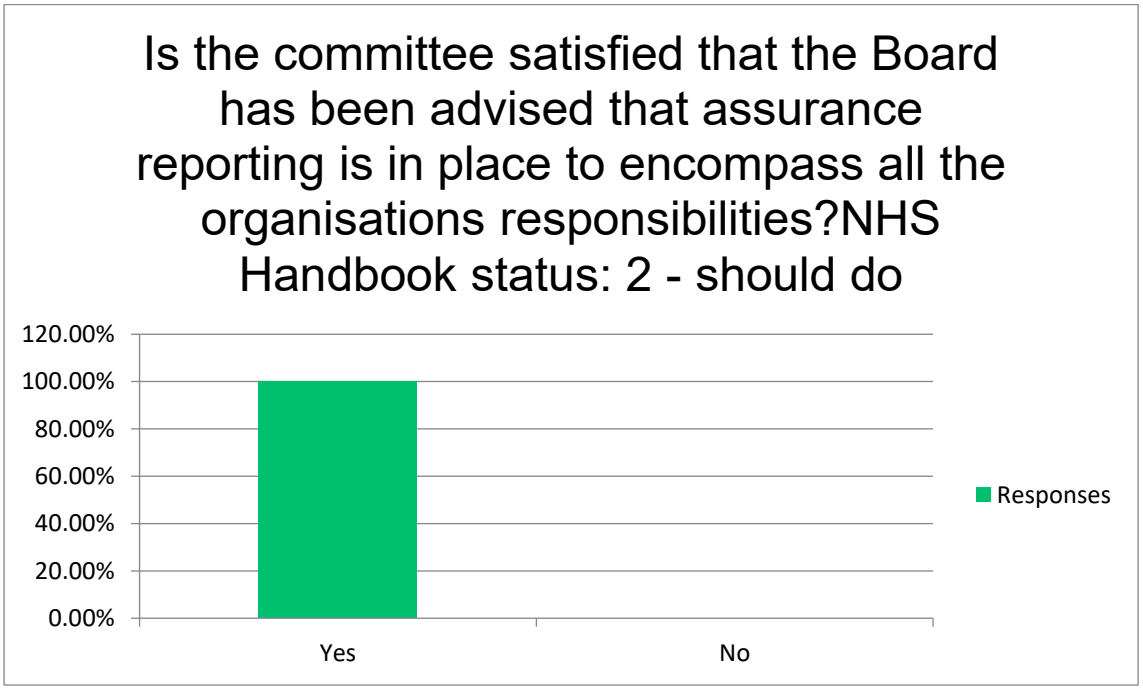
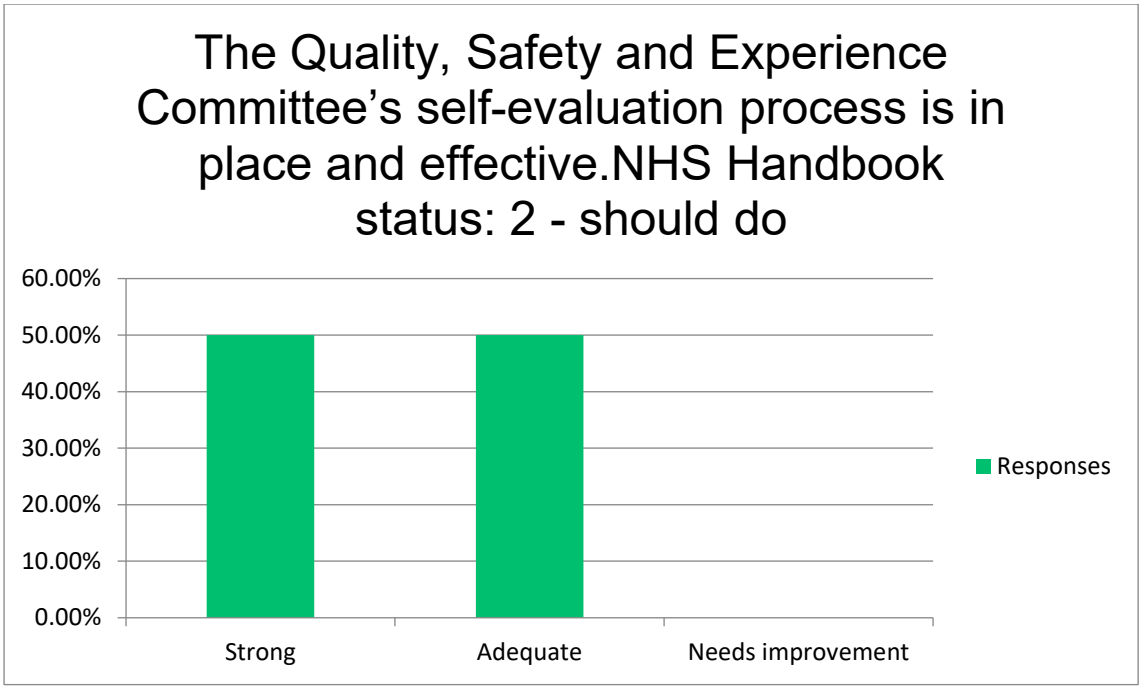
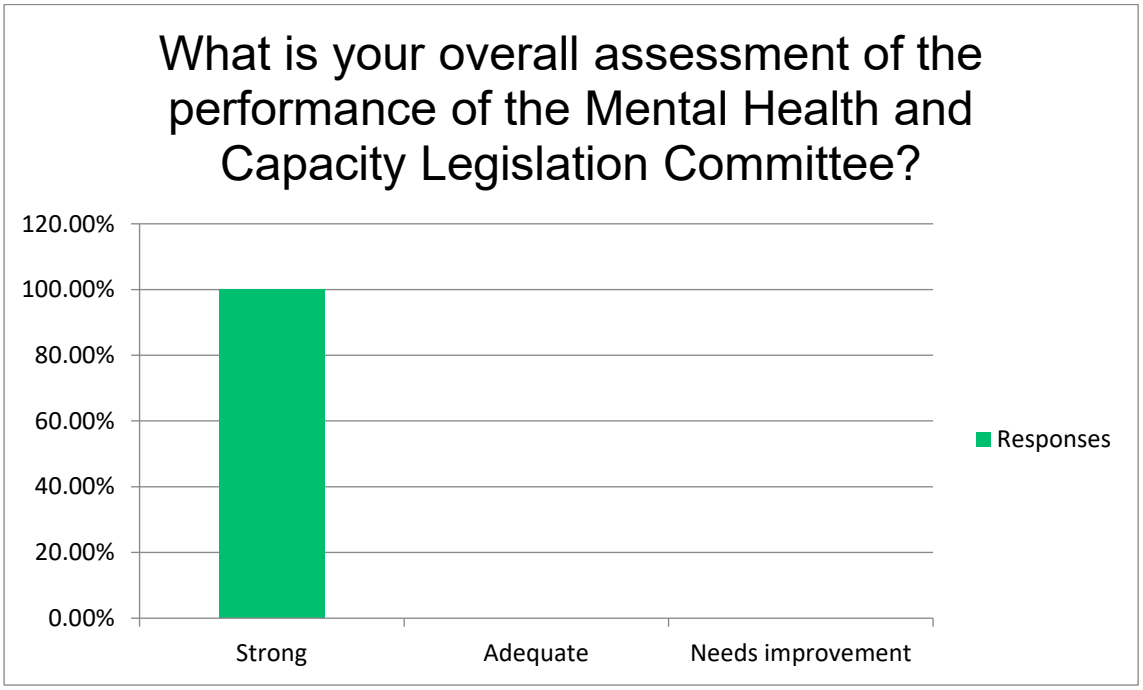
Yes
No
Responses


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?NHS Handbook status: 2 - should do
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Yes
No
Responses


Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?NHS Handbook status: 2 - should do
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Yes
No
Responses


The Quality, Safety and Experience Committee's self-evaluation process is in place and effective.NHS Handbook status: 2 - should do
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Strong
Adequate
Needs improvement
Responses


What is your overall assessment of the performance of the Mental Health and Capacity Legislation Committee?
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Strong
Adequate
Needs improvement
Responses

Quality, Safety and Effectiveness Committee – Self Evaluation 2019 Action Plan

Question asked	Action Required	Lead	Timescale to complete
The Quality, Safety and Experience Committee Terms of Reference clearly, adequately and realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Board	The QSE Terms of reference were reviewed and approved by the Committee (Feb 2019) and then the Board (March 2019) prior to the start of the financial year. The process for the coming year can be more refined to include a discussion with the Exec Lead and Chair of this Committee to ensure the right areas are covered off adequately	Director of Corporate Governance	March 2020
The Board was active in its consideration of the Quality, Safety and Effectiveness Committee composition	The Board approved the composition of the Committee at its meeting on 30th May 2019. In future this will be reviewed and confirmed on an annual basis.	Director of Corporate Governance	March 2020
The Quality, Safety and Effectiveness 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.	Meeting packages need to be reviewed and uploaded within the timescales set out within standing orders. This is an area which requires improvement. The Corporate Governance Department are being set clear timescales for delivery but it also required Executive Directors to ensure their reports are submitted on time. In future and in	Director of Corporate Governance / Committee Chair	From June 2019

	discussion with the Chair reports not submitted within the deadline will be removed from the agenda		
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 Committees Terms of Reference	The organisation of the Committee needs improvement and setting clear timescales for receipt of papers, receipt of draft minutes and action logs will assist in the process of having a well organised meeting. A meeting should be set up between the Director of Corporate Governance, Committee Chair and Executive Lead for the Committee to see how the organisation of the Committee can be further improved	Director of Corporate Governance/ Executive Lead and Committee Chair	Meeting by end of July
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 adequately.	A meeting should be set up between the Director of Corporate Governance, Committee Chair and Executive Lead for the Committee to see how this can be improved	Director of Corporate Governance/ Executive Lead and Committee Chair	Meeting by end of July
The Quality, Safety and Experience Committee agenda setting process is thorough and lead by the Chair	A meeting should be set up between the Director of Corporate Governance, Committee Chair and Executive Lead for the Committee to see what support is required for the Committee Chair in	Director of Corporate Governance/ Executive Lead and Committee Chair	Meeting by end of July

	order to improve this process		
The Quality, Safety and Experience committee self-evaluation process is in place and effective	This is the first review of Committee effectiveness which has taken place. This will be done on a 12 month basis with action plan for improvement then developed for areas requiring improvement	Director of Corporate Governance	Review for this year complete and action plan developed. Next review to take place by March 2020

REPORT TITLE:	**HEALTH AND CARE STANDARDS**								
MEETING:	Quality Safety and Experience Committee						**MEETING DATE:**	**18th June 2019**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
LEAD EXECUTIVE:	Executive Director of Nursing								
REPORT AUTHOR (TITLE):	**Head of Patient Safety and Quality Assurance**								

PURPOSE OF REPORT:

SITUATION:

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

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

REPORT:

BACKGROUND:
In December 2017 the Committee agreed an ongoing approach to align the Health and Care Standards to existing groups or committees within the UHB. The aim was to support a system that promotes continuous monitoring and development of the services underpinning each of the Health and Care Standards and to reduce variation across the UHB. It has previously been agreed that this process would be undertaken over a three-year period and that in 2018/19 seventeen standards would be aligned to committees and the Clinical Boards would undertake self-assessments against the remaining seven standards. The process was subject to Internal Audit assessment and was awarded reasonable assurance.

ASSESSMENT:
Clinical Boards undertook self-assessment of seven of the Health and Care Standards. Each self-assessment is multi-factorial and considers a number of components relating to the individual standard. To reduce variation between Clinical Boards a scoring matrix has been developed for each standard with definitions aligned to four scores:

- Getting Started
- Progressing Towards the Standard
- Meeting the Standard
- Leading the Way

Standard 1.1 Health promotion protection and Improvement
Five clinical Boards retained their self-assessed rating of Progressing Towards the Standard from the previous year. PCIC and Dental Clinical Boards both evidenced a decline in performance while Surgery increased to Leading the Way. Priorities for 2019/20 revolved around increase flu vaccination uptake and smoking cessation in line with the corporate priorities. PCIC also identified progression of the Dementia Action Plan and Surgery Clinical Board, progressing their fitness for surgery and ERAS work.

Priorities identified by the Corporate lead included delivery of the commitments in the Active Travel Charter, improving BMI in patients and Increasing uptake of screening.

Standard 3.1 Safe and Clinically Effective Care
The majority of Clinical Boards retained their self-assessed rating of 2017/18 with most stating they were Meeting the Standard. Only Medicine Clinical Board evidenced an improvement to Meeting the Standard and Surgery identified a decline in performance to Meeting the Standard. Clinical Board priorities were predominantly around improved management of Datix. UHB priorities were much wider reaching and included implementation of the Falls Framework, a focus on safety standards for invasive procedures and improved compliance around mortality reviews.

Standard 3.3 Quality Improvement Research and Innovation
All Clinical Boards retained their self-assessed rating from 2017/18 with the exception of CD&T who felt that their performance had reduced to Progressing towards the standard. The majority of Clinical Board priorities centered around their clinical audit activity or increasing R&D activity. The Clinical Board priorities are largely aligned to those identified in the overarching corporate assessment.

Standard 3.5 Record Keeping
The majority of Clinical Boards rated themselves as Progressing Towards the Standard with only Mental Health Clinical Board suggesting that they were Meeting the Standard, and the majority remaining at the same rating as in 2018/19. The majority of Clinical Boards identified improving the quality of record keeping and progression toward electronic patient records as a priority for 2019/20. Both PCIC and Mental Health Clinical Boards who are using electronic patient records prioritised audit of existing records for 2019/20.

Standard 4.1 Dignified Care
Clinical Boards rated themselves highly around the provision of dignified care with the majority stating that they were Meeting the Standard or Leading the Way. Provision of care to meet the needs of patients with dementia was a frequently occurring priority which was also reflected in the corporate UHB assessment. Reviews of continence and mouth care are both identified corporately as UHB priorities for 2019/20.

Standard 4.2 Patient Information
The Clinical Boards rated themselves as either Progressing Towards or Meeting the Standard with most retaining their self-rating from 2017/18. A number of the Clinical Boards specified that they would be undertaking work to review their patient information in 2019/20 and some innovative approaches were being developed to further improve patient information including filmed prehab information in Trauma and Orthopaedics. Further development of the technology

available in the Information Centres to share information in accessible formats is planned for 2019/20

Standard 6.3 Listening and Learning from Feedback
Clinical Boards largely retained their ratings from 2017/18 with only CD&T and PCIC increasing to Meeting the Standard. A number of the Clinical Boards identified the development of bespoke patient experience surveys as a priority for 2019/20 while Medicine Clinical Board have specified the need to ensure increased feedback is given to the wards and clinical areas to allow them to put in place the necessary improvements.

Self-assessments support analysis of compliance against the various elements of each Health and Care Standard as well as the development of actions for the following financial year. Despite this 67% of self-assessments undertaken by the Clinical Boards attributed the same score as the previous year. Furthermore there are some discrepancies in the priorities identified by the Clinical Boards compared to the recommendation made by the corporate leads. Consideration should be given as to how the UHB recommendations are communicated to Clinical Boards around the standards that are not aligned to groups and committees in order to support the necessary improvements.

The 15 Health and Care Standards that are aligned to groups and committees across the health board have been subject to ongoing scrutiny throughout the year. Performance against the individual components of each of these standards will have been monitored and where necessary the requisite improvements will have been implemented and reviewed. Clinical Boards will remain informed about performance and improvements through attendance at these groups and circulation of minutes. An annual assessment of performance and identification of the 2019/20 actions is undertaken by the Corporate lead in conjunction with each of the groups and committees. These assessments have been subject to Executive review and sign off by the Independent Member.

Standard 3.4 Information Governance and Communication Technology and standard 3.5 Record Keeping will be presented to the Digital Health Informatics Committee prior to being signed off by the Independent Member for Information Communication and Technology.

The Corporate assessment of all of the health and care standards are included in the appendices:

Appendix 1	1.1 Health Promotion protection and Improvement
Appendix 2	2.1 Managing Risk and Prompting Health and Safety
Appendix 3	2.2 Preventing Pressure and Tissue Damage
Appendix 4	2.3 Falls Prevention
Appendix 5	2.4 Infection Prevention and Control
Appendix 6	2.5 Nutrition and Hydration
Appendix 7	2.6 Medicines Management
Appendix 8	2.7 Safeguarding Children and Safeguarding Adults at Risk
Appendix 9	2.8 Blood Management
Appendix 10	2.9 Medical devices, Equipment and Diagnostic Systems
Appendix 11	3.1 Safe and Clinically Effective Care
Appendix 12	3.2 Communicating Effectively
Appendix 13	3.3 Quality Improvement, research and Innovation
Appendix 14	3.4 Information Governance and Communications Technology

Appendix 15	3.5 Record Keeping
Appendix 16	4.1 Dignified Care
Appendix 17	4.2 Patient Information
Appendix 18	5.1 Timely Access
Appendix 19	6.1 Planning Care to Promote Independence
Appendix 20	6.2 People's Rights
Appendix 21	6.3 Listening and Learning from Feedback
Appendix 22	7.1 Workforce

RECOMMENDATION:

The committee are asked to:
Note the progress made against each of the Health and Care Standards
Approve the Corporate Priorities for 2019/20

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

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

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

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

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

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

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S
Situation

Health and Care Standard:

Standard: 1.1 Health promotion, Protection and Improvement

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities

B
Background

Please Confirm the rating from the following definitions*:*

Clinical Board	Self Assessment 2017/18	Self Assessment 2018/19
Children and Women	Getting there	Evidence submitted but no self assessment
CD&T	Getting there	Getting there
Dental	Meeting the Standard	Getting there
Medicine	Getting there	Getting there
Mental health	Getting there	Getting there
PCIC	Meeting the Standard	Meeting the Standard
Specialist	Getting there	Getting There
Surgery	Meeting the Standard	Meeting the Standard

The self assessments from the Clinical Boards (CBs) that submitted evidence are largely unchanged but there is evidence of good preventative activity in all. The information submitted was limited in places, but no clinical board appears to have a systematically embedded approach to health promotion, protection and improvement. Some excellent examples of good practice are evidenced.

A
Assessment

Please provide a brief contextual narrative

The health promotion, protection and improvement standard is broad and incorporates numerous elements. There is evidence of good preventative action in all CB returns.

As in previous years, nearly all CBs highlight work to increase staff flu vaccination uptake. This year the UHB again achieved the 60% target, with an overall uptake of 60.7% and five of the

	eight CBs doing so. The highest uptake was achieved by CD&T at 70.6%. Of particular note are Surgical CB who vaccinated 60.9% of their front line staff by a combination of using their own proactive flu champions and resources made available by the UHB. This resulted in a 10% improvement on the same time last year and led to them winning the national Beat Flu 'Most Improved Campaign' Award. PCIC also report an improvement in childhood immunisation rates in the last 12 months, seeing the UHB now in third position in Wales from fifth. All CBs provided examples of implementing public health approaches: • Children and Women have appointed a Consultant Midwife for Vulnerable Women and Public Health. All women are given / directed to 'Bump, Baby and Beyond' and given appropriate public health advice regarding smoking, diet, exercise advice in pregnancy, avoid illegal substances and having vaccinations • The 'Making Every Contact Count' approach is being adopted in out-patient settings by CD&T and this was further developed in 2018/19 to include level 2 motivational interventions. • Patients continue to be pre-assessed prior to undergoing a General Anaesthetic in Dental CB and are provided with appropriate evidence based written and verbal information on weight management, smoking cessation and safe alcohol limits. • 'Choose well Campaigns' are well embedded within the Emergency Department in Medicine CB. • Mental Health CBs rehabilitation and recovery service offers support and healthy lifestyle promotion through the Recovery College • The main service focus for the commissioned services within PCIC, and the clinical board provided services, is promoting prevention, self care and well being from a physical, emotional and psychological perspective. MECC programmes and training is in place throughout the commissioned services. • All patients who attend a pre-operative assessment in Surgical CB are, if required, given advice on smoking cessation, safe alcohol limits and healthy weight management. Smoking cessation was a specific focus for many: • Women and Children are working closely with public health wales to reduce smoking in pregnancy and increase referrals to smoking cessation agencies. All women have validated CO monitoring at booking and

	again at 28 weeks. • Smoking Cessation is discussed at patient consultation appointments in Dental Clinical Board and the outcome recorded on the Clinical Outcome Form. Patients are automatically referred to the service • Medicine CB promote smoking cessation and awareness raising in all clinics and inpatient areas. They are exploring the feasibility of increasing provision of nicotine replacement therapy in Emergency/Acute medicine and linking with smoking cessation services. • In Surgical CB all smokers who attend pre assessment are highlighted as smokers on PMS, which automatically informs the smoking cessation service • In Specialist CB, cardiology have improved referral rates with support from Public Health. Smoking status is included in Cardiology Board Rounds and all smokers are referred to Smoking Cessation services Work around dementia is again evident in the self-assessment returns: • The Dental Directorate has a Dementia Lead and staff have completed the E Learning module. • Within Mental Health CB, Solace provide regular Carer support groups for those caring for individuals with dementia. • PCIC has a Dementia plan and is working closely with Public health and Mental Health to provide support to reduce waiting times and improve access to early diagnosis. Many departments have Dementia champions with some clusters working towards 'Dementia friendly environments/Communities'. • Surgical Clinical Board has a dementia care plan and some very proactive staff who embrace this agenda, leading to action around improving environments for those with cognitive impairment and auditing the use of 'Read About Me'. Dental CB has also taken a systematic approach to supporting patients with sensory loss. The UHB has a comprehensive approach to supporting Staff Health and Wellbeing with several CBs identifying specific initiatives: • Obstetric and Gynaecology Directorate is signed up to the Caring For You Charter with staff side support to promote health and wellbeing of staff with events held throughout the year. • Community Child Health have had a successful bid to support staff wellbeing. A resilience film has already

	been rolled out, and an external psychologist sourced to provide sessions for frontline staff and managers to support resilience. • CD&T is working collaboratively with Public Health Wales to deliver a package designed to encourage increased activity, healthy eating and mindfulness in the work place. • Medicine CB report that staff health and well being are supported using the relevant corporate services, such as case management for violence and aggression incidents and referrals to Occupational Health and Well Being services as part of new sickness reporting. Women and Children CB reported a wide range of initiatives to support the health and wellbeing of children, including those to support breast feeding. As in previous years, the CB returns made little mention of specific action to support carers. Minimal evidence was provided of partnership activity and no mention was made of action to reduce inequalities or the Well-Being of Future Generations (WBFG) Act. The UHB is an active participant in local partnership structures and contributes to the partnership response to the WBFG Act, as well as delivering its own organisational responsibilities in relation to the Act, with an emphasis on shifting care into community settings and primary care services. It has also recently become a signatory to the Active Travel Charter for Cardiff and has launched flagship Next Bike and Park and Ride Schemes. The UHB uses needs assessment, including evidence of inequalities, to inform its annual and strategic plans. Service delivery in communities is often informed by the evidence on inequalities, for example provision of smoking cessation services. Healthcare associated infections, and action to address them, are comprehensively reviewed at the UHBs Infection Prevention and Control Group. All CBs are expected to attend. Population Health Protection and Screening Services are provided to the population of Cardiff and Vale by Public Health Wales. Governance and reporting arrangements are in place to monitor delivery and performance.

R **Recommendation**	**The following improvement actions have been identified as key deliverables for 2019/20** **1.** Adopt a systematic approach to recording of smoking status and referral to smoking cessation services **2.** Deliver the UHB commitments in the HealthyTravel Charter **3.** Maintain a focus on improving uptake of staff flu immunisation 4. Improve recording of BMI in patients and appropriate onward referral to weight management services 5. Increase the numbers of people accepting the invitation for screening In addition, Clinical Boards should report the action they deliver in relation to: 1. Supporting carers 2. The Sustainable Development Principle of the WBFG Act 3. Reducing inequalities in disadvantaged groups 4. Working with partners

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**Standard 2.1 Managing Risk and Promoting Health and Safety** *People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.*
B **Background**	***Meeting the Standard*** Compliance to the standard is monitored both internally and by Statutory Bodies. These include HSE Fire Authority and Environmental Health. Cardiff and Vale University Health Board (UHB) is committed to ensure that all of its health and safety and statutory and mandatory obligations are achieved. It recognises that in order to meet these requirements, it is necessary to actively promote, engage staff and monitor health and safety performance. The Health Board has a Health and Safety Policy and a number of supporting policies and procedures with an aim of reducing or preventing incidents. It has a Health and Safety Committee which is a full Committee of the Board, this ensures robust governance and effective communication within the Health Board. The Committee's membership includes Board Members, Management, Safety Specialists and Trade Union/staff representatives. The Committee has four formal sub groups; these are Operational Health and Safety Group, the Fire Safety Group, Water Safety Group and the Personal Safety and Security Strategy Group in the delivery of health and safety responsibilities. Each Clinical & Service Board has have formal Health & Safety Meetings reporting into the above. The Chief Executive has appointed the Executive Director of Workforce and organisational development as Executive lead for Health & Safety including Violence and the Executive Director of Planning as the Executive lead for Fire. To ensure Health and Safety Representatives participate

	at every level, the Lead and Deputy Lead H&S Staff Side Reps will sit on the Health and Safety Committee, Operational Health and Safety Group, and the other groups. Risk Assessments are undertaken for Health & Safety. Risks which are added as appropriate to the Corporate Risk Assurance Framework. Formal Fire Risks assessment are carried out on all Health Board Premises. All incidents are reported via an electronic incident reporting system. Incidents are investigated in the first instance by the local manager and subject to an assessment by the relevant Adviser a more detailed investigation may be undertaken. The Health Board has a Health & Safety Department, Fire Safety Team, an Occupational Health Department and Well Being Service for Staff, Health & Safety, Fire Manual Handling and Personal Safety Training is delivered and refreshed to all staff at risk. All H&S Policies status is reviewed at each Health & Safety Committee within their review period. The NHS Wales launched an Obligatory Response of Violence in the Healthcare Sector. In November. This has been strongly supported by the Health Board, taking the lead on many aspects.
A **Assessment**	An Annual Report was submitted to the Health & Safety Committee in July to provide assurance to the Committee that the Health Board's health and safety risks have been appropriately managed during 2017/18. During the period The Chief Executive appointed the Executive Director of Workforce and organisational development as Executive lead for Health & Safety including Violence. The Health Board has continued to pursue a prioritised approach in eight identified strategic areas for action, these being: 1. Health and Safety Management Structure (including incident reporting) 2. Violence and Aggression Management 3. Manual Handling 4. Health Issues 5. Environment Safety and Health and Safety Patient Issues

	6. Fire Safety Management 7. Health and Safety Estates Management. 8. Sharps Safety Priority Improvement plan was considered at each Committee and Sub Group during the period demonstrating continued improvement. Regular Fire Reports were presented to Committee demonstrating that all of the 500+ areas within the Health Boards Premises are Fire Risk Assessed. Report confirmed that every area has a designated Deputy Fire Officer. Reports also demonstrate a 31% reduction in the number of unwanted Fire Singles (False Alarms) during to period and improvement in fire training continued. An Annual Audit Report on Fire Compliance was also submitted to the relevant Shared Services department during the period. An Audit of Manual Handling Compliance was conducted during the period, visiting all relevant areas, the finding submitted to committee to give assurance that lifting and hygiene equipment were sufficient for need. The Board Assurance Framework approach was reviewed and rationalised during the period. The Annual Report demonstrated that 93% of Incidents reported on Datix have been closed. Only 2 of the 3,752 staff incidents remain awaiting review at the end of the period. H&S related mandatory training compliance has continued to be improved to above 80% compliance, fire training has also continued to improve during the period to 67%. These are reviewed at the Mandatory Training Steering group and the relevant H&S Groups. Environmental Health Inspections of our food preparation and dining facilities were all rated as either 4 of 5 stars. Contractor Control and Estates H&S compliance has been enhanced by the appointment of an additional Health and Safety Adviser who has reviewed the arrangements for non-estates contractors to maintain the same standard as those directly controlled by the estates department. Estates has also continued to enhance its contractor control and permit to work requirements.

	The Health Boards continues to lead the way in pursuing those people who assault our staff by offering support to staff and criminal action where appropriate. During the period a total of 150 police referrals and 81 convictions being completed. A number of roadshows were also run promoting the new Obligatory Response to Violence scheme.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for the coming period:** • Implement plans to further reduce both the number of actual fires and false alarms by a minimum of 10% during the coming period • Health & Safety & Fire Annual Report on performance and submit for assurance to the H&S Committee • Review the interrelationship between updated of Board Assurance Framework and Risk Assessment system and progress e Datix for risk assessment data base • Assess the compliance and status of the key risks of Manual Handling and Personal Safety with an aim implement finding to diminish the risk • Progress and deliver Health & Safety Training for managers

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**Health and Care Standard:** Standard 2.2 Preventing Pressure and Tissue Damage
B **Background**	**Please Confirm the rating from the following definitions*:*** **Progressing Towards the Standard**
A **Assessment**	The Pressure Damage Group have met monthly for the last 24 months and have progressed with many work streams during this period. This Task and Finish (T&F) Group is open to staff from all Clinical Boards and to Corporate Teams. Over last 12 months the Group has completed the following: • The Tissue Viability nurses and podiatry service provide education sessions and bespoke teaching on the wards and in the community setting and have been instrumental in the last three "Stop Pressure Ulcer" days. This is in addition to the work completed by Practice Educators within Clinical Boards. • The Tissue Viability nurses team have reviewed the training they provide to ensure it is fit for purpose and have relaunched the Wound Link Nurse role and have commenced link nurse days which have been well attended. • A pressure damage passport for patients who have pressure damage and are being transferred in or out of hospital has been developed and rolled out. • The TVN's have developed a flow chart with the Safeguarding Team for use when Children develop pressure damage. • The Pressure Damage T&F Group has looked at some of the complexities around the inpatient Bed Management Contract and have worked closely with Procurement and have been instrumental in gaining funding to be able to change every bed (apart from speciality areas such as Critical Care and Maternity) in the Health Board to a MMO 500 low rise bed along with a Promatt mattress. These beds and mattresses have been rolled out across the inpatient areas in the UHB in a structured fashion ensuring that staff are trained on the use of new Promatt mattresses

	which has replaced the older Primo mattress before the product is put in. Promatt is now used as the first choice basic mattress for general inpatient beds in the UHB. However bed availability remain a big problem for us in the community as our supplies are held in Joint Equipment Store (JES) and distributed as per order to patients home. However JES only hold a finite stock which often is exhausted and requires escalation to address. The UHB is often in a situation where demand strips availability, stock is collected and returned for maintenance/cleaning and return to stores within under 7 days. There is a next day delivery predominately for palliative patients. Bed selection criteria is available for staff to use to determine appropriate ordering. • Medicine Clinical Board have developed and trialled the use of stickers to be placed in the medical notes to highlight when an e-datix has been completed, this has since been rolled out to other Clinical Boards. The aim of this is to reduce duplication of reporting. These can be ordered via Oracle and are available to all areas of the UHB. • The Pressure Damage Health Care Standard that has been aligned to the T&F group to give assurance about the UHB performance against that standard and to develop a set of actions to address requisite improvements • E-referral system with accompanying documentation has been developed and introduced for TVN and Podiatry • Pathway for the Prevention and Treatment of Moisture Associated Skin Damage • Medicine Clinical Board have developed an educational book for staff and a patient care pathway for pressure damage • Medicine and PCIC are trialling a new approach to reporting only unavoidable health acquired grade 3/4 or unstageable pressure damage to the Safeguarding Team which is currently being evaluated • Annual Pressure Damage Prevalence Audit (Feb 2019) • As part of the Welsh government project to standardise documents used by nurses, the UHB TVNs have worked in collaboration with All Wales TVN colleagues to a standardise patient skin assessment tool. Their recommendation to introduce the Purpose T has been signed off by Health Boards and Trusts in Wales and endorsed by the All Wales Nurse Directors. Over the last 18 months the UHB Tissue viability Nurses have been liaising with the All Wales Network with a view to updating the All Wales Pressure Ulcer Reporting and Investigation Tool to support the overall compliance with completion as well as learning from clinical incidents. The

	Task and Finish Group made many suggestions and comments on the drafts documents which was fed back. In January 2019 an update to the All Wales Pressure Ulcer Reporting and Investigation Tool was shared via a Health Circular. This was taken to the February UHB Pressure Damage Task and Finish meeting on 18th February 2019 for discussion to review and to ascertain whether previous suggestions and alteration have been taken on board. The change set out in this circular negates the need for an initial notification to Welsh Government of pressure damage. The new system requires a report be provided to Welsh Government at the point where the investigation and review is completed. The new report will include details of the incident and the investigation that followed to be completed within 60 days. There were some initial concerns with regards to the contradictions in the new documents. The new the documents states that all category/grade 2, 3, 4 Unstageable and Suspected Deep Tissue Injury pressure ulcers, should be investigated using the All Wales Review Tool for Pressure Damage Investigation as this is a change to the current process An all Wales Device Related Pressure Ulcer Investigation tool has been developed in order to aid investigation in relation to device related pressure damage, it is indicated that health boards may choose to use this.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for 19/20** • Update and review the UHB audit tool documentation • Review of the UHB Total Bed Management contract for the community • Developing a standardised approach to formulary ordering and management • Progressing work to meet the Welsh Information Standards for reporting of all stages of pressure damage to WG and the safeguarding process • Implementation of Welsh Health Circular WHC(2018)051 to ensure the correct reporting processes are in place • Monitoring of Welsh Health Circular WHC(2018)051 developing a SoP to ensure and robust governance arrangements are in place • Roll out of the ‘Guidelines for the Prevention and Treatment of Moisture Associated Skin Damage’ (MASD)

	• Roll out the All Wales PURPOSE–T risk assessment across the UHB and all wales • Developing a process to review the learning from all serious incidents which were reported in 2018 • Review of our heel off-loading products as no standardisation across Wales

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**2.3 Falls prevention**
B **Background**	**Meeting the standard**
A **Assessment**	**People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability** There is a UHB procedure in place for assessing for risk of falls and formulating a care plan. Health and care monitoring audits review these. Community service compliance reports are available on PARIS to monitor completion of falls risk assessments and interventions. The new Falls Framework in the UHB advocates a standardised referral and assessment process across the area to facilitate access to services. This is also aided by the new Cardiff and Vale Community Falls Alliance, consisting of multiple services and organisations both internal and external to the UHB. Lightfoot data is being used to understand who and how people are accessing services and evaluate changes in service provision. This is in early stages. A direct referral pathway from WAST has been implemented (not yet permanently) in the Cardiff CRTs for patients attended following a fall. Staff are expected to report every patient fall regardless of the level of harm. Trends in incident reporting are included in the regular Integrated Quality, Safety and Experience report to Board. Those that meet the definition, are reported as serious incidents to Welsh Government and are also included in reports to Board. All serious incidents are investigated using the injurious falls assessment template. If there are significant concerns about

	care, a full RCA is undertaken so that the root causes and any necessary changes or improvement to practice can be identified and put in to place. Clinical Boards must provide assurance in relation to the quality of the investigation, the findings and what actions have been taken as part of the closure process with Welsh Government. **Falls prevention strategies are implemented based on national standards and evidence based guidelines.** The well-established Falls Delivery Group in the UHB has a strong presence on the National Taskforce group in Wales, ensuring the UHB is well informed on latest research and evidence and links between policies and frameworks. The Falls Delivery Group has representatives from each Clinical Board within the UHB and also from external organisations such as WAST, Care and Repair and Fire and Rescue. The UHB Falls Framework is based on NICE guidelines and evidence-based practice, including sharing of learning from Canterbury District Health Board in New Zealand as part of an alliance. The new FFFAP continuous inpatient falls audit, which commenced in 2019 and the UHB is involved in, reviews compliance with evidence bases in management of injurious falls. **People are assessed for risks to their own safety and the safety of others. A plan for managing risk is agreed between the person being cared for and those caring for them.** Community falls assessments undertaken by the CRTs/Day Hospitals/ECAS/FOPAL incorporate a multi factorial risk assessment, however there is significant variation in referral pathways into community falls services at present. The new 'Falls Framework: Reducing risk and harm' has set out a standardised approach to these processes which will lead to a more effective risk assessment process, focused on the principle of 'what matters to me'. All patients seen by the CRTs have a letter sent to their GP following their initial assessment and completion of treatment to provide information on their care plans. Enhanced Supervision is in place on wards within the Medicine Clinical Board for those at greatest risk. The Care Home Integrated Support Team (CHIST) in Cardiff provides support and training to care homes with high incidences

	of falls and related ambulance calls, as well as focusing on other areas. Within secondary care the falls risk assessment is embedded in the generic nursing assessment booklet and is used for all adult admissions. Compliance with this risk assessment is reviewed as part of the internal inspection programme and is also audited as part of the Health and Care Standards Monitoring Audit. In 2017 94% of inpatients were recorded as having documented evidence that their risk of falling had been assessed and the audit demonstrated that 90% of patients identified as being at risk of falls were recorded as having an up to date care plan being implemented and evaluated and 87% of care plans had been reviewed and were up-to-date. Investigations following all injurious falls review the risk assessments and care plans for the individual patient. A Falls pathway mapping exercise demonstrated that there was variation in the assessment and management of patients at risk of falls dependant on where they presented. With referral pathways in existence from EU and Barry Minor Injury Unit but not UHL Assessment Unit. Work by the new Cardiff and Vale Community Falls Alliance is focused on reducing variation in referral pathways and establishing links between services. Pathways and manual handling training is in place to support staff in using specialist lifting and manual handling equipment, however provision of hover jack lifting equipment is not UHB and there is currently no formal UHB training procedure in place for this equipment, although it is briefly covered during Manual Handling Training sessions. There is a UHB procedure in place to manage patients following a fall, as well as new Falls Simulation Training available to all inpatient wards, elements of which focus on the collaborative assessment and intervention planning of care for patients. A new inpatient falls information leaflet has also recently been developed and implemented, offering advice and contact details for patients and their families/carers on remaining mobile. **Staff receive appropriate information, training and supervision to ensure that people and their carers are safe** Current provision of falls training across the UHB is limited. All staff are able to access e-learning modules available around falls, although what is currently available is not suitable. The module is not mandated and uptake is poor and isn't well evaluated. There is induction training including falls provided to Health Care Support Workers by LED.

	Falls Brief Intervention training, along the lines of the MECC concept, has been developed by the National Taskforce and has been delivered to some staff groups within the UHB and partner organisations outside of it by limited numbers of staff. This is felt to be suitable for all staff, particularly new starters and junior staff, but requires a formal pathway for booking and delivery. There is information on wards about falls on new 'How are we doing?' information boards, and there are falls awareness posters in outpatient clinic waiting areas and on display screens. Huddles/Safety Briefings take place on wards to discuss patients at high risk and requiring extra support. Simulation training is now available to all inpatient staff, which has been recommended by the Falls Delivery Group and features in the new Falls Framework. Training leads have attended sessions, but uptake has been low from wards despite consistent encouragement and prompting. Information on rates and trends is provided at each Falls Delivery Group meeting, which has representatives from each clinical board and partner services, who can disseminate this information to their respective services. All care homes in the Vale of Glamorgan have been offered falls awareness training while in Cardiff the Care Home Integrated Support team has been developed to offer support and education to care homes with the highest falls occurrence. **People are encouraged to develop or maintain the level of independence they wish, striking a responsible balance between risk and safety**. The Falls Framework actively encourages staff to avoid being risk averse and to promote activity and independence. Strength and balance training is well provided in the UHB, particularly in Day Hospital and CRT settings, where the Individual Strength and Balance Programme (ISBP) is used. Inpatients have started implementing the ISBP on the wards, with ongoing work to connect this to the community services. There is provision of falls specific National exercise referral scheme in the Vale but not in Cardiff. The Royal Voluntary Service also provide 'Move it or lose it' exercise groups on the wards at St David's Hospital and UHL. People are encouraged to develop or maintain the level of independence they wish, striking a responsible balance between risk and safety. The 'Get Up, Get Dressed, Get Moving' initiative

	has been rolled out across the UHB following the success of the End PJ Paralysis campaign. The new inpatient falls leaflet is linked to this. In the community patients receive the 'Get up and go' booklet from the Chartered Society of Physiotherapy. Stay Steady clinics are now available in two locations in Cardiff, with the aim of spreading across the whole UHB area if funding is secured from the transformation bid. These provide easy-access assessments of strength and balance and other falls risks for those at lower risk of falls, to take a preventative upstreaming approach to reducing falls and injuries. Patients can self-refer via the Independent Living Services in Cardiff, who also provide a single point of contact for falls in Cardiff. These elements are part of the Pacesetter funding. Home hazards assessments are completed by CRTs and Day Hospitals, and also by partner services such as Care and Repair and Fire and Rescue Service. In Cardiff, Age Connects are commissioned by the CRTs to complete home hazard checks. However, there is a lack of joined up approach to this and awareness of what input other services have already had. This is now being addressed by the Cardiff and Vale Community Falls Alliance. **People are able to summon help easily at all times, using a telephone, bell or other convenient means. If unable to do so their needs will be checked regularly**. The National Audit of Inpatient Falls 2017 demonstrated that in UHW 79% of patients had a call bell to hand while in UHL only 56% of patient were able to access their call bell. There are plans to repeat this audit of call bells imminently. Intentional rounding is in place on wards for those unable to use a call bell to summon help. In the community all patients at risk of falls, particularly those who live alone, are offered community alarms and provided with the relevant information on them. Patients on the ISBP with the CRTs have regular telephone reviews to assess how they are getting on.
R Recommendation	**The following improvement actions have been identified as key deliverables for 19/20** • The Falls pathway has been identified as a priority for the Health Pathways programme of work associated with Canterbury the Cardiff and Vale way • The Falls Delivery Group will form the basis for the development of a falls alliance for Cardiff and The Vale of

	Glamorgan • Evaluation of the Pace setter funded model for the Community • Simulation suite training to spread and embed • Implementation of Falls strategy aligned to the work on Pathway transformation and development of an Alliance approach • Follow up audit of call bells • Review of the procurement and governance of hover jack equipment and training • Standardisation of advice around lying and standing BP recording • Revision of the ambulatory care pathway • Development of the Community Falls Prevention Alliance to produce actionable recommendations • Set up of an Inpatient Falls Prevention Alliance • Ongoing development of Nursing e-documentation elated to falls risk on wards (All Wales) • Pursue funding for improved pathway from EU to community services for people aged 75+ at risk of falls

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**Health and Care Standard 2.4** **Infection Prevention and Control**
B **Background**	***Progressing Towards the Standard*** The IP&C team provides support to the Clinical boards and is structured to provide specific named IP&C nurse support to each Clinical Board. **Currently:** Medicine, Surgery, Children & Women, Specialist Services, PCIC and Mental Health each have a designated IP&C Nurse lead from the team. Dental have their own IP&C nurse arrangement which links in with the IP&C team. CD&T is supported by the Senior Nurse for IP&C. IP&C Doctor support is provided by 2 Consultant Microbiologists - 1 supports UHW and PCIC, the second provides support for UHL, Barry, Rookwood and St David's hospitals. The IP&C team is responsible for providing training in IP&C, developing IP&C policies and procedures for the organisation, managing outbreaks of infections, and much more. All these aspects of work have been delivered.
A **Assessment**	**HCAI** Across the UHB improvements and achievements have been made to reduce preventable healthcare associated infections. Cardiff and Vale UHB were one of only two Health Boards in Wales to achieve the reduction goal for *C. difficile* for 2018/19 for the second year running. Disappointingly for *S.aureus* as a whole C&VUHB has again exceeded the reduction goal, this financial year 2018/19 by 75 cases. Having previously seen an improvement in incidence of Meticillin sensitive Staph aureus (MSSA) bacteraemia C&VUHB has seen an increase. This year has also seen an

	increase in the numbers of MRSA bacteraemia by 6 cases. C&VUHB achieved a reduction in the number of cases to reduce *E.coli* bacteraemia to no more than 60 per 100,000 population; however, the reduction goal was not achieved. The goal was not achieved by any Health Board/Trust in Wales. Despite not achieving the reduction goal, C&VUHB continues to have the lowest rate of *E.coli* bacteraemia per 100,000 population of all acute Health Boards in Wales. There were new challenges for us for 2018/19 with new reduction goals included for *Klebsiella* sp. and *Pseudomonas aeruginosa* bacteraemia. C&VUHB is the only Health Board to achieve the reduction expectation for *Klebsiella* sp. with a rate of 17.43 per 100,000 against an All Wales rate of 20.09 per 100,000 population. Unfortunately, the reduction goal for *Pseudomonas aeruginosa* was not achieved. Disappointingly there was an increase in the number of cases compared to the previous year. Clinical Boards are developing better systems for managing infection risks and learning from incidents, but practice remains variable. A challenge for next year is to ensure that Root Cause Analysis (RCA) is consistently undertaken by all relevant members of the Multi-Disciplinary Team to identify which infections are healthcare associated and so that lessons learned and best practice can be rapidly shared between clinical boards to facilitate standardisation of practice, standardisation of equipment used, and reduce variation. Continued rollout of interventions to reduce community onset healthcare associated Gram negative bacteraemia will be key. This includes a trial of a product to improve the collection of mid-stream urine which in turn leads to more appropriate prescribing to treat urinary tract infections. The corporate IP&C team is small and it continues to be challenging to continue proactive preventative work when managing major outbreaks and incidents such as VRE on Haematology/BMTU, CPE incident in Medicine, TB in the prison, Gastroscope/colonoscope decontamination incident, failure of the RO plant in the HSDU and, in the winter months, widespread flu and norovirus outbreaks, particularly in the unscheduled care units and medical wards.

	Following a review of the requirements of the Clinical Boards and the PADR process within the core IP&C team, the structure of the team to specifically support clinical boards has been altered. Improvements in review and consultation on IP&C procedures are resulting in continued improvement in communication and engagement between the IP&C team and Clinical Boards. Additionally IP&C nurses have been involved with the development of a pilot bacteraemia ward rounds; the aim is to review all patients in UHW with significant bacteraemias and provide holistic infection management advice, including IP&C advice where relevant. The aim is to optimise patient care and improve AMR rates and IP&C standards. **Cleaning** Environment and equipment decontamination continues to be a challenge at times however the IP&C team aims to work collaboratively with Housekeeping and Estates with monthly joint audits arranged in both UHW and UHL. Attendance by estates staff remains poor and needs further discussion with the managers. The IP&C team receives monthly reports of the C4C audit results and follow up with the housekeeping managers any areas that have not achieved the minimal compliance score. The age of our estate in many areas hampers effective cleaning and few of the IP&C environmental audits achieve a high pass. This has been identified as a contributing factor in serious outbreaks/incidents of infection including an outbreak of VRE in Haematology/BMTU resulting in decant from and refurbishment of the clinical areas. HPV decontamination of environments and equipment continues to be utilised more, particularly during periods of increased incidents/outbreaks of infection. New UV equipment has been purchased for use in the acute sites to support a more proactive decontamination programme. **Isolation/single room availability** The availability of side rooms continues to be a challenge, particularly for patients being admitted with or suspected to have an infection, and during the winter months when the incidence of respiratory and gastroenteritis illness is higher. Staff have to risk assess daily to prioritise patients for the single rooms.

	Audit There is a plan for audit to be undertaken by the IP&C nurses for 2019/20.This includes: • Monthly pre-arranged joint audits of the environment in clinical areas in conjunction with Housekeeping, Estates and the Ward Sister/Charge Nurse. • Six monthly validation audits of all acute inpatient areas, which will include core audits of the environment, equipment, linen, commodes and beds/mattresses in clinical areas. Other non-acute inpatient areas will be audited yearly and prioritised according to risk and incidence of infection. • Additional audits will be conducted in the event of an outbreak or period of increased incidence (PII). • Audit results will be discussed initially with the Ward Sister/Charge Nurse and support will be provided towards resolving any issues highlighted during the audits. • Audit results will be fed back formally to the teams including lead and senior nurses in the form of an Action Plan. It is agreed that Ward Sisters/Charge Nurses will complete and return the Action Plan within three weeks to the IP&C team and the Senior Nurse team. Clinical areas failing specific audits will be re-audited once the Audit Action Plan has been completed by Ward Sisters/Charge Nurses. • Compliance with C&VUHB policies and procedures (e.g. MRSA, MDRO Admission Screening) will be conducted alongside core audits and fed back to the clinical teams. Additional audits may be conducted according to identified needs within the UHB as a whole. • IP&C audit results will be fed back to the Clinical Boards in QSPE and the IP&C Meetings. **Education** The IP&C team provides education and training on IP&C and supports the implementation of the policies and procedures and best practice in IP&C. Education provided by the team includes: • The UHB programme for Induction Training, including Consultant and senior medical staff, and as a supplement to Mandatory Training (e-learning). • Education in response to audit findings, outbreaks, periods of increased incidence (PII) and emerging infections. • Clinical Board education programmes in collaboration with the Clinical Board Practice Educators/Ward Sisters/Charge

	Nurses/Senior nurses. • Collaborate with LED and Clinical Board Practice Educators to support continuing IP&C improvements and introduction of new IP&C practices and products (e.g. ANTT). • Limited support for mandatory mask fit testing in Clinical Boards in conjunction with Practice Educators and designated fit testers. • Work with the Higher Education Institutes to provide learning placements for students and develop education tool to support a good foundation in IP&C practice. • Ad-hoc training is delivered in relation to outbreak management, Personal Protective Equipment and Periods of Increased Incidence of infection. Specific training is also be delivered in support of new IP&C procedures. IPCT engage with local Universities and provide education support for IP&C related topics. **Other areas of work** The IP&C Team work collaboratively with many other groups both within and out with the Health Board, these include: • Water Safety Group • C&VUHB Decontamination Group • All Wales Decontamination Group • Procurement - local and national • Antimicrobial Resistance Group – local and national • Medical Gas Group • ANTT – local and national • Clinical Standards and Innovation Group • Clinical Board Q&S meetings • Big Room • C section surveillance steering group – national • IP&C Neonatal Advisory Group – national • Mandatory Training Steering Group – local • HCAI Delivery Board – national
R Recommendation	**The following improvement actions have been identified as key deliverables for 2019/20** **Clinical Boards** • Continue to work to deliver the standard • Develop an Annual Programme for IP&C • Continue to roll out ANTT to all relevant staff, including medical staff, and ensure allocation of time for staff to attend training, time and IT access to undertake the e-learning module, and purchase of appropriate equipment. • Continue with the RCA process to ensure a

	multidisciplinary approach and to make sure lessons are learned from incidents/outbreaks of healthcare associated infection. • Ensure there is a rolling programme for maintenance or replacement of equipment. • Work with Capital & Estates to develop a rolling programme for ward/department refurbishment and to ensure the IP&C team is involved at the start of Capital projects related to new builds **IP&C Team** • Support the Clinical Boards to deliver the standard • Continue to support the antimicrobial resistance delivery plan • Work closely with C&V and NHSSS procurement departments to standardise products and equipment in use and to eliminate unnecessary costs to the Health Board • Work with relevant Clinical Boards to develop further robust winter plans to deal with outbreaks of infections e.g. norovirus, influenza, to avoid disruption to patient flow • Continue to work with companies and suppliers to ensure support with audit and education and promotional opportunities e.g. WHO Hand Hygiene Awareness week • Continue to develop the IP&C Link Practitioner programme to ensure that engaged and knowledgeable staff are out in clinical areas to support the IP&C agenda • Continue to support the AMR Patient Safety walkabout programme with the Medical Director

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS MAY 2019

S **Situation**	**Healthcare standard 2.5 – Primary Outcome:** **People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury**
B **Background**	In 2018/19 the corporate review of the standard has enabled us to give the assurance that the UHB is 'Progressing towards the standard'. The primary outcome of people supported to meet their nutritional and hydration needs is multifactorial and Health Board evidence is based on the following driver diagram (appendix 1). **http://www.wales.nhs.uk/governance-emanual/health-and-care-standards-supporting-gui-14** Additionally the Patient Nutrition, Hydration and Catering Experience Management action plan has been developed to continue to gather evidence and address the ten key recommendations set out in the Public Accounts Committee report on Hospital Catering and Patient Nutrition ensuring that all elements of Nutrition and Hydration Standard 2.5 are being met. A review of the action plan document are monitored, reviewed and reported to the Nutrition and Catering Steering Group.
A **Assessment**	Good progress has been made in many areas notably staff catering and public health with reference to the delivery of the corporate health standard framework. The implementation of a model ward across four wards within the Health Board has enabled a standardisation of nutrition and hydration practices across the inpatient setting. Data is being gathered in real time around outcomes following a successful bid to the UHB Health Charity. Model ward has also been accepted as a Bevan Exemplar and for a pathways to portfolio research grant. Further evidence for this assessment has been collected through the audits and a cohort of questions to the clinical boards to provide a level of assurance against the standard. The refreshed two week menu cycle has been embedded across the UHB as well as specific menus to meet the needs

of maternity and specialist clinical areas.

Highly coloured crockery arrived for all areas of the Health Board in April to improve the mealtime experience of our patients. (Appendix 2).

Collated responses from a recent CHC visit food and drink review can be read in Appendix 3.

Nutrition education training has been delivered across the UHB to a range of staff including qualified nursing health care support workers and facilities staff. Nutrition nurses have a rolling programme of training for nasogastric tube placement, gastrostomy aftercare and competencies delivered to both qualified nurses and medical students 48.

Training	Frequency	Staff Group
'Online'		
All Wales Food and Fluid chart e-learning	On line	Available to all staff groups
Induction/Foundation		
Nurse Foundation Training inc sessions on enteral feeding, ONS and HCS 2.5	X4 per year (3 hours)	Newly qualified Band 5 staff (not women and children's services)
HCSW Induction training	12 per year	HCSW
General Nutrition and Dietetics		
Agored Unit NH22CY024	xFour per year	HCSW
Essential Ward Based Catering training inc allergen updates	Ongoing, all sites	WBC and supervisors
IDDSI updates for WBC	All sites, x1 event	WBC and supervisors

The following collated responses have been sourced from the Health Care Monitoring System within corporate nursing

1) What is your Clinical Boards percentage compliance to:

	a. Undertaking nutrition risk screening within 24 hours of admission? Children & Women - 99.59% Medicine - 93.83% Mental Health - 86.67% Specialist - 95.72% Surgery - 96.36% **b. Weighing patients within 24 hours of admission?** Children & Women- 100% Medicine- 93.53% Mental Health- 98.82% Specialist- 95.51% Surgery- 89% **2) Describe the strategies within your clinical board to ensure that inpatients are prepared for a mealtime with respect to:** **a) Preparing the environment** Patient tables/trolleys are cleared of any clutter and cleaned, and placed near the patient. Some areas have lunch clubs and will ask patients to join a group of patients to socialise whilst having their meals. All of our wards try to protect mealtimes with varying degrees of success; the Health Board fully supports the principles of John's campaign in families' involvement at mealtimes. **b) Preparing the patient** Patients are assisted to wash hands or use hand wipes, ensure that they are positioned correctly to eat meals and ensure appropriate oral care/dentures are available. This was a particular focus within the model ward. Mobilising patients to and from bathroom facilities before and after meals supports the Health Board's focus on preventing deconditioning. **C) Supervision of the mealtime** The principles of John's campaign and the model wards for Nutrition and Hydration has a renewed focus on mealtime supervision and roles and responsibilities. Directorates employ protected mealtimes wherever possible barring emergencies/urgent patient issues, except unscheduled care. Carers are able to support patients during meal times if required. Patients being specialled are supported by their nurse. Bed plan identifies patients requiring assistance and identified at safety briefing.

	Parents supervise their own children at meal times, if parents not present which is rare, then play specialists/HCSWs supervise. Where possible qualified staff are allocated to oversee mealtimes but again this is dependent on to acuity of the patients on the ward. The Nutrition and Hydration Bedplan is available in all areas across the UHB. Nurse handover information and safety briefings includes key information from the bed plan. **3) Health standard 2.5 states 7 beverage rounds should be undertaken within a 24 hour period. Facilities services are responsible for 6 of these, nursing teams should undertake the 7th at bedtime. Across your Clinical Board what is the percentage compliance with a nursing bedtime drinks round?** Children & Women - 66.67% Medicine - 73.08% Mental Health - 100% Specialist - 63.64% Surgery - 86.67% Results from dietetic nutritional screening audit was presented to the Nursing Clinical Standards and Innovation Group. (Appendix 4) Model ward data showed significant improvements in screening within 24hrs of admission compared to baseline (Appendix 5).
R Recommendation	**The following improvement actions have been identified as key deliverables for 2019/20** • The Nutrition and Hydration Bed plan to be embedded in ward routine and processes as the tool that is used to record patient's dietary needs and for the Nursing and Midwifery Board to mandate its use for all wards across the UHB requires further work. • Ward Managers take up the role of supporting the implementation of the bed plan on the ward through raising awareness of the benefits of using the tool and auditing its use on the ward. • Review the role of the qualified nurse in overseeing the meal service and develop a role profile. • Ensure new descriptor for dysphagia International Dysphagia Diet Standardisation Initative (IDDSI) knowledge is embedded across the Health Board. • Development of a suite of models of delivery for nutrition training offer in the light of reduction in nurse induction

	time. • Address concerns highlighted in the CHC visit and HIW report around nutrition and hydration at front door following. No funded dietetic service in the Emergency Unit. • Subject to business case approval the Implementation of All Wales catering IT system. • Roll out of model ward for Nutrition and Hydration to other wards in the UHB subject to a funding stream. • Roll out of essential nutrition training for ward based caterers to include allergy and IDDSI.

S **Situation**	Standard 2.6 Medicines management (Corporate) Self-assessment completed April 2019 **Overall rating: Getting there**
B **Background**	The overall conclusion is that the Health Board is **Getting there** The rationale for this is that, whilst there are some areas of very good quality and consistent practice in relation to safe and effective medicines management and very good governance processes, this is not yet consistently evidenced across the Health Board. Improvements over the past year include the widespread implementation of MTeD (electronic discharge) on all wards, except Mental Health and some specialised day units. In addition, a "discharge on demand" functionality is available and a standardised order set for routine procedures will be introduced imminently. The links to the Community Pharmacy Choose Pharmacy platform facilitate discharge communication to primary care, safe transfer of patient care and supports post discharge medicines review with patients. All target outpatient clinics have implemented electronic prescription generation (COPPS). An out-patients transformation/partnership project is progressing and will improve the patient experience and release staff to make further improvements in discharge communication and patient education. Dissemination and actions related to Patient Safety Notices and internal communication of medication safety issues is led by the Medicines Safety Executive (reporting to corporate Medicines Management Group). Effective sharing of lessons from medication-related incidents is supported through this process, including a widely circulated monthly medicines safety briefing. Systems to manage the UHB joint formulary and manage the entry of new medicines are well embedded. The New Treatment Fund has supported timely and robust patient access to new medicines. Medicines-related procedures have been updated to align with the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal published November 2015 (update imminent) and a single UHB

	Medicines Code was launched in November 2017 and is now fully embedded with a six monthly review. A Health Board wide audit of all inpatient areas relating to storage and security has been undertaken supported by Clinical Board Nurse Directors and the Nurse Advisor and is now part of formal annual audit schedule. Continued development of Antimicrobial stewardship across primary and secondary care remains a challenge due to lack of resource and clinical engagement. Positive outcomes have been realised in relation to HCAI but these may not be sustainable. The UHB enabling medicines management project for 2019-20 will include a focus on antimicrobial resistance targets and will improve medical engagement. A patient medicines helpline to support provision of information and advice (after hospital discharge or outpatient consultation) is available and learning is monitored and fed on to the Pharmacy Medicines Management Practice Group to inform our improvement strategy.
A Assessment	Medication chart (prescribing and administration, including omitted and delayed doses) audits need to be fully implemented and reported with supporting remedial action plans across all sectors (including district nursing and domiciliary care). Audit tools have been tested across the UHB and a date for full audit is to be agreed. Recent NICE guidance on management of controlled drugs in hospitals (May 2016) has been used to support review of all related processes across primary and secondary care, via the Local Intelligence Network. All Nursing and Midwifery education on good medicines management practice has been updated to reflect the removal of NMC Standards for Medicines and references Royal Pharmaceutical Society guidance. Wales e-learning programme is available and well publicised across the UHB and must be completed by any registered nursing staff who have not had a medicines update in the preceding three years. Extensive work to update non-medical prescribing processes in the UHB. All NMPs will have an updated scope of practice (May 2019) with a robust process to maintain this linked to annual PADR thereafter. A UHB NMP Forum has been established to support NMPs across all relevant professions to maintain competence and

	confidence in prescribing (in collaboration with HEIs. National Prescribing Indicator performance is maintained at a high standard and C&V performs best for number of practices meeting the NPI thresholds, with particular improvement in antimicrobial prescribing. Pain management shows greatest variation and is a specific focus for the Medicines Management Incentive Scheme 2019-20 (through a range of local actions). Improved access to the GP-record of a patient's medication has been implemented, and facilitates safe admission processes including medicines reconciliation. MTeD supports safe transfer of care at discharge. Yellow care (adverse event) reporting has increased across primary care and by pharmacists in secondary care.
R **Recommendation**	With the aim of achieving "Meeting the Standard", progress with each of the actions noted above will be monitored through the corporate Medicines Management Group. Specific areas for focus in 2019-20 are: • Strengthen medicines-related audits in non-ward areas and address findings • Medicines storage, security and destruction compliant with UHB Medicines Code (and updated MARRS policy when available) • Specific support to patients/carers in presence of sensory loss • Work to understand and reduce medicines-related admissions This assessment will be signed off by the interim Executive Medical Director and Independent member (Susan Elsmore) and through the corporate Medicines Management Group. April 2019

ANNUAL SELF ASSESSMENT
Health Care Standards
2.7 Safeguarding Children and Safeguarding Adults at Risk
April 2019

S **Situation**	**Standard 2.7 Safeguarding** Health services promote and protect the welfare and safety of children and adults at risk at all times. Clinical Boards (CB) across the UHB have completed self-assessments of their compliance with the Health Care Standard. Information has been shared directly with Clinical Board Nurse Directors and also through the UHB Safeguarding Steering Group (SSG). Safeguarding is everybody's business; all staff are expected to complete mandatory training and additional safeguarding training where appropriate.
B **Background**	**Leading the Way** The Health and Care Standards were launched by Welsh Government in April 2015. All Health Boards are required to complete an annual self-assessment of compliance against each of the 22 standards. CBs have self-assessed that they have increased awareness and provided contextual narrative to provide assurance to the corporate team. The corporate assessment has been elevated from the previous year definition of meeting the standard to a self-assessment of leading the way. The process for 2019-2020 will be assessed by ensuring that safeguarding for the organisation as a whole is sustained at the current level to maintain the elevated position by providing an overall assurance of compliance for training, staff awareness of the expanding safeguarding agenda and monitoring through the SSG. The introduction of the Public Health Wales and Welsh Government Safeguarding Maturity Matrix in 2018/19 following an initial pilot will consolidate the UHB self-assessment position and give guidance to benchmarking with other Health Boards in Wales. The published report in January 2019 evidenced Cardiff and Vale University Health Board as working in line with other Health Boards in all areas and evidencing good Multi-Agency Partnership Working. All but one recommendations identified in 2018 are completed. Undertaking an audit for Children aged 16/17 years old has been carried over to 2019.

A **Assessment**	Standard considerations and compliance are: • Ensuring staff are aware of legislation, All Wales Child Protection Procedures (2008), All Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (2010), Social Services and Well-being (Wales) Act 2014, Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, Mental Health Act 1983, Mental Capacity Act 2005, updated NICE guidance - Child maltreatment: when to suspect maltreatment in under 18s (2018). All legislation information is available on the Safeguarding intranet web pages, CBs report that all grades of staff have access to computers and electronic access to CAV-WEB. Legislation is discussed at each safeguarding training session. Safeguarding children, safeguarding adults, VAWDASV and MCA are all part of the Mandatory Core Skills framework within the UHB. Cardiff and Vale Regional Safeguarding Board (RSB) has been commissioned by Welsh Government to write the Wales Safeguarding Procedures. The procedures are expected to be ready for publication by the summer 2019, a consultation period will be arranged. The procedures will replace the AWCPP and IPPPVA that are currently in use. MCA slides are embedded in the safeguarding adults at risk training to ensure that there is an awareness of the links between capacity and the protection of adults at risk. Safeguarding Nurse Advisors are affiliated with each CB and attend CB Quality & Safety (Q&S) Meetings to update on safeguarding twice a year. Each CB has Designated Lead Managers in place (DLM), safeguarding supervision is provided to DLMs from the safeguarding team. A session has been arranged for DLMs in May 2019 to re-visit the adult at risk process following an internal audit and a recently published HIW report from ABMU. CBs report that DLMs provide safeguarding feedback at CB Q&S meetings and that safeguarding is a standard agenda item. • Safeguarding services and processes are evident within the Clinical Board at all levels. Monthly Key Performance Indicators are collated from each CB establishing the amount of referrals made in relation to safeguard children and adults at risk, the data is shared at the bi-monthly Safeguarding Steering Group meeting and the quarterly Executive Quality and Safety meeting. There has been an increase in pressure damage reporting predominantly in PCIC, Medicine and Surgery

	CBs since implementation of the Social Services and Well-being Act. Discussions with Local Authorities regarding duty to report is on-going. A UHB six-month pilot commenced in December 2018 following agreement with the RSB. This involves only reporting avoidable pressure damage to the LA. Medicine and PCIC CB are undertaking the pilot with a view to roll out to all CBs if deemed successful following an audit by the Adult Audit sub-group of the RSB in July 2019. PCIC CB will introduce Annual Governance review visits during this year to include questions on safeguarding policies and staff training. • Effective multi-professional and multi-agency working and cooperation is in place. Practitioners routinely hold multi-disciplinary meetings to share information for discharge planning, complex needs and safeguarding strategy meetings for children and adults at risk. The launch of Cardiff Multi Agency Safeguarding Hub (MASH) in July 2016 demonstrates the UHB commitment to collaborative working with partner agencies as a strategic partner in the Cardiff MASH. There are good links and working partnerships with both Local Authorities and Police in the Cardiff and Vale UHB locality. Part 1V and Professional Concern arrangements with police and LAs are productive and demonstrate good partnership working. The Department of Sexual Health (DOSH) in PCIC CB has agreed a process with Cardiff RISE to use the skills of an Independent Domestic Violence Advocate (IDVA) within the department to support victims. C&W CB will audit the effectiveness of the Looked After Child service during 2019 and the MH CB will commence a pilot to support the Public Service call centre in conjunction with ABMU and Cwm Taf Health Boards. A representative from Advocacy Support Cymru will be presenting at the SSG meeting in May, to encourage all CBs to consider the use of an advocate in all appropriate adult at risk cases. • Staff are trained to recognise and act on issues or concerns, including sharing of information and sharing good practice and learning. There is a training programme available for six, all day level 3 sessions that cover safeguarding themes, these are available to all staff members and booked through the Learning & Education Department (LED). Mandatory

	training is available through classroom based training and e- learning. CBs give assurance that Mandatory Safeguarding Training compliance is over 75% which includes Safeguarding Children & Adults at risk. Mandatory Domestic Abuse training for Group 1 is 78.1%. Additional training includes PREVENT awareness, Safeguarding awareness for the chaplaincy and volunteer service, FGM, County Lines and Modern Slavery from August 2019 is also available. (DOSH) will complete an audit during 2019 of the use of SERAF in their assessments, this has been identified by the CB. HV service has identified that their routine enquiry recording for new mother's needs to be addressed, improved practitioner recording and compliance will be addressed during 2019. MH CB recognises that improved mandatory training compliance is required. • Staff and visitors know how to make their concern known. Staff are able to access the safeguarding web pages that contain details on how to make a referral; a safeguarding newsletter is shared with staff on a quarterly basis. A safeguarding team poster has been circulated to all clinical areas to notify staff how to contact the Safeguarding Team. The public facing screens in the concourse and out-patient areas are used to publicise campaigns such as White Ribbon. Staff at all levels should be able to inform visitors on how to raise a concern. The newly formed Youth Board is aware of how to raise concerns and will advertise this through social media and during visits around the Children's Hospital. The UHB "Putting things Right" information is advertised within key areas around the UHB. The UHB participated in the Regional Safeguarding Board (RSB) safeguarding week activities during November 2018. This included organised events in public areas at both UHW and UHL to raise awareness of domestic abuse. In addition information is visible across the UHB and on the intranet for staff to contact the complaints team and whistleblowing should a situation arise. CD&T CB report that a language line mobile interpreter on wheels is used in POD and is accessible to departments.

	• Providing services that enable children and adults at risk to express themselves and be cared for through the medium of Welsh is given priority. All CBs are able to identify Welsh speakers in departments. Some CBs will maintain a register and staff will have a logo on their uniform. Safeguarding recently published an information leaflet for parents in both Welsh and English. Any correspondence within the UHB can be translated as required. Children are encouraged to express themselves within the UHB by Children's Rights training being incorporated into all safeguarding training to staff who are able to advice and advocate in their care. • Suitable arrangements are in place for people who put their safety or that of others at risk to prevent abuse and neglect. Appropriate risk management is in place for lone workers such as HVs and CPNs. Arrangements such as Whistle blowing, "Freedom to Speak Out", supervision and collaborative working with identified employee groups are in place. The All Wales Child Protection Procedures (2008) and All Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (2010) are available in both hard copy or electronically within the UHB. A risk assessment to support staff and provide assurance to the UHB is completed by the line manager and Human Resources (HR) in all cases where an allegation has been made involving staff. Staff will be signposted to the UHB Emotional Well-being service, Occupational Health and their own General Practitioner. Since 2016 the UHB safeguarding team has raised awareness of Female Genital Mutilation (FGM) by providing additional bespoke training to specific groups within Midwifery, HV and school nursing. The UHB is working in partnership with Cardiff police and Cardiff LA to ensure that an appropriate response to the identified risk is undertaken. The UHB Midwifery service will be launching an FGM clinic in May 2018. This is the first such clinic in Wales. The UHB will be meeting with members of the community from an area in Cardiff along with Social Workers from Cardiff LA in May 2019, to raise awareness of the referral process, educate the community to the UK Law and to consult with them on how this affects their neighbourhood. This evidences good practice through

	engaging with the community. The UHB has purchased personal alarms for the use of staff and patients who are victims of domestic abuse, in some cases lone worker alarms will also be provided to staff. The Health, Independent Domestic Violence Advocate (IDVA) will provide advice and support in a number of cases. The safeguarding team will provide support to staff that are required to complete police or Court statements. • Any identified risk is managed in a way that empowers people to feel in control of their own life Patient and staff surveys are in place across CBs to empower individuals to express themselves. Risk assessments should be completed for children aged 16-17 years admitted to adult wards. It is unclear if there is compliance across all areas, a corporate audit will be considered for 2019. South Wales Police presented the Anti-Violence Collaborative- obligatory responses to violence in healthcare at the UHB SSG meeting in March 2019. The report has been relaunched in 2018 and recognises that NHS staff are amongst the most likely to face violence and abuse during the course of their employment. The legislation introduces a new offence for minor assaults, affords greater protection for staff through increased penalties for offenders convicted of assault. • Each Clinical Board has arrangements in place to respond effectively to changing circumstances and regularly review achievements. The Safeguarding Steering Group (SSG) disseminates learning from Child and Adult Practice Reviews and published Domestic Homicide Reviews to influence future practice. Information cascaded at the SSG meeting is shared at CB Q& S meetings. Provider Performance Reviews in PCIC CB demonstrates a collaborative approach to safeguarding and are proactive in maintaining standards. CB Directors of Nursing report safeguarding and professional concerns regularly to the Executive Nurse Director at Professional Performance Review meetings. Mandatory safeguarding training is monitored through Pay Progression/PADR. C&W CB report that all frontline staff are encouraged to attend Level 3 safeguarding training, this is in line with the Intercollegiate Document.

	There is on-going work with both child / adult practice reviews and Domestic Homicide Reviews (DHR) this year with publication of reports and action plans shared at the SSG with all CBs. Mental Health CB are able to evidence that assessments for clients in a parental role are undertaken, an audit with Public Health Wales has been shared at an SSG meeting, the action plan completion will be discussed at a future meeting. The UHB will undertake an audit during 2019 to evaluate the support offered to staff involved with a child or adult practice review, this has been identified during completion of the 2018 Safeguarding Maturity Matrix (SMM). Safeguarding supervision is embedded within child health services and DLM professionals across the UHB, with the launch of a specific Cardiff and Vale UHB safeguarding pathway launched in September 2018. The supervision pathway had been piloted with Health Visitors over an 18 month period and evaluated by Cardiff University, the pathway has been shared at the CNO Conference in May 2018 and the Public Health Wales Safeguarding Network. Further evaluation work will be undertaken with the HV service in 2019 by Cardiff University. The UHB pathway has been presented at an RCN Education Conference in Bristol. The continued progress of work within the Multi-Agency Safeguarding Hub (MASH) as well as the Regional Safeguarding Board demonstrates the UHB commitment to partnership working at all levels. Attendance and participation at all meetings arranged by PHW National Safeguarding Team; evidences the UHB allegiance to working at a strategic level with other HBs in Wales. Thus ensuring that practice and standards are maintained to provide a consistent approach to the evolving safeguarding agenda.
R **Recommendation**	Cardiff and Vale UHB is able to demonstrate reasonable evidence to support that it is **Leading the way** with this standard in a number of areas. To effectively sustain this status the UHB will need to continually consider areas of development and demonstrate on-going innovativeness to raise awareness of emerging safeguarding themes; areas that will require further advancement are:

	• PCIC CB will introduce Annual Governance review visits during this year to include questions on safeguarding policies and staff training. • C&W CB will audit the effectiveness of the Looked After Child service during 2019. • MH CB will commence a pilot to support the Public Service call centre in conjunction with ABMU and Cwm Taf Health Boards. • (DOSH) will complete an audit during 2019 of the use of SERAF. • MH CB recognises that improved mandatory training compliance is required, measures to be introduced to improve the current situation. • Undertake a corporate audit to ensure that the needs of children aged 16-17 years admitted to adult wards are met and documented on a risk assessment check list • The UHB will undertake an audit during 2019 to evaluate the support offered to staff involved with a child or adult practice review • Continued compliance with the duty to report and investigate cases of child or adult at risk cases where abuse or neglect is suspected using the framework within the Social Services and Well-being Act (2014).

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**2.8 Blood Management** **People have timely access to safe and sufficient supply of blood, blood products and blood components when needed**
B **Background**	**Please Confirm the rating from the following definitions*:*** **Progressing Towards the Standard**
A **Assessment**	The UHW transfusion laboratory was inspected by the MHRA against the BSQR 2005 regulations in Dec 2018. Two major non conformities were identified. These have been addressed, with actions completed. In April 2019 the transfusion laboratory was inspected as part of the haematology department by the United Kingdom Accreditation Service against the ISO 15189:2012 standards. Accreditation was maintained with very positive feedback from the inspectors. As part of the response to the MHRA inspection CD+T have developed a 'Regulatory Compliance Group' (see recommendations). The transfusion laboratory participates in the National Blood Stock Management Scheme and has a local procedure to optimise stock management. The UHB has a 'Blood and platelet shortage planning procedure' in line with national guidelines and successfully responded to the recent 'Amber' shortage of platelets. The response to the activation of the 'Massive haemorrhage procedure' is audited on each occasion. The clinical rating of the response is generally excellent. The procedure has been modified for patients presenting to the EU Resus department. The UHB transfusion team is actively involved in incident management and investigation and reports all significant clinical incidents, including all externally reportable incidents to the UHB transfusion group. The transfusion team delivers education and training within

	the UHB including: • Annual All-Wales half day standardised training and assessment to all year 5 medical students • Participation in Nurse foundation programme • Participation in I.V. study days • Porter training and assessment • Assessor workshops x 4 per year • Link Nurse Study Days The present system of recording which staff have successfully completed training and competency assessment is not robust and requires strengthening (see recommendations). The transfusion team participate in National Comparative audits. The UHB transfusion procedure is updated regularly in line with national guidelines. The attendance at the UHB transfusion group is weak at times and this should be strengthened to improve the dissemination of lessons learnt from incidents, audits and national guidelines. (See recommendations). The UHB is represented on several All-Wales transfusion groups including the 'National Oversight Group', the 'Transfusion team all Wales group' and 'Transfusion manager group'. The cold chain and final fating of blood products rely on paper records. This is a potential weakness and requires significant time to maintain. It is recommended that these should be replaced by electronic solutions including electronic blood tracking and the electronic final fating of products by the patient bedside. There are several areas where the UHB has led the way in transfusion. The most notable being the OBS Cymru initiative.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for 2019/20** Competency assessments for pre-transfusion sampling and the administration of blood products to be held within the Electronic Staff Record and discussed as part of annual PADR. Monitoring of the compliance position will be a standing agenda item at the Transfusion Group. This

	action remains incomplete from 2018/19 and is being taken forward to 2019/20. The UHB is undertaking a LIPS project looking at the requirement for two samples prior to crossmatch or electronic issue. The UHB to look towards the implementation of electronic blood tracking and electronic fating of blood products at the patient bedside.

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**Standard 2.9 Medical Devices, Equipment and Diagnostic Systems**
B **Background**	This assessment of compliance with Health and Care Standard 2.9 Medical Devices, Equipment and Diagnostic Systems has been compiled by the Clinical Board Medical Device Safety Officers (MDSOs) and co-ordinated through the UHB's Medical Equipment Group.
A **Assessment**	The UHB continues to make progress in the effective life cycle management of medical equipment. The WAO 2018 progress review acknowledged this but highlighted a number of actions including compliance to the UHB's medical device risk management and governance framework which, in turn, will be informed over coming months by revised MHRA guidance (due to be published mid-2019) aimed at assisting health institutions prepare for the full implementation of MDR 2017 by 26 May 2020. **Significant achievements in 2018/19** • Refreshed and strengthened UHB's Medical Equipment Group in line with recommendations of WAO progress review. • Development of the UHB's Medical Equipment Strategy. • Introduction of medical procurement officer role. • Setting up of the Clinical Board MDSO network within the UHB. • UHB Point of Care Testing (POCT) Department have implemented the All Wales POCT Connectivity Solution (WPOCT) for all connectable point of care testing devices and are leading on ensuring a 'joined up' approach to POCT both within the UHB and across Wales. **Risks** • Funding for both capital and non-capital items is still the major risk to sustainable service delivery, compliance to national performance standards and assured patient and user safety. On balance a fair assessment the Corporate level of compliance would be '**Progressing Towards the Standard.**
R **Recommendation**	**Improvement actions:** • Revision of UHB Medical Equipment Management Policy in line with the pending revised MHRA guidance. • Progress delivery of the UHB's Medical Equipment

	Strategy. • Implement action plan to deliver recommendations of WAO 2018.

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**3.1 Safe and Clinically Effective Care**
B **Background**	**Please Confirm the rating from the following definitions*:*** Meeting the Standard
A **Assessment**	**People are safe and protected from avoidable harm through appropriate care, treatment, information, support and early detection of risks.** The management of Serious Incidents is integral to the provision of safe care. Clinical Board performance around the reporting investigation and closure of Serious Incidents is reported and managed through the Executive Performance Reviews. Systems ensure non-compliance or variance from best practice is properly recorded and audited and any risks identified are managed appropriately. Serious Incidents are reported through the QSE sub-committees and an annual special report is taken to QSE as well as being reviewed at a weekly executive concerns meeting. The electronic incident reporting software purchased from Datix and implemented in 2015 is now well embedded in the UHB. A revised Incident Reporting Policy and new supporting procedures have been agreed at the Quality, Safety and Experience Committee in September 2018. The UHB continues to upload patient safety incidents to the National Reporting and Learning System (NRLS). This is generally undertaken on a weekly basis. Timely management of incidents in line managers queues are reviewed as part of the monthly Executive and Clinical Board performance review procedures. An important safety net and key benefit of the electronic incident reporting software is that it allows the establishment of various trigger mechanisms to assist earlier central knowledge and escalation of concerns. Where appropriate, actions have been implemented to address arising clinical risk in response to individual incidents. Following investigation, it is recognised that focused attention is required on particular areas to address the root causes and ensure shared

	learning across the UHB, in particular relation to: • Never Events • Unstageable, Grade 3 and 4 healthcare acquired pressure ulcers • Patient accidents/ falls • Behavior and Unexpected death or severe harm incidents particularly in the Mental Health setting • Diagnostic processes/procedures • Healthcare Acquired Infections • IR(ME)R breaches due to patient misidentification The monthly reporting of Key performance indicators including the management of patients safety incidents, hospital acquired thrombosis, health care acquired pressure damage, IP&C indicators safeguarding and prescribing indicators drives up quality, gives assurance around service provision and acts as a “smoke signal”. The performance dashboard has been reported monthly through the Executive Performance Reviews monthly in 2018/19. Monitoring of IP&C data around MSSA/ MRSA E coli and C difficile is undertaken monthly and performance is measured against targets set by Public Health Wales. The Medical Director undertakes Antimicrobial Stewardship Walkround with the IP&C team to areas of increased IP&C reporting. There is a robust Quality Safety and Experience structure in existence across the health board with sub committees in each of the Clinical Boards. The majority of committees have a generic agenda that is aligned to the health and care standards to prompt consideration of all seven themes. As well as the QSE Committees there a number of formal multi disciplinary and multi professional forums in existence within the Clinical Boards to discuss and consider risk. These include: • A Labour ward Professional forum which reviews new and emerging guidance and evidence • CD&T have developed a 60-day improvement cycle group to understand, support and challenge improvement innovation • Surgery Clinical Board have a Bi monthly IP&C group In addition the majority of the clinical Boards have at least one person in post dedicated to managing patient safety and governance. A well-established process is in place to undertake Level 1 Mortality Reviews for all adult inpatient deaths. Compliance with this process is monitored and reported through the Executive Performance Reviews which has been successful in driving up compliance

	throughout 2018/19. The UHB has in place an electronic Mortality Audit Tool (EMAT) for gathering and generating reporting data relating to mortality reviews. A once for Wales approach is also being explored to procure a platform to records and monitor mortality reviews. A Medical Examiner role will be introduced from April 2019 with an aim of improving the quality of certification and will provide clarity over which deaths will require further review. NatSSIPs - Clinical Boards have identified all of their Invasive procedure and a process is in place to develop LocSSIPs around a number of procedures already. **Practice evolves to reflect new evidence and provides an efficient and effective response to promote safe and clinically effective care.** An assurance process around the National Clinical Audits is now well embedded with requisite improvement plans being developed and reported through the Medical Director to Welsh Government. QSE subcommittees are utilised to discuss the results of these audits and to support the development of improvement plans. A target approach reporting National Clinical Audits through QSE committee has been in implemented during the year with National Hip Fracture Database, Heart Failure Audit and NELA being reported through the Committee. Local clinical audit activity is underway to give assurance around the quality and safety of the care we deliver. Last year it was agreed to subdivide clinical audit into a three tier system and a clinical audit plan was devised by each Clinical Board detailing the Level 1 and Level 2 audits planned for the year. This will be reported to the QSE committee in June 2019 detailing the progress made against the audits and the governance arrangements to monitor each of the audits. Tier 1 National Clinical Audit (including non-mandated national audits) Tier 2 audits undertaken to address quality and safety priorities Tier 3 audits undertaken for any other reason including revalidation A UHB clinical audit database is administered by the clinical audit team and records all registered audits and their results. This process allows for the dissemination of clinical audit results reported into the database to be disseminated to the Clinical Boards for consideration at QSE. There is some doubt about the extent of local clinical audit that is being registered and reported through the agreed health board process and therefore it is not possible to give assurance around the consideration given to the results of all of these audits. The National Clinical Enquiries into Patient Outcomes and Death

	(NCEPOD) publish several reports each year. A revised process of gap analysis and action planning to ensure that care provision is in keeping with best practice guidelines is being undertaken around the most recent publication and will be reviewed. There are a number of UHB wide Committees that have representation from all of the Clinical Boards that consider local performance around specialist areas e.g. Falls, Pressure damage, medical devices. As well as considering risk these groups are tasked to consider and implement Best Practice guidance where appropriate. There are local examples of excellent practice: • Children and Women have a multi professional forum to review all MBRACE reportable cases each month and review the associated care. • Medicine Clinical Board are implementing a trigger system for frequency of audits. • Mental Health have a process of reviewing best practice guidance and considering audit requirements. **Systems and processes comply with safety and clinical directives in a timely way, including alerts.** A corporate programme of unannounced internal inspections as well as inspections internal to the Clinical Boards give assurance about the quality of care delivery and documentation. External inspections are reported through QSE along with requisite improvement plans. Performance management of key performance indicators and review of quality indicators are undertaken on a monthly basis. Weekly Executive Review of concerns and Serious Incidents as they emerge. **People receive a high quality, safe and effective service whilst in the care of the NHS which is based on agreed best practice guidelines including those defined by condition specific Delivery Plans, National Institute for Health and Clinical Excellence (NICE), NHS Wales Patient Safety Solutions, and professional bodies.** The UHB regularly receives alerts and notices from Welsh Government. These cover a range of patient safety issues. Each notice or alert contains a list of actions to be completed before compliance can be declared. The timescale given to undertake these actions varies according to the complexity of the actions required. By the specified deadline, the UHB must report a position of compliance, non-compliance or not applicable.

	The notices/alerts are issued to all Welsh Health Boards and Trusts. Each organisation's compliance status is published on a monthly basis by Welsh Government. An internal flowchart is in place to compliment the UHB's Safety Notices and Important Documents Policy and ensure the UHB complies with necessary Welsh Government requirements.
R Recommend ation	**The following improvement actions have been identified as key deliverables for 2019/20** • Implementation of the Falls Framework • Implementation of the revised WG guidance for pressure ulcer reporting and investigation • Embedding a human factors approach through education and training • Putting in structures to support the medical examiners role • Focus on national safety standards for invasive procedures in particular Central Line, Chest Drain and Nasogastric Tube insertion • Introduction of an electronic clinical audit system • Continued increase in compliance with patient safety solutions • Focus on compliance with level 1 mortality reviews and further review processes

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**Standard 3.2 Communicating Effectively** • In Communicating with people, health services proactively meet individual language and communication needs
B **Background**	Standard 3.2 consists of a number of criteria relating to communication, including: • Welsh Language • Individual and specific needs (e.g. age, sensory loss, learning disability, mental capacity) • Reasonable adjustments and accessibility • Carers needs • Compliance with legislation and guidance In previous years the Clinical Boards have been asked to undertake a self-assessment of their compliance against the Health Care Standards. This year, for the first time, Standard 3.2 is being assessed corporately. By mapping the criteria out against reports provided to the Strategy and Delivery Committee (Equality and Welsh Language) and the Quality, Safety and Experience Committee (Sensory Loss) we are able to see areas where the criteria is achieved and where further work or improvement is needed. Other sources of evidence have also been considered where appropriate, as highlighted below. Assessment against the Standard is rated from the following definitions: Getting Started; Getting There; Meeting the Standard and Leading the Way. The overall Performance against Standard 3.2 is assessed as Meeting the Standard. Following sign off of this assessment by the Lead Independent Member and Executive Director, it will be reported to Board via the Quality, Safety and Experience Committee.
A **Assessment**	**Welsh Speakers are offered language services that meet their needs as a natural part of their care:** The Welsh Language Standards, after a very comprehensive and systematic consultation process, were issued to the UHB at the end of November 2018 and the UHB has between 6 and 24 months to achieve compliance. In most cases, the Standards can be reached or we are already compliant. For example there is an expectation that we provide staff who can speak Welsh with the 'iaith gwaith' lanyards or they wear the logo on their uniform. This practice is already widespread across the organisation, and there are more bilingual posters and patient information. However, there are other areas which pose significant challenge (e.g. the translation of all job descriptions has huge financial

	and time implications) and a robust, evidence based response is being prepared for the Welsh Language Commissioner. A Welsh Language Standards Group has been established to bring together Corporate and Clinical Board representatives to share successes, challenges and good practice. The provision of a bilingual communications services remains a challenge, with a significant proportion of the website still available in English only, with limited resources to provide this or our social media fully bilingually. **Special Care is taken in Communicating with those whose mental capacity may be temporarily or permanently impaired and language and communication needs are addresses for people with specific care needs including sensory loss** The All Wales-Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. Progress against the organisation's action plan for the current operational year is reported bi-annually. In addition, there is a legal duty under the Equality Act 2010 to ensure that reasonable adjustments are made to deliver equality of access to healthcare services for disabled people, and the UN Convention on the Rights of Persons with Disabilities provides an international standard for disabled people's human rights. Effective and appropriate communication is fundamental to ensuring services are delivered in ways that promote dignity and respect. There have been a large number of key actions achieved during 2018 include (but are not limited to): • Establishment of an Accessible Health Service Team at the Centre of Sign, Sight and Sound (COS) in October 2018 • DAISY online interpreting pilot • Roll out of the Patient Communication Portal (online appointment information) • Roll out of text (SMS) message reminders • Dedicated email address for patients who are deaf • Patient pagers in the out-patients department, UHW) The continued success of 'Show Me Where?' is transforming care for vulnerable adults and children who experience barriers to communication. The Show Me Where Tool is a series of sheets that feature illustrated body parts for patients to tell clinicians where they feel pain, without verbally speaking. Its usefulness has been established in patient groups including those with learning disabilities, stroke patients, intubated and tracheostomy patients, those with disabilities that affect their speech

	(cerebral palsy, multiple sclerosis), people with onset dementia, and patients with hearing problems. It's also been proved an effective communication aid for non-English speakers. Medical Practitioners must be fully aware of the diverse needs of the patient when performing any function under the Mental Health Act. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter would be obtained. Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering taking any course of action under the Mental Health Act. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way. Mental Capacity Act training and Dementia training are included in the programme of mandatory training for staff. At the end of March 2019, these had been undertaken by 3,048 and 8,483 staff respectively. So far over 100 people have taken up the basic BSL lessons currently available to staff. **Methods of on and off line communication in various languages and accessible formats are used**. There is a UHB Interpretation and Translation Policy in place which includes provisions for Welsh Language and Mental Capacity as well as service users who are unable to communicate effectively in English. Examples of accessible communication tools available include those listed in the section above, as well as the provision of patient information in braille/large print and hearing loops. Other achievements in this area include: • The UHB became the first hospital in the UK to be awarded the RNIBs Visibility Better Accreditation in the Radiology Department. • Dental Clinical Board has gained the Action on Hearing Loss Louder Than Words Accreditation Charter Mark. The University Dental Hospital is the only hospital in the UK to have this accreditation. There is some scope for recording patients' communication preferences on PMS, but currently this is limited to English/Welsh/BSL and this is not visible on the PMS booking pages or flagged. It is essential that developments are progressed within all IT systems to record communication preferences and flagging as a priority. Working in collaboration with Cardiff and Vale College, Public Health Wales and Velindre Hospital, health-specific English language courses have been developed and piloted for speakers of other languages (ESOL). The new courses will allow those for whom English isn't their

	first language to learn and use terminology that will empower them to have effective conversations with English-speaking NHS Professionals, be able to vocalise their symptoms, be more aware of free national screening programmes and engage with preventative health promotion messages. **Communication is age appropriate and considers people's ability to engage in health related conversations.** Within all Acute Child Health Speciality consultants and specialist nurses will identify those children approximately 12 years old and start introducing them to the process of transition. This is then taken forward with the appropriate professionals within the adult services in the set-up of joint transitional clinics. Each child formally transitions according to their needs. Within paediatrics there has been an introduction to a Children's Charter, which has been developed using the UN Charter for the Rights of the Child. Some of the promises of the Children's Right Charter includes: • 'Give you the chance to have your say' • 'Respect your privacy' • 'Give you choices wherever possible' • 'Tell you what might happen while looking after you' In line with this Strategy and Charter there has also been the development of a Cardiff and Vale Youth Board. Following a recruitment event in November 2019, over 40 young people, aged 14-23 signed up to make their voices heard and to inform and influence the future of the health service in Cardiff and the Vale. Also, the Health Board is part of a regional multi-agency 'Transition Steering Group' to progress development of transition for children, young people and young adults (14-25) in line with legislation (the Social Services and Well-Being Act, Future Generations Act, ALNET Act). The Deceleration of Rights for Older People in Wales combines the following statements: • 'I have the right to be who I am' • 'I have the right to be valued' • 'I have free will and the right to make decisions about my life' • 'I have the right to decide where I live, how I live and with whom I live' • 'I have the right to work, develop, participate and contribute' • 'I have a right to safety, security and justice' E-learning Dementia training is provided to 'front-line' staff, with 8483 members of staff trained from April 2018 to March 2019.

The Cardiff and Vale UHB 2018-2028 Dementia Strategy is underway. The vision of this Dementia Strategy includes "people with dementia have equitable and timely access to a diagnosis; they will have person-centred care delivered locally with kindness. Carers will feel supported and empowered". Areas of priority within the strategy include:

- Ensure a timely diagnosis of dementia
- Raise awareness of prevention messages starting with children
- Children should be linked with older adults in a safe structured environment to benefit both groups from intergenerational interactions
- The message 'What's good for your heart is good for your brain' to be a promotional campaign across CAV

Support is Given for Carers and Advocates who in turn are supporting the needs of people with communication needs

The UHB provides a web based service, called Stepiau, developed by the Primary Mental Health Support Service (PMHSS) for Cardiff and the Vale of Glamorgan. Stepiau primarily provides accessible self-help resources.

The EPP (Expert Patient Programme) runs two health and wellbeing workshops for unpaid carers who are looking after a relative, neighbour or friend. The two hour workshops are free and look at the carers Mental Health and Well-being and their Physical Health and Wellbeing.

Effective accessible appropriate and timely communication is tailored to the needs of each individual person and reasonable adjustments are made as defined by the Equality Act 2010

Corporate work is undertaken through our work under the Strategic Equality Plan Fair Care 2016-20 and its Annual Delivery Framework Plan that is associated with the Act.

The current plan is now in its final year. During 2018/19 there has been steady progress on the plan, with nearly all of the 17 key actions completed or nearing completion, though meeting the Sensory Loss Standards fully as set out in the Plan continues to provide challenges. Work has now begun on implementing the Welsh Language Standards.

There is compliance with legislation and guidance to ensure effective, accessible, appropriate and timely communication and information sharing.

The relevant legislation / guidance for this Standard are:

Legislation/guidance	Reporting mechanism
Equality Act	Strategic Equality Plan – Strategy and Delivery Committee

	Welsh Language Measure	Welsh Language Standards - Strategy and Delivery Committee
	All Wales-Standard for Accessible Communication and Information for People with Sensory Loss	Quality, Safety and Experience Committee
	Mental Capacity Act	Mental Health and Capacity Legislation Committee
R Recommendation	The following improvement actions have been identified as key deliverables for 2019/20: 1. An action plan is developed and implemented so that the UHB can continue its work on implementing the Welsh Language Standards. 2. Developments are progressed within our IT systems to record communication preferences and flagging as a priority. 3. The UHB develops its next four year Strategic Equality Plan ready for implementation from April 2020.	

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**3.3 Quality Improvement and Research and Innovation** **Cardiff and Vale University Health Board**
B **Background**	**Please Confirm the rating from the following** definitions **Progressing Towards the Standard**
A **Assessment**	**Local capacity and capability to identify and address local improvement priorities** The Research Delivery Team now has a dedicated senior manager responsible for R&D education and training and has produced its first Research Education and Training Annual Report. Highlights for 2018/19 included 110 training events attended by 441 people, a new standardised training file and research competency framework and formalised induction training for all new R&D Delivery staff. Audit activity is implemented in order to meet National requirements of the National Clinical Audit and Outcome Review Programme, Local quality and safety priorities and individual learning and development requirements. In 2018/19 a clinical audit plan was developed by each Clinical Board to identify the tier 1 - national clinical audit activity and tier 2 - local clinical audits designed to give assurance around quality and safety. Clinical Audit leads are identified in every Directorate and it is their role to agree the suitability of the clinical audit programme in each area and to ensure the governance around the reporting processes. A number of National Clinical Audits have been reported through the UHB QSE Committee throughout the financial year to give assurance around the result and the associated Improvement plans.

	Corporate governance leads provide data on incidents, concerns and complaints and mortality reviews to Clinical Boards and these are communicated via the Quality, Safety and Experience Committee structures to inform priorities. Clinical Audit skills sessions are held several times per year to meet demand. Two cohorts of Leading Improvement in Patient Safety programme (which includes IQT Silver) were delivered in 2018-19 where 175 people worked on 31 QI projects. IQT bronze and silver e-learning are promoted and IQT silver courses are delivered for individuals to work on improvement projects. Further skills, expertise, confidence and experience are developed through the Clinical Leadership Programmes and a forum for project managers has been established. **Progress is measured** All Clinical Boards reviewed and amended their R&D Strategy and this was accepted by the UHB Board in March 2019. Performance meetings with each Clinical Board now take place every six months led by the Medical Director where performance issues are discussed including progress with increasing numbers of both commercial and non-commercial studies and increasing patients recruited and other key performance indicators specified by Welsh Government. The Research Performance Team within R&D produced a Research and Development Performance Report for the first time covering the years 2016-2018 which formed the basis of the discussions at the Performance Meetings but has also been circulated widely within the UHB and presented to Welsh Government. The report highlights key research outcomes including grants awarded and publications. A reporting structure is in place for clinical audit plans. Performance is measured against Welsh Government targets. QI projects delivered through IQT consist of measurements for improvement over time. The Project Management Office monitors progress of some of the large projects. Learning is shared locally through: an annual R&D Day and newsletter; LIPS Celebration events; Nursing and Midwifery Conference; Clinical Senate; Grand Rounds and Clinical Board showcasing events. Learning is shared

	nationally/internationally through publications and presentations at conferences. The UHB holds an Annual R&D Day to promote research taking place within the UHB, with presentations by all Clinical Boards to showcase their research, to mobilise knowledge and share learning, with prizes awarded for best poster presentations. In 2018 this was jointly chaired with Cardiff University with presentations from both organisations, with an announcement made on plans for a joint C&V UHB and Cardiff University Research Office to help further strengthen our important partnership working. **Framework for Health and Social Care R&D** There is a UHB R&D Governance Team and a group including the Clinical Board R&D leads. The UHB has a Research & Innovation research strategy. Specialist R&D leads belong to national networks to share and spread new findings and drive adoption of best practice. There is a process in place to disseminate NICE guidance and self-assess compliance with it. **Direct impact on services and better health** The UHB strives to support improvement in services as a direct result of research and innovation. For example, CAR-T cell therapies are amongst the first in the pipeline of cell therapies transitioning from 'bench to bedside' for both malignant and non- malignant diseases. They are considered to be highly innovative personalised treatments offering potentially effective therapy with severe but manageable adverse events (AEs) which require specialised monitoring and management. A business case has been submitted to seek approval for Cardiff and Vale UHB to be the Welsh centre for CAR-T therapy and seeks investment as part of WHSSC ICP for 2019/20. Close liaison between the UHB Innovation team and the R&D office ensures that potential new products/ innovations can be developed by supporting appropriate applications for financing through non-commercial grant funders or by collaborating with commercial partners. In addition the UHB works with commercial companies on delivering commercial sponsored studies and continues to have the largest portfolio of commercially sponsored studies in Wales. The UHB has a Research and Innovation Strategy. There is often a disconnect between research an innovation and the UHB plans and services. However, resources such as

	Continuous Service Improvement and LIPS are aligning to the UHB priorities and the Transformation agenda. **Structured approach to promoting and supporting research and innovation** The Clinical Board Leads attend the quarterly Research Governance Group (RGG) where research incidents are reported and discussed and lessons learnt disseminated. This Group thus oversees the UHB compliance with the principles and requirements of the UK Framework for Health and Social Care Research and Development and is responsible for approving Policies and SOPs which underpin this framework. The R&D Office Audit programme is agreed by RGG and audit results reported to it. Robust pharmacovigilance and monitoring arrangements are in place for research projects led (sponsored) by the UHB, with the involvement of accredited trials units seen as a necessity for trials involving medicines. The UHB has successfully sponsored a Nephrology clinical trial of a medicine in 2018, the first in several years, with 3 sites in the UK. Risks associated with research and innovation are managed through a robust capacity and capability process with relevant contractual arrangements put in place to ensure all organisations involved are aware of their responsibilities. Vulnerable adults and children are safeguarded through ensuring ethical approval, appropriate policies, SOPs and guidance, and encouraging attendance of staff at relevant training events. The R&D office have been working with HCRW support centre on a new All Wales Internet site with links to local internet pages, to embrace the 'One Wales ' vision for R&D and to make information more accessible for patients and the public. In addition the UHB is committed to ensuring all its sponsored research is registered on appropriate public facing databases. Opportunities to apply for grants are circulated via corporate communications and cascaded through Clinical Boards. Expert support is available to develop the applications. The research governance policy has an EHIA and the ethics committee will scrutinise applications to ensure there is no deliberate bias built into the proposal.

	Clear and visible leadership 6 of the 8 Clinical Boards have a Clinical Board R&D Lead with the further two boards currently in the recruitment process. The R&D Office leads on ensuring reports are submitted to the various bodies within specified timelines through close liaison with Clinical Boards and Directorates through their appointed R&D Leads, and corporate finance. The UHB ensures a visible leadership commitment to research by strong representation of senior staff on most Health and Care Research Wales Boards, Committees, Working Groups and training events.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for 19/20** Improvement actions identified as key deliverables for 2019/20: • Implementation of the All Wales R&D Finance Policy • Progress with the vision of a Joint R&D Office with Cardiff University • Continue to develop capacity and capability in R&D, Audit and improvement skills • To develop a clinical audit plan aligned to clinical Board quality and safety priorities • To identify the resources required to facilitate the National Paediatric Asthma audit, the National Paediatric Epilepsy audit and to support the National Vascular audit • To further develop governance arrangement for reporting Clinical Board level clinical audits. • To increase PPI where applicable.

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S **Situation**	**Standard: 3.4** Corporate Assessment
B **Background**	**Please Confirm the rating from the following definitions*:*** Information Governance (IG) – Progressing Towards the Standard Information – Progressing Toward the Standard
A **Assessment**	**IG** Work continues to meet ongoing compliance with the GDPR obligations. Action plan created in response to Internal Audit review in 2018. IG matters reported to Information Governance Executive Team which operationally supports the Information Technology and Governance Sub-Committee. The following give insights into the above: • Current level of mandatory IG training is 72.8%. • Corporate Information Asset Register including all major systems and servers held by UHB is up to date. Departmental IARs are available in approximately third of settings. • Following GDPR awareness sessions, Clinical Boards should be aware of the legal requirement to complete Data Protection Impact Assessment, Data Processing Agreements and report certain data breaches to the Information Commissioner's Office (ICO). Following our IA report, we are aware that some areas require additional attention. • There have been several information governance breaches that have been reported to the ICO however no action was considered necessary by the regulatory body. **Information** • Good progress has been made in developing the clinical information model and a data repository storing clinical and non-clinical information which is semantically interoperable with UK wide clinical

	information. This includes implementation of Snomed-CT and the coding of outpatient activity. • The level of use of the UHB's Business Intelligence (BI) system, associated dashboards and other analytical products have been accelerated by the UHB's transformation enabling programme – Accessible Information. • The UHB has started to link data from primary, community and hospital care systems and has taken the lead in Wales in analysing primary care data to inform workforce transformation and service sustainability • Coding has maintained levels above 95% completion and continues to comply with national accuracy and quality standards • The PROMs programme has collected nearly 18,000 responses, as we strive to collect the evidence to understand how we are improving outcomes. **IT** • Significant progress being made in the use of national product Welsh Clinical Portal which includes Medicines Transcribing and e-Discharges, e-Referrals and Pathology Electronic Test Requesting to eliminate the use of paper clinical communications. Access to the All Wales results and documents has encouraged the take-up of WCP amongst clinicians. • Significant progress has been made in the completion of IT audits providing particular assurance in relation to Business Continuity. Four audits have been completed in 2018 including: MTeD, Welsh Patient Referral Services (WPRS) Theaterman, specialist Service Patient Care IT system. • A review of all Clinical Boards Service Level Agreements (SLA) in relation to core systems used within their service is continuing and will support the development of the BC plans. • The IT Work plan reflects the Clinical Boards IMTP IT requirements. • E-Learning development for core systems is ongoing for WCP, Paris, PMS and modules of PMS (WCW, EU Workstation etc). • Continued development of PMS/ WCW/ EU is progressing. • The E-Advice & Comms application, developed in-house, is being utilised in various settings including GP e-advice and internal e-referrals. • PCIC & Mental Health Clinical Boards continue to expand PARIS based mobile platforms, minimising

	paper records thus reducing problems such as misplaced records etc. In recognition of the above, the **"Progressing Towards the Standard"** rating previously suggested by the majority of Clinical Boards is agreed. It is also recognised that improving this rating to "Meeting the Standard" appears to be well within the scope of all Clinical Boards. Completion of all BC plans will support the delivery of 'Meeting the Standards' as it requires each CB to recognise the value and reliance on the electronic systems they use within their clinical and business areas
R **Recommendation**	The following improvement actions have been identified as key deliverables for 2019/20: **IG** The UHB needs to ensure that the key GDPR requirements are known, understood and followed by all UHB staff. **IM & T** A tactical approach to providing informatics needs to be agreed, involving all stakeholders. Informatics staff require a development plan to continue to enhance their skill sets. • Clinical Boards have been working with the UHB Emergency Planning Officer whose remit includes coordination of Business Continuity Plans. Further attention is still required to ensure that CBs can ensure continuity of core business delivery in the event of temporary IT system failure. It should be noted the all Clinical board managers have been trained and a number of exercises/test have been carried out to support business continuity plans which have been put in place. All Clinical Board BC plans are monitored via the Chief Operating Officer as part of their quarterly performance plans. Further progress has been made at corporate IT level to "keep the lights on", i.e. the strengthening of infrastructure. Continued investment in line with agreed plans will be required to ensure resilience of IT systems and to counter Cyber security threats. • Implementation of the IMTP workplan including national and local IM&T Projects continues in line with plan and resources assured via IT & Governance sub-committee (ITGSC). • Co-ordination of IT assurance process is through continuous review via the ITGSC.

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S **Situation**	The corporate leads for the standard **3.5 Record Keeping** have reviewed the Clinical Board self-assessments and rated accordingly as set out further in this document.
B **Background**	The UHB is required to perform a self-assessment against the Health and Care Standards on an annual basis. The corporate leads have reviewed the evidence against the criteria outlined in the related driver diagram document and assigned an overall rating based on the individual outcomes. **Clinical Board self-assessment ratings:** 'Getting there' for the majority of Clinical Boards though more are now achieving 'Meeting the Standard'. C&W: Meeting the standard CD&T: progressing towards the standard Dental: progressing towards the standard Medicine: progressing towards the standard Mental Health: Meeting the standard PCIC: progressing towards the standard Specialist: progressing towards the standard Surgery: progressing towards the standard **Corporate lead overall rating:** **Progressing towards the standard.**
A **Assessment**	**Corporate leads assessment** Review of Clinical Board self-assessments for the last year indicates continued improvement with regards record keeping, albeit this should be conducted with a greater degree of priority. There continues to be a spectrum of operational rigour in terms of compliance, with some very encouraging evidence of audit across a number of Clinical Boards. There remain areas of weakness in relation to fully evidencing fundamentals of good record keeping practice, such as up-to-date and comprehensive Information Asset Registers. There is also a lack of clarity in some Clinical Boards as to channels of accountability, as well as

	governance arrangements. This continues to be reflected in input into corporate assurance groups such as the Medical Records Operational Group. The evidence provides a satisfactory level of assurance indicating good attention to the requirements needed for documentation management; digital and non-digital. Similar to previous years, record keeping is clearly an integral element to the quality of patient safety and experience and there is a clear understanding of this. There is demonstrable progress to moving to digital platforms which by their nature, provides much greater control and consistency. The UHB recognises the need to blend the requirements of GDPR with good day to day record keeping and as such more awareness and training is required. In summary, the assessment again indicates a **"Getting there"** rating, though there is some evidence that continued levels of progress should move the position to 'Meeting the Standard' within the coming twelve months.
R **Recommendation**	Recommendations are consistent with those given previously, with emphasis again focusing on fundamentals such as: • Record keeping audits and more regular reviews need to be further developed and applied consistently throughout the organisation • The outputs of these need to be better aligned with corporate assurance mechanisms • Key assurance indicators need to be developed to support the above audits and reviews • Continued and enhanced promotion of good record keeping practice, particularly through targeted staff training • Improved attendance and participation at relevant assurance groups; both at Clinical Board and Corporate levels • To gather specific evidence and assurance is required of good record management arrangements for non-medical records

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

<table>
<tr><td>S
Situation</td><td>Health and Care Standard 4.1 - Dignified Care

People’s experience of health is one where everyone is treated with dignity and respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, and cultural, language and spiritual needs.

Corporate Assessment

This report is intended to provide the Executive Nurse Director and the Lead Independent Member with an update of compliance against Health And Care Standard 4.1.</td></tr>
<tr><td>B
Background</td><td>The Health and Care standards were launched by Welsh Government in April 2015. Health Wards are required to complete an annual self-assessment of compliance against each of the 22 standards.

Clinical Boards have submitted their self-assessment which includes their rating against compliance with the standard:

<table><tr><th>Rating</th><th>Clinical Board</th></tr><tr><td>Leading the way</td><td>Surgery</td></tr><tr><td>Meeting the Standard</td><td>Medicine, PCIC, Mental Health, Children & Women, CD&T</td></tr><tr><td>Progressing Towards the Standard</td><td>Specialist Services</td></tr></table></td></tr>
<tr><td>A
Assessment</td><td>Each Clinical Board has undertaken a self-assessment. Sufficient assurance and evidence has been provided to indicate that each clinical board achieves compliance with the standard, or is progressing towards compliance.

Examples have been put forward which confirm that progress is being made. A selection of these examples are:

Surgery Clinical Board
Sister/Charge Nurses present their annual internal inspection reports to Nursing Board, as well as details about how action plans are progressing.
Newly developed Band 5 induction programme specifically addresses dignified care standards.
‘Enhanced care model’ introduced to medicine clinical board has been introduced within surgery areas.</td></tr>
</table>

	• Lead nurse, Andy Jones, continues to provide UHB-wide leadership relating to LD pathway and flag system.
	• Significant capital works that have taken place to improve the environment and facilities for patients and staff, including the total refurbishment of A2.
	• In the last 12 months, staff have introduced:
	  ○ "Get up get dressed get moving" in T&O wards. This initiative has been acknowledged within internal inspections.
	  ○ Monthly 'Read about me' audits to embed practice in daily care.
	• Following completion of Kings Fund environmental audit, H&N and T&O have received £41k to improve environments for cognitively impaired patients.
	• Dedicated Day of surgery admission (DOSA) unit in SSSU has opened. This has reduced late starts, increased performance against national day case admission rates and allows patients to sleep at home the night before surgery.
	
	Dental
	• Sensory loss initiatives are now fully embedded across the Dental Directorate. We have been awarded the Louder than Words Accreditation from Action on Hearing Loss and this has been extended for another 12 months.
	• The Dental Directorate has implemented Hearing loops, listening devices and Next Generation Text.
	• Mobile video and audio unit for patients who require interpreters.
	• "Bedside" dental care is provided for patients who are unable to leave the HYC premises.
	• Internal quality checks inspections highlighted excellent practice in working with families of patients with dementia.
	
	Specialist Clinical Board
	
	• All areas have Dementia champions and resource packs.
	• Learning Disability Bundle has been introduced with the support of LD link nurses.
	• Continence Bundle in place.
	• Cardiac services have introduced Patient Passport.
	• N&T B5 Introduced End PJ Paralysis and get up, get dressed, get moving.
	
	PCIC
	• PCIC has a patient engagement group and N&W Locality Patient Engagement group has been established in the last 12 months.
	• Feedback received from services directly delivered by the

	board or through commissioned services, shows service users satisfaction at 90%>. • The Hospice at Home service was commenced through a commissioned service with Marie Curie, working directly with District Nursing services. There has been a significant increase in the numbers of patients supported to die at home. Feedback from service users and families confirms the excellent work undertaken by staff. • The Clinical Board actively promotes advanced care planning through Ambulatory Care sensitive (ACS) pathways for GP's. In partnership with Macmillan, two ACP facilitators have been recruited to provide training to staff about advanced care planning and DNA CPR. • PCIC have commenced values based recruitment training. **Mental Health** • The CB has commissioned a 3rd sector organisation to undertake feedback surveys with both adult and MHSOP service users and carers. • Visitor rooms are provided at the entrance to the ward to reduce the number of people accessing the bedroom areas. • Child visiting takes place off the ward in an appropriate environment. • Personalised bedroom areas are developed for patients with dementia or cognitive impairment. • Each service user in Hafan y Coed has a band that only allow them (and staff) access to their bedroom and safe. **Medicine Clinical Board** • The MCB have used funding to acquire Dementia friendly equipment for all areas. • MCB have introduced "Enhanced Monitoring Levels of care" for our most vulnerable patients, individualised in line with risk assessment and care plans. • Patient experience animation videos are being piloted within UHW wards. These videos show twelve months of patient feedback in 2 minutes, to provide staff with an opportunity to view patient compliments and identify areas for improvement. • MCB teams implement action plans to address "lessons learned" in response to findings from concerns, safeguarding outcomes, internal inspections and external inspections. • Sensory Impairment toolkit including use of hearing loops. • The Model Ward for Nutrition and Hydration had been extended to 4 wards and has improved nutrition and hydration, protected meal times and social engagement.

	CD&T • There is a developing Equality Champion network and partnership working process. • The clinical board has been improving its provision of alternative communication methods for people with a sensory impairment. • The Clinical Board has developed a dementia action plan including the role of the Dementia Champions and the Dementia Friends initiative. • The Clinical Board is involved in the development of use of the Welsh language in the workplace. **Children & Women Clinical Board** • Values based interviews are undertaken within the Directorate. • Welsh speaking staff in post to support women who prefer their care to be delivered through their preferred language • 'Memory Making / Dignity Room' newly opened to support hand and foot prints and storage of cold cots for deceased babies • Language line / SKYPE interpretation services in place throughout the Directorate • Directorate works closely with Ty Hafan to support end of life care and support families and staff. • Fast Track Protocol developed for Children at end of life who require continuing care. Assessment of improvement actions for Corporate teams to support and progress indicates that progress is being made toward meeting the standard Dignified Care: • The Health and Care Standards Monitoring audit was completed between October 2018 and December 2018. 110 clinical areas took part and over 1,100 patients/parents provided feedback. • Of the patients that provided feedback, 98% felt that they were treatment with dignity and respect. Some patient comments include: *"Hugely impressed with the attitude and competence of staff. Always patient, always intent on retaining the patient's dignity."* *"I could not have had better care. From the ward cleaners to the very top- they have made me feel that they really wanted to care for me."* *"The kindness of the nursing staff bought me back to life, for which I will always be grateful."*

	The Corporate Nursing team coordinated the completion of nearly 120 internal inspections to wards/departments. The finding for the past year confirm many of the comments made by clinical boards, including: • Information displayed on patient information boards is standardised and many areas provide “You said We did” updates. • Responding to estate issues. • Principles of ‘Get up get dressed get moving campaign’ is used widely. • Patients provide excellent feedback about staff attitude and the provision of dignified and respectful care.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for 19/20** • Continence- review of provision of continence products and training • Trans awareness training • Evaluation of mouth care provision • Wider adoption of Red to Green days • Continue to build on work undertaken to improve environment of care for patients with cognitive impairments

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

<table>
<tr><td>S
Situation</td><td>Health and Care Standard 4.2: Patient Information

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.</td></tr>
<tr><td>B
Background</td><td>Please Confirm the rating from the following definitions:

Progressing Towards the Standard</td></tr>
<tr><td>A
Assessment</td><td>Please provide a brief contextual narrative

The Clinical Boards undertook a self-assessment against standard 4.2 Patient Information. There were many areas of good practice noted across all Clinical Boards and they have assesses themselves as:

<table>
<tr><td>CD&T</td><td>Meeting the Standard</td></tr>
<tr><td>Children and Women</td><td>Self-assessed but no rating attributed</td></tr>
<tr><td>Dental</td><td>Progressing towards the standard</td></tr>
<tr><td>Medicine</td><td>Meeting the Standard</td></tr>
<tr><td>Mental health</td><td>Meeting the Standard</td></tr>
<tr><td>PCIC</td><td>Progressing towards the standard</td></tr>
<tr><td>Specialist</td><td>Progressing towards the standard</td></tr>
<tr><td>Surgery</td><td>Meeting the Standard</td></tr>
</table>

People’s rights and individual circumstances are respected so they have a voice and control, empowering them to make decisions that affect their lives.

Across the Health Board we have 3 information centres that provide a variety of information leaflets etc and are manned by volunteers who can advise patients, visitors and carers to sign post them to information and some community resources.

Some third sector agencies hold regular sessions in the information centres.</td></tr>
</table>

	Patients are provided with information about their care and treatment to allow them to participate in their care. There are good examples across the health board of how this is achieved: In Surgical Clinical Board as part of the pre-operative brief intervention counselling patient are informed about smoking cessation/diet advice and the National exercise scheme and written information is made available. EIDO information leaflets are available and proactively used throughout Pre-Operative Assessment and outpatients to inform patient, families and carers about procedures and what to expect alongside procedural information leaflets/these leaflets are available in both English and Welsh. These EIDO leaflets are also available in Braille and other languages if required. **They have also piloted a system called Patient Knows Best** Patients Know Best (PKB) is an e-health solution which empowers patients to manage their care, enabling professionals to share information while improving efficiencies. It is the first patient-controlled health information exchange (PCHIE) which is built around the patient, not the organization. PKB allows patients to create their own health profile and share this with family and professionals involved in their health care. The Cardiff and Vale UHB Audiology team were honoured with the Sustainability Award from the National Planned Care Programme for the introduction of an interactive electronic solution to the UHB's audiology health pathway. In Children and Women Clinical Board practitioners in CCH work with Children and young people and their families with a holistic approach. The Directorate is in the process of updating their website which will now include CAMHS. A partnership agreement document has been developed for parent and CYP care for be the CCNS service which informs about what the service provides and what to expect etc. The clinical board has established a youth advisory board that will provide a peer review of the relevant patient information. Language line and SKYPE interpretation services available for staff and women, with Hearing loops available in all areas including the Childrens Hospital. Also Antenatal Screening Wales provide information for women in many languages. Monitors purchased for Children's Centres – currently exploring link to UHB screens for patient information.

	Welsh speakers are empowered to express their needs and they are able to fully participate in their care as equal partners. Where needed people are provided with access to a translator or a member of staff with appropriate language skills. Welsh Language Standards are in place from 31.05.19 and the UHB is working towards recording patient's preference around receiving information in Welsh. Just under 300 of our patients have signed up to say that they require their information in Welsh this is recorded on PMS. There is provision to record this on some but not all of the electronic care systems across the Health Board. Patient experience questionnaires undertaken across the health board specifically ask "Were you able to speak in Welsh to staff if you needed to?" Similarly, within the three new surveys, data is collected asking about preferred language? The surveys also record BSL as the language used by the patient. There are processes in place to collate themes around Concerns and complaints including around the provision of care and information in the Welsh Language. In 2018/19 one complaint was received into the Health Board relating to this theme. **Women and Children** Welsh antenatal education in place for women and their partners and Welsh speaking staff in post who provide care in Welsh where required. Speech and Language and Health Visiting services are available with Welsh speaking staff on request. **Dental** There are examples of excellent practice across the Clinical Boards e.g. patient information leaflets and posters have been developed in line with the current UHB guidance and are available in in both English and Welsh. This ensures that the Dental Directorate comply with the Welsh Language Service Delivery Standard. **Health, personal and social care needs are assessed and set out in regularly reviewed plans of care.** In 2018/19 Fundamentals of care audit 95.38% of patients assessed under the mental health measures had a care and treatment plan completed. Since 2017 a significant amount of work has been undertaken

	across the health board Led by the Surgical Clinical Board to enhance the care delivered to patients with a learning disability who are cared for in our hospitals. All patients with a formal diagnosis are flagged on the clinical work station and details of patient assessments documentation etc are made available on this system. In 2018/19 71% of patients admitted to the wards who had a formal diagnosis of a learning disability had evidence of the learning disability bundle being implemented and evaluated. Learning disability champions are being trained across the Health Board to support the development of care planning developed in conjunction with the individual, their relatives and carers. Read about me was implanted in 2017 to ensure that staff were able to capture meaningful information that would enhance the care given to patients with cognitive impairment. In 2018/19 75.29% of inpatients with an identified care need in respect of cognitive impairment had evidence that and up to date care plan had been implemented and reviewed within the agreed timescale. A patient experience questionnaire has been developed to support patients with learning disabilities, their carers and relatives to give feedback about the care that was delivered. **Assistance or specialist aids are provided to those with speaking, sight or hearing difficulties, and special needs such as memory problems or learning disabilities, enabling them to receive and respond to information.** The UHB reports their progress against the sensory loss standards to Welsh Government every six months. EQIA extra tool is implemented around services for building and engineers- equality check for patients with sensory loss and other specific needs. 120 staff have attended deaf awareness training to date. One day Deaf Awareness sessions are planned April – November 2019 – with capacity for 84 staff. Half day Deaf Awareness sessions are planned June 2019 – March 2020 with capacity for 300 staff. The Annual Quality Statement is developed in conjunction with the Stakeholder Reference Group and is written in an accessible format and available in all formats on request. Sensory Loss Awareness Month is promoted within the organisation. A sensory loss pack has now been created for hospital wards to empower staff to become more

	understanding and knowledgeable around sensory loss when with interacting with patients and colleagues. There are excellent examples of care provision that takes into account communication difficulties: In Dental Services Sensory loss equipment has been installed and in use. Language line, WITS, BSL interpreters and the Next Generation Text Service is available and used for patients. A patient photographic journey is available in the Dental Service Group intranet page. Dental services have now purchased a braille embosser successful through charitable funds bid. They are able to produce information for patients on request. In Surgical Clinical Board theatre guidelines have been produced in larger font and coloured paper for patients suffering from dyslexia and visual impairment. Fasting instructions are available in Braille and audio form on request. CD&T have developed Aphasia friendly materials in Speech and Language Therapy. Sonido digital listeners are available in all areas of the Clinical Board. Also the 'Show Me Where App' in use for adults and children. Communication Apps such as 'Pre Hospital Communication' promoted within the Clinical Board. Additionally, sensory Loss is an agenda item on Directorate and Clinical Board QSE agenda and a key priority for the Clinical Board. **People's personal records are kept safe regularly updated and available to them.** All staff across the UHB are supported to understand their duty of confidentiality by completing Information Governance training which is included in the suit of mandatory training e-learning modules. There is 72% compliance with this module across the UHB at the end of April 2019. GDPR awareness sessions were run for all Clinical Boards and they are aware of the need to complete Data Protection Impact Assessment, Data Processing Agreements and report certain data breaches to the Information Commissioner's Office (ICO). **Time is taken to listen and actively respond to any questions and concerns that the individual or their relatives may have, treating their information confidentially.** Putting Things Right is embedded across the Health Board. In 2018 /19 95.6% of wards and clinical areas had information

	for patients, relatives and advocates to support them to raise a formal or informal concern. Complaints and concerns are reviewed and themes are identified to support requisite improvements. **Valid consent is obtained in line with best practice guidance; and assessing and caring for people in line with the Mental Capacity Act 2005, and when appropriate the Deprivation of Liberty Safeguards 2009.** To support clinical staff, the UHB employs a Consent/Capacity lead who: • Runs training sessions on both consent to treatment and Mental Capacity Act • Tries to ensure that the law on patient treatment is correctly reflected in policies and procedures • Provides support and advice to clinical staff Mental Capacity Act training is mandatory for all clinical staff and compliance is recorded and reported through Executive Performance Reviews. **CD&T** have undertaken a baseline audit of MCA compliance within the Clinical Board. **Specialist Clinical Board** have undertaken an audit of mental capacity assessments. Results were discussed at a Quality and Safety meeting.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for 2019/20** **Consent and capacity** All Clinical Boards to ensure that at least 75% of their medical staff have undertaken MCA training. All Clinical Boards to undertake an audit of mental capacity assessments and report their findings at a Clinical Board Quality and Safety/Audit meeting. PKB is being rolled out across other specialities and pathways. To further develop the learning disability questionnaires and to share more widely the services changes that has resulted from this feedback. Ensure compliance with the Welsh Language Standard.

	To develop the information centres and use more interactively the screens installed in the centres to share information in a variety of formats e.g. visual. Audio, BSL and other languages.

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**Health and Care Standard:** The corporate lead for the standard **5.1 Timely Care** has reviewed the elements of the timely care standard and rated accordingly as set out below.
B **Background**	The UHB is required to perform a self-assessment against the Health and Care Standards on an annual basis. The corporate lead has reviewed the evidence against the criteria outlined in the related driver diagram document, assigned an overall rating and set out the key improvement actions for 2019/20.
A **Assessment**	The corporate lead has reviewed the evidence against the criteria outlined in the related driver diagram document and assigned an overall rating of '*Getting there'*. This rating is based upon the following assessment: • The timeliness of care is regularly monitored and reported, both within the organisation and externally. This includes formally at the monthly Clinical Board Executive Performance reviews, monthly reporting at Management Executive, reporting and oversight at each Strategy and Delivery Committee and Board, monthly Quality and Delivery meetings with Welsh Government, and regular national reporting and publication of key statistics as part of the national outcomes and delivery framework. • This is supplemented by internal and external (e.g. the Delivery Unit) audits in identified areas. • The organisation's performance reports (see Board papers) demonstrate that the organisation does not currently routinely meet all of the relevant timeliness standards; however there has been substantial and sustained progress in a number of areas (see summary of progress below). • The organisation now has an approved three-year IMTP which sets out a continuation of these improvements, with an ambition to achieve compliance against all the standards within the period covered by the plan. • The organisation shares best practice internally through the transformation programme and externally as part of national programmes in both planned and unscheduled care, and regional forums. In addition the UHB contributes to the NHS Benchmarking service to identify areas for improvement in the design and delivery of services. • The organisation has well-established and well developed Quality, Safety and Patient Experience Committees within

	each of the Clinical Boards and at a UHB level to identify and address themes or serious incidents which may relate to timely access of care. **Areas of progress during 2018-19:** • There has been a 55% reduction in the number of patients waiting over 36 weeks for elective treatment compared to this period in 2018. • Over 800 fewer patients are waiting over 8 weeks for a diagnostic test compared to the same period last year and the Health Board is approaching the elimination of waits greater than 8 weeks. • The Health Board and partner organisations has maintained the improvement made in 2017/18 in the number of patients whose transfer of care is delayed in hospital. • Over 80% of part 1 mental health assessments are now provided within 28 days, a significant improvement over the past 12 months. • The number of patients treated within four hours in our Emergency Department (ED) has increased by 3% during 2018-19 despite more than 5000 additional attendances. • The number of patients waiting over 12 hours in the ED has also reduced by 30%, and ambulance handover times improved by 12%. • Improved compliance with GPOOH standards. The organisation continues to have challenges in reliably meeting the standards in a few key areas; stroke, cancer and outpatient follow ups in particular.
R **Recommendation**	The following improvement actions have been identified as key deliverables for 2019/20: • Complete roll out of new primary care models to increase capacity and improve access to in hours primary care services • Implementation of single cancer pathway • Elimination of patients waiting over 36 weeks for elective treatment and over 8 weeks for a diagnostic • Improved access for Specialist Child and Adolescent Mental Health Services following repatriation of the service to the organisation • Continued improvement in the performance of emergency services • Roll out of Health Pathways to continue to improve the interface between primary and secondary care and reduce waste, harm and variation

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

<table>
<tr><td>S
Situation</td><td>Corporate Assessment

Standard: 6.1 Planning to Promote Independence

Care provision must respect people’s choices in how they care for themselves as maintaining independence improves quality of life & maximises physical & emotional wellbeing.</td></tr>
<tr><td>B
Background</td><td>Please Confirm the rating from the following definitions:

<table>
<tr><td>Children and Women</td><td>Meeting the Standard</td></tr>
<tr><td>CD&T</td><td>Leading the Way</td></tr>
<tr><td>Dental</td><td>Meeting the Standard</td></tr>
<tr><td>Medicine</td><td>Leading the Way</td></tr>
<tr><td>Mental Health</td><td>Leading the Way</td></tr>
<tr><td>PCIC</td><td>Leading the Way</td></tr>
<tr><td>Specialist</td><td>Meeting the Standard</td></tr>
<tr><td>Surgery</td><td>Meeting the Standard</td></tr>
<tr><td>Integrated Discharge Service</td><td>Leading the Way</td></tr>
</table>

A review of the evidence submitted by Clinical Boards provided within the self-assessments demonstrates that there has been continued progress implementing schemes and models to promote a person’s independence and wellbeing. This supports an overall corporate rating of Meeting the Standard with some Clinical Boards and Corporate Delivery Teams Leading the Way.</td></tr>
<tr><td>A
Assessment</td><td>There are some excellent examples of individualised care planning where patients are involved in planning of their care. The examples set out below is a sample of the evidence submitted;:

In Women and Child Health Clinical Board:
• All women have a named midwife who is the coordinator of their care and provides continuity throughout the antenatal and postnatal periods.
• A full time women’s experience midwife is in post to ensure that women’s concerns are heard and actioned.
• A process has been developed for women with hearing loss to text a senior midwife 24/7 should they have concerns or if they go into labour.
• A Consultant Midwife for vulnerable women is in post to ensure that women from vulnerable groups have a voice and are represented/supported in making choices</td></tr>
</table>

	about their care. • In CDAT, Therapists continue to be involved in the training programmes for Get Me home delivering multidisciplinary sessions across sites promoting the message of Get up Get Dressed and Get Moving, supporting culture change across all inpatient settings. • Speech and Language Therapy have a pilot project looking at training 3rd sector, staff and exercise providers re communication impairments to enable people to access exercise schemes e.g. training yoga teachers. • Dietetic service has an accredited training programme through Nutrition Skills for Life that provides training to carers of older adults enabling them to support nutrition and hydration. • Get Cooking programmes to vulnerable groups to support development of cooking and menu planning skills. This programme is delivered through our flying start and families' first dietetic services to parents with young children, community groups, children and young people including the Pupil Referral Unit. • The community neurological rehabilitation services (CNRS) now offer rehabilitation classes and interventions across Cardiff and Vale to provide services closer to home with easier access. A neurological pathway is being developed for transition from paediatric to adult services. • Physiotherapy teams collaborate to plan care Falls Prevention Clinics in the community Stay Steady scheme in North Cardiff. • Patients set goals with Therapists (Stroke, Community Neurology and Mental Health) using the Bridges technique which is a self management programme that trains clinicians to integrate self management support for patients into their routine rehabilitation interactions. • The community neurological rehabilitation services (CNRS) now offer rehabilitation classes and interventions across Cardiff and Vale to provide services closer to home with easier access. • Continuation of de-conditioning exercise groups run by physiotherapists to promote patient mobility and independence whilst maintaining safety in line with risk assessments with the aim of preventing patient de-conditioning during their hospital stay. • Care Aims is being rolled out across the paediatric physio service, ensuring meaningful patient goals are set, with agreed actions to meet them. • In Medicine Clinical Board a Sensory Loss Champions information folder has been created to provide information, help and support for staff, patients and visitors.

	• Intensive programme of Red to Green across medicine clinical board to promote Home First and rapid discharge. • The Model ward for Nutrition and Hydration is now operating on four wards promoting improved nutrition and hydration, protected meal times and better outcomes for patients such as social engagement and minimising deconditioning during a stay in hospital. • Third sector support at ward level providing meaningful activities for those with Dementia. • The Intergrated Discharge Team, now has Local Authority employed, hospital based Get Me Home Officers present at Board rounds, having “What Matters to Me” conversation with Patients and families as early as possible following admission. • Commissioned Advocacy support to ensure patients are able to access appropriate services. • Robust IDS training planning to support promoting independence, discharge planning and Home First. • Multiagency Get Me Home work stream action plan to support service development in community and hospital which promotes decondtioning and rapid discharge. • In Mental Health Clinical Board, Getting to Know Me booklets completed with carers of dementia sufferers. • Stepiau (website) publishes self help leaflets on 25+ most common mental health issues in 5 languages. • All mental health inpatients have access to IMHAs (Independent Mental Health Advocates) as directed by the Mental Health (Wales) Measure. The Clinical Board is 100% compliant with this. • Adult mental health inpatients can access the gym in Hafan y Coed. The activity team assists with activities in the community, such as swimming, cycling etc. • All mental health patients looked after by secondary mental health services must have a CTP as directed by the Measure. • The Mental Health partnership Board is jointly chaired with CAVAMH (umbrella organisation for all service user and carer groups) to agree on the service plans. • Within PICIC Community Resource Team (CRT) and District Nursing services, patients have hand held records and staff work with patients to agree the plan of care with the patients and the family. • A registered “Training Mats” trainer if the team who provides training to staff to use this resource if appropriate. • A “What Matters to You?” approach is taken to all CRT interactions with patients. • The CRT approach is focussed on supporting people to maintain or improve independence and the teams

	always look for ways in which the person could be supported to do things themselves without having to rely on others. • Get Me Home plus is aimed at ensuring rapid discharge to assess model to prevent deconditioning and more appropriate assessment of need in patients own home. • Within Specialist Services Clinical Board, Nephrology and Transplant has established an information review group- all patient information is peer and patient reviewed before being produced. This ensures that the patients are receiving the information required, in the right format at the right time. • There are specific health promotion initiatives, such as the BALANCE programme with transplantation. • Wards have been refurbished to ensure they support people with low vision. • There is continued evidence of individualised planning of care to promote independence following neuro and spinal rehabilitation (Rookwood Hospital) this is evidenced in individualised goal planning meetings and MDT discharge planning. • To aid rehabilitation and promote independence there is evidence of continued close working with charities that support services and promote independence e.g. Headway Day Centre, Spinal Injuries Association, MS Society. • In Surgery Clinical Board, daily board rounds are carried out on all surgical inpatient wards answer the question “what do we have to do today to get this patient home”. • West 4, UHL, recognised as exemplar ward by NHS Delivery Unit is an acute trauma ward, providing post-operative care and continuing rehabilitation until the patient is ready for discharge. From day 1 on the ward, patients are treated as individuals. This includes encouraging them to get dressed and sit out in chairs, helping to orientate them and, as much as possible, create awareness of routines that are normal for them. • ERAS (enhanced recovery after surgery) continues and is being rolled out in other specialities such as Orthopaedics and Upper GI. • Pre-assessment of patients to ensure they are as fit as possible for their treatments and able to have the best possible outcomes.
R Recommendation	**The following improvement actions have been identified as key deliverables for 2019/20:** • Move from a position of service improvement to service transformation in promoting independence, focusing on Primary Care and Community.

	• Monitor the use of Advocacy services within the hospital setting. • Develop further opportunities for alliance work with all sectors to create patient focussed Pathways. • Monitor and review of Model ward. • Evaluate the opportunities within the new St Davids model aimed at prevention of deconditioning and encourage active re-enablement. • Evaluate and monitor the services provided by Third Sector colleagues within the hospital environment. • Monitor and improve attendance at discharge planning training. • Continue the deconditioning campaign and promote independence via comprehensive training programme. • Explore further opportunities to involve patients with planning care and discharge planning. • Continue to promote and roll out the 'Get Me Home' campaign strengthening linkage between HCS 6.1 Promoting independence and 2.1 Falls Prevention. • Further roll out of John's campaign to more clinical areas within the Health Board.

S **Situation**	**Standard 6.2 *Peoples Rights*** Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.
B **Background**	Standard 6.2 consists of a number of criteria relating to people's rights, including: • Individual needs and human rights of children and older people are recognised and addressed • Discrimination is challenged • Strategic equality Plans are published • Care is consistent for everyone regardless of age • Spiritual and pastoral care needs of people and carers are recognised and addressed • People are encouraged to involve others according to their wishes A full list of this criteria is attached as Appendix 1. In previous years the Clinical Boards have been asked to undertake a self-assessment of their compliance against the Health Care Standards. This year, for the first time, Standard 6.2 is being assessed corporately. By mapping these against the Annual Equality Report and Statement, the Strategic Equality Plan Fair Care 2016-20, the Welsh Language Scheme and the All Wales Standard for Accessible Communication and Information for People with Sensory Loss we are able to see areas where the criteria is achieved and which need further work or improvement. Other sources of evidence include the activities of our Clinical Board and our Patient Experience Team which have been used to supplement the formal report. They have been considered, where appropriate below. Assessment against the Standard is rated from the following definitions: Getting Started/Getting There/Meeting the Standard/Leading the Way. On the basis of the evidence provided through the WOD Delivery Plan end of year performance report, along with some additional knowledge referenced below, performance against Standard 6.2 is assessed as 'Meeting the Standard'. Following sign off of this assessment by the Lead Independent Member and Executive Director, it will be reported to Board via the Quality, Safety and Delivery Committee.
A **Assessment**	**EVIDENCE THAT THE CRITERIA HAS BEEN MET:** ***1a. Needs of individuals are recognised and addressed whatever their identity, background, and their human rights upheld.*** The organisation is proud to provide a wide variety of training to members of staff that aim to support the needs of individuals. Equality, Diversity and Human Rights E- learning training is mandatory every three years to ensure all employee's knowledge and awareness is maintained and kept

	up-to-date. The compliance rate for this training is at 80.36% at March 2019. Further training offered by the organisation includes Trans Training and Unconscious Bias Training that recognises equality and human rights. In addition, the Equality Team also offers bespoke, tailored training to departments around human rights. Sensory Loss Awareness Month is promoted within the organisation. A sensory loss pack has now been created for hospital wards to empower staff to become more understanding and knowledgeable around sensory loss when with interacting with patients and colleagues. ***1b. Discrimination is challenged, equality and human rights are promoted and efforts are made to reduce health inequalities through strategies, equality health impact assessment, policies, practices, procurement and engagement.*** The UHB's Equality, Diversity and Human Rights Policy is available to all staff within the organisation. The aim of the policy is to support the elimination of all forms of unjustifiable discrimination from all UHB functions and policies and the creation of an environment where diversity is valued, respect for personal dignity and recognition of human rights by and for all employees, patients and the public. The Maternity, Adoption, Paternity and Shared Parental Leave Policy was reviewed and updated in January 2019. The policy now includes the use of gender-neutral language to be inclusive of all staff regardless of gender identity. ***1c. Strategic equality plans are published setting out equality priorities in accordance with legislation*** The UHB has a current Strategic Equality Plan (SEP) Fair Care 2016-20 and is closely aligned to our ten year strategy 'Shaping Our Future Well-being', our Intermediate Medium Term Plan, the Well-being Future Generations Act as well as to the organisation's values. Communication, respect, access, quality of care and equality of pay are at the heart of this plan. The Health Board is currently in the fourth year of its Strategic Equality Plan. This legal requirement is presented to the Executive Board through Strategy and Delivery Committee and to Staff Side through the Local Partnership Forum. This year there will be consultation on the next SEP which will begin in April 2020. The Annual Equality Statement and Report publishes all major achievements made by the Health Board with regards to equality (in accordance with the Equality and Human Rights Commission guidelines). Both the SEP and the Annual Equality Statement and Report once approved, are published via the UHB's intranet and website for viewing by the public and staff. ***1d. Care is consistent whatever the age of the person being cared for, so that for example for younger people with serious illnesses should expect efficient transition from child services to adult services with good communication between those agencies.***

	Within all Acute Child Health Speciality consultants and specialist nurses will identify those children approximately 12 years old and start introducing them to the process of transition. This is then taken forward with the appropriate professionals within the adult services in the format of joint transitional clinics. All professionals are engaged in the transition process through joint clinics and Multi-Disciplinary Teams (MDT'S) with paediatric and adult services. Each child formally transitions according to their needs. Within paediatrics there has been an introduction to a Children's Charter, which has been developed using the UN charter for the rights of the child. Also, the Health Board is part of a regional multi-agency 'Transition Steering Group' to progress development of transition for children, young people and young adults (14-25) in line with legislation (the Social Services and Well-Being Act, Future Generations Act, ALNET Act). Attendance at monthly Learning Disability Transition Meetings ensures that those children with learning disabilities receive further assistance and adapted care when transitioning to adults. The Health Board ensures that there are integrated pathways between health and social care services by attending and inputting into the quarterly Multi-Agency Transitional Review (TRIG) in the Vale of Glamorgan. These include representation from Social Services, Health (Child and Adult Services) and Education (Education Psychology, Careers Wales). The Mental Health Services for Older People directorate provides care and support to patients aged 65 years and over living within Cardiff and the Vale of Glamorgan with a diagnosis of a dementia or functional mental illness, such as schizophrenia, depression, mood disorders and anxiety. Our Integrated Community Mental Health Team (CMHT) is a multidisciplinary team, where Local Authority and health staff including medical, social workers, nursing, therapies, psychology and admin staff work together to provide community care to patients and their families across the region. A large proportion of the community team's work takes place in patients' homes as well as providing clinic sessions and group sessions in the sectors, following the principle of providing care closer to the patient's own home. ***1e. The rights of children are recognised in accordance with the United Nations Convention on the Rights of the Child (UNCRC).*** The Health Board has been working closely with Cardiff Council and wider Cardiff Public Service Boards to contribute to the Child Friendly Strategy. On the 20th November 2018 the Health Board celebrated World Children's Day by launching the Youth Board and Children's Right Charter. Some of the promises of the Children's Right Charter includes: • 'Give you the chance to have your say' • 'Respect your privacy' • 'Give you choices wherever possible' • 'Tell you what might happen while looking after you'

In line with this Strategy and Charter there has also been the development of a Cardiff and Vale Youth Board. Following a recruitment event in November 2019, over 40 young people, aged 14-23 signed up to make their voices heard and to inform and influence the future of the health service in Cardiff and the Vale.

1f. The rights for older people in Wales are recognised in accordance with the Declaration of Rights for Older People in Wales and the UN principles for Older Persons

The UHB HAS refurbished facilities co-located with the Local Authority and third sector so that once the health crisis is resolved, social care assessment is available for immediate support.

E-learning Dementia training is provided to 'front-line' staff, with 8483 members of staff trained from April 2018 to March 2019.

The Cardiff and Vale UHB 2018-2028 Dementia Strategy is underway. The vision of this Dementia Strategy includes "people with dementia have equitable and timely access to a diagnosis; they will have person-centred care delivered locally with kindness. Carers will feel supported and empowered". Areas of priority within the strategy include:

- Ensure a timely diagnosis of dementia
- Raise awareness of prevention messages starting with children
- Children should be linked with older adults in a safe structured environment to benefit both groups from intergenerational interactions
- The message 'What's good for your heart is good for your brain' to be a promotional campaign across CAV

1h. ***The spiritual and pastoral care needs of people and their carers are recognised and addressed.***

Hospital Chaplains provide spiritual care to the hospital community. They take their place alongside the multi-disciplinary team which seeks to provide holistic care for patients and those close to them. Spiritual care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill-health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener.

A Ward Guide is available on CAVWEB to advise staff on the spiritual care of patients. This includes a several religious and spiritual views. The guide includes information such as an overview of the religion, diet and fasting, views on blood transfusion, etc to give clinical staff awareness of the needs and care required by patients with different spiritual and religious views.

1h. People are encouraged to maintain their involvement with their family and friends and develop relationships with others, according to their wishes

vCreate Secure Video Messaging was introduced into the Neonatal Intensive Care Unit in April 2019. This lets staff record and send secure video updates to parents and carers of their new-born babies when they're

	unable to be by their child's side, allowing them to build and develop relationships at what is an extremely distressing time. The 'Read About Me' person-centred toolkit ensures a continuity of personable care for people with dementia or cognitive impairment. Created by the Dementia Champions the toolkit is an easy-read guide for carers to complete and staff to use. The 'Read About Me' toolkit includes information such as patient's likes and dislikes, personal interests and family details. These are kept with patients throughout their time in hospital to avoid patients and their carers repeating their story and allows staff to understand their patients better and improve care. A Visitor's Café has been introduced onto the Llanfair Unit to make visiting times more enjoyable for patients and carers or family members. Comfy corners have been created to reflect a traditional home setting to make people feel more relaxed and the visitor café has been fitted with a coffee machine so families and carers can visit their loved ones away from the ward environment. Volunteer interaction is encouraged within the Health Board so that patients develop relationships and reduce isolation while in hospital. Some of the volunteer schemes in the hospital include: • Art Groups • Musicians • Our Orchard • Visits from local school children • Forget Me Not Productions
R **Recommendation**	The following improvement actions have been identified as key deliverables for 2019/20: 1. An increase to at least 85% in equality training compliance figures. 2. To undertake internal and external consultation on the next Strategic Equality Plan 3. More identifiable work *in relation to the Rights of Older People and the UN principles*

Appendix 1 - Standard 6.2 Peoples Rights

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

The health service will need to consider the following criteria for meeting the standard:

Criteria
1a. Needs of individuals are recognised and addressed whatever their identity and background, and their human rights are upheld.
1b. Discrimination is challenged, equality and human rights are promoted and efforts are made to reduce health inequities through strategies, equality impact assessment, policies, practices, procurement and engagement.
1c. Strategic equality plans are published setting out equality priorities in accordance with legislation.
1d. Care is consistent whatever the age of the person being cared for, so that for example for younger people with serious illnesses should expect an efficient transition from child services to adult services with good communication between those agencies.
1e. The rights of children are recognised in accordance with the United Nations Convention on the Rights of the Child (UNCRC).
1f. The rights for older people in Wales are recognised in accordance with the Declaration of Rights for Older People in Wales and the UN principles for Older Persons.
1g. The spiritual and pastoral care needs of people and their carers are recognised and addressed.
1h. People are encouraged to maintain their involvement with their family and friends and develop relationships with others, according to their wishes.

ANNUAL SELF ASSESSMENT
STANDARDS FOR HEALTH SERVICES IN WALES
Standard 6.3 Listening and Learning from Feedback

S **Situation**	**Health and Care Standard:** People, who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback. **Corporate Assessment** This report is intended to provide the Executive Director of Nursing and the Lead Independent Member with an update of compliance against Health And Care Standard 6.3.
B **Background**	The Health and Care standards were launched by Welsh Government in April 2015. Health Wards are required to complete an annual self-assessment of compliance against each of the 22 standards. The specific criteria are: **Health services and boards demonstrate how they are responding to user experience to improve services**. • Partners are engaged in supporting and enabling people to be involved in the design planning and delivery of services. • The patient's and carer's voice is heeded by health services and boards, including through the use of patient stories. • Feedback is captured, published and acted upon in a way that provides an ongoing and continuous view of performance and demonstrates learning and improvement. • Service delivery improvement for all people is captured and demonstrated which includes as a consequence meeting statutory responsibilities for children and young people. • Equality and diversity, and the Welsh language. • It is clear how data reported in national surveys and audits are used and applied. **There are processes in place that assure a good experience for people which include:** • Assessing and evaluating service user experience, especially for those who are vulnerable; • Provision for people who are less able to speak for themselves;

- Delivering and measuring improvement;
- using patient feedback to influence/drive changes to service provision and delivery;
- Recognising the spiritual, pastoral and religious dimension of care.

There is compliance with legislation and guidance to deal with concerns, incidents, near misses, and claims as set out in the "Putting Things Right" arrangements.

- Concerns are reported, acted upon and responded to in an appropriate and timely manner and are handled and investigated openly, effectively and by those appropriately skilled to do so.
- Patients, service users and their carers are offered support including advocacy and where appropriate redress.
- Health services are open and honest with people when something goes wrong with their care and treatment.
- Appropriate support is provided to health staff and learning and services improve through sharing lessons from local and national reviews.

The Patient Experience team is structured to provide support to each Clinical Board.

They are supported to deliver the Patient Experience framework which includes adherence to the Putting Things Right Regulations and engaging in a diverse system of attaining patient experience feedback.

Clinical Boards have submitted their self-assessment which includes their rating against compliance with the standard:

Clinical Board	**Self-Assessment 2018/19**
Children and Women	Evidence submitted but no self-assessment - Meeting the standard
CD&T	Meeting the standard
Dental	Getting there
Medicine	Leading the way
Mental health	Leading the way
PCIC	Meeting the Standard
Specialist	Getting there
Surgery	Meeting the Standard

A Assessment	The self-assessments completed, and the evidence provided by the Clinical Boards gives sufficient assurance or evidence that they are progressing towards or compliant with the standard. There is evidence of meeting the criteria across the UHB. **The patient's and carer's voice is heeded by health services and boards, including through the use of patient stories** The link below is a carers story on our intranet pages **Carers Story.** Each Board and Quality, Safety and Experience Committee meeting starts with a patient/carer or staff story. A Carers annual report is shared at the Quality, Safety and Experience Committee September 2018 We worked with our local authority and third sector partners to deliver projects **1.** GP Accreditation To improve access to information and raise awareness of carers, among community including ensuring early identification of carers. **2.** Young Carers in Schools Project (YCiSP) We recognise and support young carers in school and offer training and support to staff. **3.** Health and Social Care Accreditation (H&SC) Areas can gain accreditation through evidencing that they are a carer friendly environment-the evidence is reviewed by a peer support group. **Feedback is captured, published and acted upon in a way that provides an ongoing and continuous view of performance and demonstrates learning and improvement** In excess of 1,000 surveys are returned monthly with feedback shared with clinical areas. They receive the quantitative and qualitative comments and act upon the feedback which is often demonstrated in the 'you said we did' sections of our report to Board which are published on our internet site. We also use Happy or Not machines to gain real time feedback and we undertake some bespoke surveys on kiosks in secondary and primary care to capture some quick feedback which can be shared in real time.

There are processes in place that assure a good experience for people which include:

- Assessing and evaluating service user experience, especially for those who are vulnerable;
- Provision for people who are less able to speak for themselves.

We recognised that we seldom heard from people who were deaf or hard of hearing via our concerns or feedback routes, therefore we decide to hold a public meeting and listen to their views. This lead to working with the community to make several changes.

In order to ensure an improved service for all people with sensory loss the Health Board Charitable Funds Committee supported Centre of Sign, Sight and Sound (COS). COS improves the quality of life and equality of access for deaf people and people with a sensory loss. Whether the service is delivered online, remotely or face-to-face, they assist members of the community with a wide range of issues, from making GP appointments to communicating with Health Care professionals. They provide support to service providers ensuring they are able to meet their responsibilities under the Social Services and Wellbeing (Wales) Act 2014. We trained over 200 staff in basic BSL with a programme planned for 2018/19

Recognising the spiritual, pastoral and religious dimension of care.
Our multi faith chaplaincy service has developed a multi faith events calendar to celebrate and honour a diverse religious calendar.

There is compliance with legislation and guidance to deal with concerns, incidents, near misses, and claims as set out in the "Putting Things Right" arrangements
Each Clinical Board displays increasing maturity in this standard there is notable practice in each Clinical Board

The PTR annual report was shared at the September QSE 2018 and the report is published on our Internet site.

PTR Annual Report

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

	improvement. The Health Board has a robust process in place to manage concerns in a proportionate manner in accordance with the regulations. **Ombudsman** Internal Audit have undertaken a review of the Concerns Team management of Ombudsman cases in 2017/18 and provided substantial assurance with no recommendations. They noted areas of good practice throughout the process. **Redress** We are committed to using the redress process when appropriate this enables a timely resolution for those people seeking an apology, remedial treatment and/or financial compensation to the value of £25,000. As indicated in the report our use of the redress system has steadily increased since 2011. It should be noted that to date since NHS Wales Shared Services Partnership - Legal and Risk Services began charging individual organisations for legal advice we have not incurred any costs to date. **Claims** Claims Managers try to engage with clinicians' at all available opportunities. We are targeting training for individual Clinical Boards and this has been supported by solicitors from NHS Wales Shared Services Partnership - Legal and Risk Services. The feedback has been very positive. We are mindful of reviewing costs throughout the process of the claim to avoid any unnecessary expenditure. The lessons learned from claims are identified as early as possible in the investigation to ensure that we do not wait for completion of the process to embed the learning. **Specific actions from the Clinical Boards** • **Children and Women** - Children and Young People's Youth Board has been established to ensure engagement with service users around service design etc. • Children's Charter developed and launched in Nov 18. • **C, D &T** - The Clinical Board has developed a 'Patient Experience and Engagement Framework'. • **Dental** - Compliments and concerns are shared with staff at audit/Locality meetings. • **Medicine -** Continued Model ward Nutrition and Hydration implemented to 4 wards. Feedback from patients, relatives and staff has been very positive and has enabled the Clinical Board to demonstrate a model of care that has

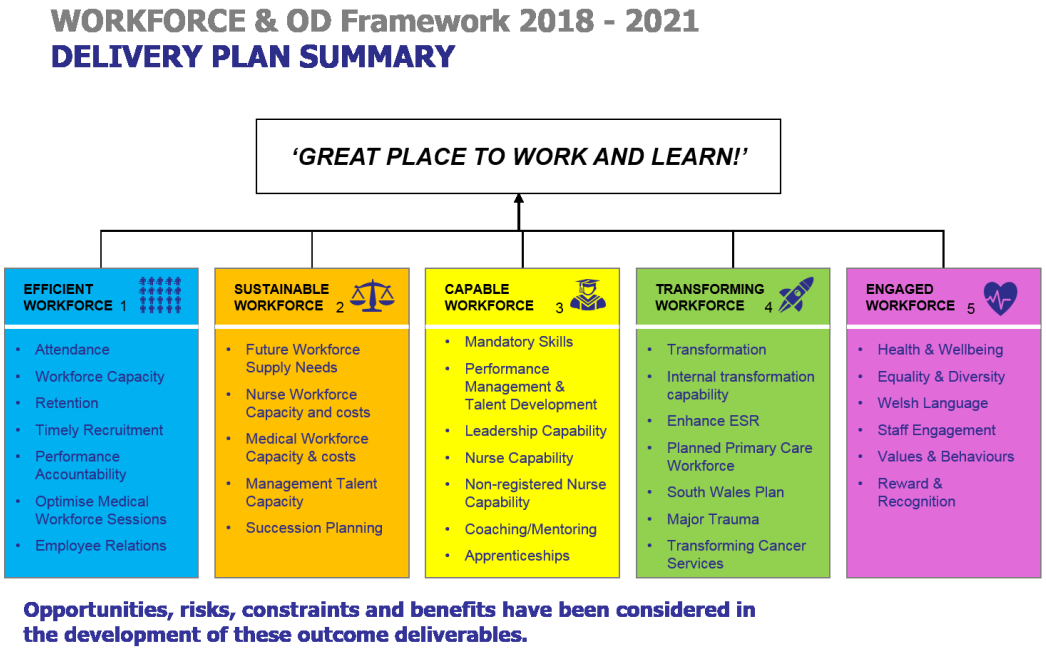
	listened to patient feedback in improving the quality and availability of food, drinks and snacks. • **Medicine** - Patient Experience Groups and Carers clinics are established across the Board. • **Mental Health -** The CB is part of a UK Benchmarking club for MH and utilises the data to inform service improvement projects. • **PCIC -** A Clinical Board patient engagement group has been developed and in operation within the Clinical Board for the last 2 years, there is also a second group that has been established in the N&W Locality. • **Specialist -** B4 have initiated 'nibble and natter' sessions for carers and families on the ward. Carers raise issues, concerns and feedback on behalf of patients and these are acted upon. • Critical Care has introduced ICU Steps to help support patients and relatives who have experienced critical illness and to learn from these experiences. • **Surgery** - Patient Know Best Platform in ENT is able to give us real-time feedback from specific patient groups.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for 2019/20** • More work needs to be done in regard to patient feedback in our Children's Centres as previous initiatives have not been appropriate. We are working with UHB patient experience on this. • Dental - Reinstate the Public and Patient involvement group. • **Medicine** - Wider Feedback to the ward area and individuals so that key messages and experiences are shared; Development of Sister/Charge feedback session from Serious incidents and RCA so that they in turn can share this with their ward staff. • **Mental Health -** Development of an over-arching action plan following untoward events will assist in the implementation of action plans and the development of theme specific training. • **PCIC -** Continue to develop the planning to secure patient and service user feedback and engagement against the PPE framework. • **Specialist -** Ensure compliance with regard to response times for informal and formal concerns as per KPI's. • **Surgery -** Look at ways in which they can action feedback via PKB (Patient Knows Best) system. Across the UHB we will train in excess of 500 staff in basic BSL training.

	In June 2019 we will be the first health board in Wales to sign the BSL charter. In 2019 we plan to undertake further public meetings with seldom heard groups to listen and engage with communities to focus upon improving their experiences and access to our services.

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

S **Situation**	**Standard 7.1 Workforce** Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet the need
B **Background**	Standard 7.1 consists of a number of criteria relating to: • Working with partners to develop an appropriately skilled, safe and sustainable workforce • Recruiting, training and managing the workforce • Providing the workforce with appropriate support • A list of this criteria is attached as Appendix 1. By mapping these out against the Workforce chapter of the UHB IMTP (Integrated Medium Term Plan), along with the NHS Staff Survey Results and other sources such as the WOD Delivery Plan and UHB Employment Policies, we are able to see areas where the criteria is achieved and where further work or improvement is needed. This is not an exhaustive list and not does not capture all relevant Workforce and OD activity in 2018/19. Assessment against the Standard is rated from the following definitions: Getting Started; Getting There; Meeting the Standard and Leading the Way. Performance against Standard 7.1 is assessed as 'Meeting the Standard', though in some elements (including student recruitment, performance management and talent development, and the transformation programme) we are 'Leading the Way'. Following sign off of this assessment by the Lead Independent Member and Executive Director, it will be reported to Board via the Quality, Safety and Experience Committee.
A **Assessment**	***1a. have effective workforce plans which are integrated with service and financial plans*** The UHB Workforce Delivery Plan "A ***Great Place to Work and Learn***" was developed to support the IMTP and form a consistent approach to workforce planning within the IMTP. It supports our overall aim of "*caring for people, keeping people well"* and is embedded throughout the IMTP due to the integrated nature of the Plan. It is based upon five core objectives demonstrated in the following diagram and aligned to the Prudent Healthcare principles, *A Healthier Wales* and the organisation's ten year strategy, *Shaping Our Future Wellbeing 2015-25.* There are 7 Clinical Board Plans that sit beneath and support the UHB IMTP. These describe in detail the integrated workforce plan in the context of the Clinical Board requirement against population need, service and finance. The high level UHB Plan and objectives have been

replicated within the Clinical Boards – an excellent example of this is the PCIC IMTP.



Opportunities, risks, constraints and benefits have been considered in the development of these outcome deliverables.

1b. Meet the needs of the population served through an appropriate skill mix with staff having language awareness and the capability to provide services through the Welsh language.

The Welsh Language Standards, after a very comprehensive and systematic consultation process, were issued to the UHB at the end of November 2018 and the UHB has between 6 and 24 months to achieve compliance. In most cases, the Standards can be reached or we are already compliant. However, there are a number of Standards which present significant challenges to the UHB and a response to the Welsh Language Commissioner is being prepared.

Examples of work undertaken in 2018/19 include providing training opportunities for staff and working with local dementia networks to develop a reminisce resource for use with Welsh speaking patients.

Only 8% of Staff Survey respondents said that they could speak Welsh, with a further 7% learning. When asked if they use it in the workplace the responses were as follows:

- 2% - Most of the time
- 35% - sometimes
- 39% - rarely
- 24% - never

1c. promote the continuous improvement of services through better ways of working

New ways of working are continuously being explored as part of resourcing strategies designed to fill service critical or hard to fill posts. For example, the UHB has a significant number of staff who evidence

	working at the Advanced Practice level and Nursing Advanced Practitioner (AP) roles are well established within the majority of Clinical Boards. New trainee APs are being developed in Children and Women, Medicine, PCIC and Specialist Services and work is being undertaken in Mental Health to support the development of new AP roles, particularly for the community. AP roles are also being developed in Allied Health Professions, for example First Contact Physiotherapists who are being appointed to work in GP practices and provide patient care instead of GPs. An inter-professional Advanced Practice Working Group has been established to provide strategic drive and support for this agenda and to standardise the approach to the development and governance of AP roles across the UHB. In 2018 the UHB became a member of the Quest Group, which allows collaborative working with 15 high performing Healthcare Trusts in England. The organisations work together with the triple aim of improving patient safety and quality; being recognised as the employer of choice; and improving innovation through greater enabled technology. Whilst the UHB's involvement in Quest is in its very formative stages it is apparent that we can benchmark and learn from others, allowing us to introduce and inherit processes other organisations have already benefitted from. There is a significant amount of work taking place within PCIC Clinical Board as part of the delivery of the IMTP and 'Planned Primary Care Workforce for Wales'. This includes: • OOH (Out of Hours) Services across Cardiff and Vale. The multi-disciplinary model has been shared as a case study for inclusion in the Primary Care Compendium of roles/models demonstrating the service successes through the introduction of clinical practitioners, with a nurse or Paramedic registration, as an alternative where GP cover has been continually challenging. Recent demand and capacity modelling has supported the creation of a workforce plan and service model of the future which includes the continued development of the multi-disciplinary team focused on skills. • Creation of a Novice to Expert pathway for District Nurses to support the education and development needs of the workforce in line with the DN principles, the interim guidance on staffing principles, as a result of Nurse Staffing Levels (Wales) Act 2016. The UHB continues to develop and implement service and workforce plans in Cellular Pathology, and Laboratory Genetics as part of the Modernising Scientific Careers programme. Genetics staff (Clinical Scientists, Bio informaticians, Technologists) receive further training to meet the increasing demands of the growing Genomic service. It is also progressing analogous integrated workforce planning in Radiology which is outside MSC. This has resulted in new structures and skill mix to support 7 day working and change in service pathways. (For information on the transformation programme taking place within the UHB see sections 3f and g below).

1d. enable the supply of trainees, students, newly qualified staff and new recruits and their development

We are keen to create a culture where opportunities for people to develop their skills, experience, education and qualifications are explored. In 2018 the UHB launched a new Apprenticeship Academy to underpin our commitment to the *Well-being of Future Generations Act; a prosperous Wales*. The launch included signing the Cardiff Commitment Pledge. This investment in apprenticeships and the widening access agenda remains a key development in our workforce plan for 2019/20 and our intention is to develop 100 entry level apprenticeships in 2019/20 and also continue to upskill our current workforce with opportunities to study apprenticeship courses. The UHB is working with an external educational accredited provide to achieve this. We see apprenticeships as an opportunity to maximise the potential of our workforce by engaging with our experienced staff, so that they pass on their skills and experiences to others and support learning opportunities at all levels. We envisage growing our apprenticeship opportunities and the widening access agenda over the next three years in traditional areas such as estates and crafts and also to broaden to our essential support functions of administration, housekeeping, catering, IT, HR and Finance. We will also focus on support within clinical areas such as nursing, clinical administration and central servicing areas.

A comprehensive project plan is in place for nurse recruitment and retention via the Project 95% group. Actions during 2018/9 included: increasing local campaigns and use of social media to attract applicants, student streamlining, regional and national events, and return to practice. A business case and tender process are in development for an international recruitment campaign in 2019/20. A successful UHB wide Recruitment Campaign in January 2019 led to 71 job offers being made and we have recently had 166 offers accepted via student streamlining.

A robust Adaptation programme for Overseas Nurses was developed in 2018/9 and will be more widely implemented and evaluated in 2019/20. 4 cohorts have been profiled up to February 2020 which will allow 53 Adaptation Nurse to progress through the programme.

Newly registered nurses are supported through an innovative Nurse Preceptorship Programme (NPP) for their first 12 months post registration. This programme is currently under review and a new programme will be tested in 2019/20. Additional induction pathways are being developed to support the acquisition of competence in other roles e.g. Ward Sisters and Charge Nurses.

	In 2018/19 nine MTI (Medical Training Initiative) doctors were recruited through the BAPIO (British Association of Physicians of Indian Origin) initiative. We have also increased the number of Clinical Fellows, especially in Medicine which is a 'hard to fill' area. As a Health Board we continue to promote and support the two year graduate trainee management scheme. ***1e. Ensure plans reflect cross organisational/regional/all Wales workforce requirements where appropriate.*** Formal Joint Regional Planning and Delivery Committees are in place for the South Central and South East Region (Cwm Taf Morgannwg, Cardiff and Vale and Aneurin Bevan) and the South West Region (Swansea Bay (previously ABMU) and Hywel Dda). The workforce transformation required to support these change programmes is embedded within each of the two streams and no longer sits alone. These include Vascular; ENT; Paediatrics, Obstetrics, Neonatal and Gynaecology (PONG); and Regional Priority programmes covering Orthopaedics, Ophthalmology and Diagnostics. As part of its role in the Cardiff and Vale Regional Partnership Board, the UHB participated in a Workforce Planning Development Session. The purpose of this was to review, in partnership, the strategic workforce context across the health and social care region, noting the working already taking place in each of the three areas at a local, regional and national level and considering further strategic priorities and action plans. Coming out of this, last year, the senior leadership teams in Workforce & OD in the UHB and Cardiff Council met informally in order to develop working relationships and share practice across sectors. Under the direction of the NHS Wales, Deputy Chief Executive and Deputy Chief Medical Officer, Welsh Government has commissioned the establishment of a directed national programme to improve the provision and sustainability of endoscopy in Wales. A National Programme Board will oversee the work and delivery of the programme. Last year the UHB Deputy Director of Workforce & OD was the All Wales Workforce representative on the group; specifically tasked with bringing together baseline workforce data and intelligence across Wales to feed into a key workshop which was held in December last year. The workshop outcome and recommendations will feed into the national delivery programme. ***2a. The workforce have all necessary recruitment and periodic employment checks and are registered with the relevant bodies*** The Recruitment and Selection Policy was reviewed in 2018/19. This requires all employees to have undertaken all relevant pre-employment checks (PECs) prior to commencing employment. There is a robust PEC process which is undertaken for us by NHS Wales Shared Services Partnership and our Medical Workforce Department.

	Previously there had been concerns around new starters commencing employment without all pre-employment checks being completed. However, from 1 May 2018 a new electronic appointment form was introduced which is only be generated after the applicant has completed **all** of the required pre-employment checks (including DBS). It should therefore not be possible for an individual to be paid unless the necessary checks have been completed. The only exception to this is where a newly qualified professional is allowed to start in a pre-registered/ unqualified post pending receipt of their professional registration number (providing all other checks are completed). This has strengthened the governance and control mechanisms. It is monitored on our behalf by NWSSP and is reported on a monthly basis to the Head of Workforce Governance. Professional Registration is a contractual requirement for certain professions as described in the UHB Professional Registration Procedure. NMC and GMB registration are monitored via ESR and a flag is automatically raised for managers. In 2018/19 HCPC membership was also added to ESR. Registration with other professional bodies is monitored locally by the Clinical Boards. ***2b. The workforce are appropriately recruited, trained, qualified and competent for the work they undertake*** Ensuring sustainability of current and future workforce supply, especially in nursing and medical roles, remains a priority for the UHB. Specific actions identified within the IMTP are: deliver Project 95% and sustain Project Switchover; continue to deliver Medical Training Initiative (MTI) strategy; monitor the implementation of the Welsh Government Agency and Locum Circular, recruit hard to fill vacancies; develop talent management and succession planning for senior management posts. The successful recruitment campaigns co-ordinated by the Project 95% group in 2018/19 is referenced above. Recent work has also focussed on the development of a Nurse Retention Plan to ensure that when we recruit we also retain our nurses. As at end of December 2018, there were four hard to fill Consultant vacancies and 25 hard-to-fill trainee and higher grade medical vacancies. Whilst the UHB have had a number of successes in 2018 in filling key roles in Emergency Medicine and Paediatrics, our recruitment strategies continue to be reviewed especially in Medicine, Paediatrics and Psychiatry. Our plans to address other professions include: newly qualified nurses, Sonographers, Radiologists, qualified mechanical and electrical trades, Perfusionists, Cardiac scrub nurses and Advanced Nurse Practitioners. Performance management and talent development are integral to our appraisal, recruitment and retention plans for 2019/20. During the last 6 months of 2018/19 we undertook a Pilot Programme with invited Managers (clinical and non-clinical) to form a Talent Management

Community of Practice. An action plan based on national work on talent and succession planning will ensure our local plan draws on best practice. An early indication of how the 9 Box Grid to enable the career conversation with individual members of staff is developing is outlined below. Areas of focus are: recruiting talent; identifying and retaining talent; deploying talent; and succession planning. Outcomes will include: a values-based recruitment process; a promotional plan for the UHB; an increase in our graduate-management scheme places; a post-graduate scheme; a talent-management tool for use across all Clinical Boards and Corporate Departments; a bespoke programme of development for those identified through the talent management process; and a career-pathway brochure. Benefits will be identified through a reduction in hard-to-fill posts and reduction in expenditure on interim staffing arrangements. The new approach will promote value based appraisals which includes having a career conversation. This will be launched in June 2019.

2c. the workforce act, and are treated, in accordance with identified standards and codes of conduct

We have involved patients and their families, and clinical and non-clinical staff in creating a behavioural framework to bring our Values to life. In doing so we have also refined our Values to ensure they are memorable and relevant. As an organisation we strongly believe that it is vital our leaders exhibit the behaviours and values that we expect from all our staff. In 2018/19 these behaviours were integrated in to all workforce processes, including recruitment, promotion, appraisals, induction and performance management. Each of our core values comes with a set of behaviours that are measurable and specific. Incorporating core values as part of the performance management process will enable employees

	TRANSITION EMPLOYEE High potential though underperforming, may be in wrong job / manager or new to role *(needs support)* **DEVELOP**	**FUTURE POTENTIAL** High potential, capacity for key roles, strong, valued contributor *(recognise and develop)* **STRETCH / DEVELOP**	**ROLE MODEL** High potential to go further *(reward, recognise and promote)* **STRETCH**
	DEVELOPING GENERALIST Potential for some growth, Needs stretching, some under performance *(provide coaching)* **OBSERVE**	**CORE EMPLOYEE** Solid and adaptable *(motivate, engage and reward)* **DEVELOP**	**GROWTH EMPLOYEE** Pivotal and flexible, strong contributor *(challenge, reward, grow and motivate)* **STRETCH / DEVELOP**
	DEVELOPMENT ROLE Has reached job potential and is not meeting objectives / behaviours *(Support, manage)* **OBSERVE**	**FUTURE PROFESSIONAL** Reliable performer with potential in current role, specialised, expert *(engage, focus, motivate)* **OBSERVE**	**TRUSTED PROFESSIONAL** Specialised, expert, reached career potential *(retain, reward, encourage, mentoring others)* **DEVELOP**

to be recognised whenever they behave in alignment with core values. Reviewing people based on values is interrelated with rewarding people for demonstrating the values. All leadership and management training in Cardiff & Vale now incorporates training on a coaching style and managers are encouraged to coach and support employees on how to demonstrate the core values which eventually lead to recognition and rewards.

Between April 2018 and March 2019, 12,405 individuals undertook the Equality (Treat Me Fairly) training which equates to a compliance rate of just less than 79%.

Our UHB Professional Registration Procedure requires individuals who work within certain professional groups and who are employed and/or undertake work on behalf of the UHB, to be registered with their respective professional organisation, and therefore work to their Code of Conduct. The NHS Wales HCSW Code of Conduct applies to all staff who are not covered by a profession specific Code.

2d. The workforce are able to raise, in confidence without prejudice, concerns over any aspect of service delivery, treatment or management

During 2018/19 a working group was established to consider our current mechanisms for raising concerns including the Procedure for NHS Staff to Raise Concerns, Freedom to Speak Up, Safety Valve and other mechanisms including DATIX, anonymous letters etc. These are separate but inextricably linked and a Standard Operating Procedure was developed to ensure consistency, robustness and good governance – this sets out that the Director of Corporate Governance will be responsible for logging, monitoring and reporting of all formal concerns.

The 'Freedom to Speak Up' helpline was also relaunched in September 2018 and a video was developed to be displayed around the UHB sites. However, the number of contacts remains very low and the Staff Survey responses around staff wellbeing are concerning:

- 34% of respondents had been injured or felt unwell as a result of work related stress in the preceding 12 months
- 18% of respondents had personally experienced harassment, bullying or abuse at work from managers / line managers / team leaders or other colleagues in the preceding 12 months
- 94% knew how to report harassment, bullying or abuse at work if they experienced it
- 56% thought the UHB took effective action if staff are bullied, harassed or abused by other members of staff

In response to the Staff Survey results, an Employee Stakeholder Group, chaired by the Executive Director of Workforce and Organisational Development was established. Volunteers from across the UHB were sought and around 50 members of staff expressed an interest in being involved. Three workshops were undertaken to explore the key themes identified (including leadership and culture/behaviours) and agree

improvement actions. The next step is to establish a Staff Survey Steering Group to oversee progress against the actions.

The staff Exit Questionnaire was redesigned in 2018/19 and is now much easier to access and complete (via a QR Code and Survey Monkey). The Exit Questionnaire is an important mechanism for gaining feedback from staff when they leave the organisation or move internally. This information is used to improve staff experience and patient care, and to identify any specific areas of concern which may require intervention.

In 2018/19 we launched the Consensus Mediation Service to provide confidential, impartial support to two or more people in dispute, to attempt to reach an agreement. Mediation is used as a first resort in dealing with Dignity at Work issues and can be described as an informal, voluntary process, in which a neutral person helps individuals in dispute to explore and understand their differences so they can find their own solution.

2e. The workforce are mentored, supervised and supported in the delivery of their role

Two different level of management programmes are being delivered in the UHB up to four times per year each. Skills to Supervise is aimed at new and aspiring managers and Skills to Manage includes the core management skills. Management programmes have been opened up to all grades with staff from all levels now applying and attending both programmes. Their managers are also engaged in their training through reflective practice logs and discussion before competencies are signed off. 130 employees were trained in developing a coaching style, to continue to develop a coaching culture within the UHB. In addition to this, areas with a need for more bespoke support are supported with focussed OD sessions working on specific areas of need.

2f. ***The workforce are dealt with fairly and equitably when their performance causes concern***

Employee Relations (investigations, disciplinary, grievance etc.) processes have been reviewed in 2018/19 and have resulted in:

- A significant reduction in formal investigations (from 90 at its highest to 34 at its lowest).
- Disciplinary and Appeal hearing are arranged in a timely manner; wherever possible formal grievances are resolved informally.
- The duration of formal investigations is starting to reduce, with only 1 case which has taken over 12 months to conclude.

	A revised NHS Wales Capability Policy was adopted in June 2018 and an online 'Managing Capability Toolkit' was developed to assist and guide managers to manage capability issues effectively. The primary purpose of the Capability Policy and the toolkit is to ensure that employees receive the support needed to help them to improve their performance to the standard required and that all employees are treated fairly and with dignity and respect, in line with our UHB Values. ***2g. The workforce are provided with appropriate skills, equipment and support to enable them to meet their responsibilities to consistently high standards;*** **and** ***3a. The workforce maintain and develop competencies in order to be developed to their full potential*** Leadership and Management Skills remain a key focus for the UHB as we continue to invest in development to build leadership capability. In 2018, the leadership development offered in the organisation was reviewed in line with the UHB strategy. The focus, at all levels, is on working as a system for the benefit of patients. The programme allows networking, supporting each other and stimulating leaders to solicit ideas and innovative solutions from each other and their teams and encouraging them to present ideas that are different from their own and utilising a improvement methodology. Other relevant activities in 2018/19 include: • The Clinical Directors leadership programme is now embedded into the suite of leadership programmes offered. • A 'Nursing and Midwifery Education and Development Framework' in under development to support nurse progression through career pathways. • Induction pathways are being developed to support the acquisition of competence for Ward Sisters/Charge Nurses. • The ESR competency module is now being used to document the achievement of competence for nursing clinical skills and will continue to be implemented for all clinical skills in 2019/20. Strong development pathways are now in place for all non-registered nurses working across all settings in the UHB. Development pathways now help HCSW to access undergraduate nurse training through the traditional route or one of the flexible routes that are now open to HCSW (University of South Wales and Open University). A structured refresher training and assessment programme is ongoing within Operational Services for staff to undertake NVQ's for cleaning standards and customer skills, IQT, dignity and respect and customer communication. The Staff Survey results from 2018 show that: • 50% of respondents say there is still strong support for training in their area of work (45% 2016, 35% 2013)

	• 51% are able to access the right learning and development materials when they need to (previous data not available) • 43% of respondents believe there are opportunities for them to progress in their job (41% 2016, 32% 2013) • 60% of respondents are supported to keep up to date with developments in their field (55% 2016, 47% 2013) • 63% are encouraged to develop their own expertise (57% 2016, 50% 2013) • 53% are encouraged by their line manager to continuously develop new skills (57% 2016, 50% 2013) • 69% say that their training and development has helped them to their job better (64% 2016, 56% 2013) • 72% say that their training and development has helped them to stay up to date with their job and professional requirements (67% 2016, 2013 data not available) However, while these figures are lower than we would like, all but one show an improvement since the surveys conducted in 2016 and 2013. ***3b. The workforce attend induction and mandatory training programmes;*** Mandatory training compliance is monitored and reported monthly to ensure we are moving toward 85% compliance target. During 2018/19 the ESR system was utilised to develop a training needs analysis for all level 1 (awareness raising) mandatory training. This has replaced the previous blanket approach and now provides a system for staff to identify the modules and refresher period they are required to undertake for their role. In 2019 the same approach is being adopted for level 2 and 3 mandatory training which, again, will identify the roles that require the relevant training, therefore avoiding duplication and unnecessary time undertaking training not relevant to the role. Classroom based training also continues to be available several times a year as an alternative to the level 1 e-learning programme. Compliance rates for 2018/19 are (against a target of 85%): • Statutory and Mandatory Training Rate (12- Month Cumulative) – 75.55% • Fire Training – 67.27% 44% of staff survey respondents said that they have sufficient time at work to complete any statutory and mandatory training (increase from 38% in 2016). The process for how staff are invited to attend the Corporate Induction programme changed in 2018/19. Candidates are now being booked on via the TRAC recruitment system at the 'offer accepted' stage. Monitoring processes have been put in place to ensure staff are invited to their Corporate Induction as close to their hire date as possible and that the

	mandatory training modules are completed within 2 months. 858 individuals attended 24 (2 half days a month) corporate induction sessions during the year 2018/19. ***3c. The workforce have an annual appraisal and a personal development plan*** The appraisal process and documentation is being thoroughly reviewed due to reported PADR compliance remaining static at around 56-60% for many years. The process will be aligned with the talent management process and fundamentally this new approach will enhance the staff experience and improve the career conversation. A task and finish group has been established to develop the material in collaboration with staff, ready for implementation of the new approach in 2019. Through our own analysis and through Audit we are aware that there is under-reporting currently in ESR. This is supported by the staff survey results (below). Further training and support continues to be provided to Managers to help ensure they are inputting data at source. The 2018 Staff Survey results show: • 82% of respondents had a PADR/appraisal in the preceding 12 months (75% 2016, 68% 2013) • 53% said this helped them to improve how they did their job (54% 2016, 44% 2013) • 83% said that the appraisal helped them agree on clear objectives for their work (79% 2016, 72% 2013) ***3d. The workforce develop their role*** *(See also section 1c above)* The 2018 Staff Survey results show positive improvements in this area when compared to previous surveys: • 56% of respondents stated that they can influence what goes on in their work area (45% 2016, 43% 2013) • 55% said that their line manager asked their opinion before making decisions affecting their work (45% 2016, 44% 2013) • 55% said they are involved in discussions/decisions on change introduced in their work/department/team (47% 2017, 47% 2013) • 75% said they are able to make improvements in their area of work (60% 2016, 56% 2013) ***3e. The workforce demonstrate continuing professional development*** CPD is an important part of our staff development. The UHB believes that lifelong learning is an investment in quality, and that CPD is one component in the drive to developing a lifelong learning culture. All employees have a personal duty to maintain their knowledge and skills throughout their working lives, as specified within their respective Codes of Conducts.

	Revalidation exists within the nursing and medical professions, and CPD is an integral part of this. CPD should be part of the PADR discussion and is part of the ongoing development of meaningful PADRs. CPD is referenced in the PADR Policy and the Study Leave Guidelines. The Study Leave Guidelines were reviewed and updated in 2018/19. **3f. *The workforce* access *opportunities to develop collaborative practice and team working,* and** ***3g. The workforce work closely together, preventing duplication of effort and enabling more efficient use of resources*** We have continued to build internal transformation capability in 2018/19 to ensure we 'can do it for ourselves' and reduce reliance and expenditure on external support, integrate transformation principles into all leadership activity, and leverage internal skills and support. We have developed national and international links with our alliancing partners, including strong relationships with Canterbury integrated health system, New Zealand. Organisational Development interventions and principles are being utilised and will be key in achieving the new ways of working and cultural alignment within and across organisations The UHB Nursing Productivity Group (NPG) is an excellent example of collaboration and multi-profession working. Chaired by the Executive Director of Nursing, the group consists of representatives from nursing, finance, WOD, programme management and Staff Representatives. The purpose of the Group is to make the best use of nursing resources including recruitment, e-rostering (time) and agency and variable pay. The 2018 Staff Survey results show that 82% of respondents have shared objectives with team members, and that 85% believe team members have to communicate closely with each other to achieve the team's objectives. However, only 56% reported that team members often met to discuss their effectiveness, and just 58% said that team members took time out to reflect and learn. An inter-profession Advanced Practitioner Working Group has been established to provide strategic drive and support for this agenda and to standardise the approach to the development and governance of Advanced Practitioner roles across the UHB. The UHB has put in place dedicated Primary Care Workforce Planning and OD expertise which provide advice to the 62 GP practices and core Sustainability Team. They also work directly with Clusters and Practices supporting the delivery of actions aligned to the Primary Care Plan for Wales. The Team have identified a three year Workforce operating model with significant progress having been achieved during 2018 and further detailed action plans in place for 2019. The Workforce Planning and OD Manager works closely with the Public Health Wales Cluster development group and with Academi Wales.

	We participate actively in the development of the public sector partnership leadership programmes through our involvement in the Public Services Board. In line with the Canterbury model we will be working closer with our colleagues in social care in regards to the leadership offerings in 2019/20 to become more integrated system.
R Recommendation	The following improvement actions have been identified as key deliverables for 2019/20: • Leadership Capability through engagement and development for the leaders of the UHB which commenced in March 2019 and will continue throughout 2019/20 • By September 2019 we will streamline our Employment Policies, and we will continue to monitor their effectiveness in partnership • By March 2020 all clinical boards / service boards will have robust workforce plans which will be aligned to SOFW and the IMTP • By March 2020 we will recruit to 95% of the nursing establishment in line with Project 95% • Continuation of developing the diversity of our workforce through entry level apprenticeships and widening access for example working with Elite and Wallach organisations

Appendix 1 - Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

The health service will need to consider the following criteria for meeting the standard:

Criteria
Staff are enabled to learn and develop to their full potential. The leaders of any NHS organisation have a duty to set the appropriate tone and promote the right culture, and ensure that individual members of staff can fulfil their responsibility to deliver high quality and safe services.
1 Health services work with partners to develop an appropriately skilled safe and sustainable workforce by: a. having effective workforce plans which are integrated with service and financial plans b. meeting the needs of the population served through an appropriate skill mix with staff having language awareness and the capability to provide services through the Welsh language c. promoting the continuous improvement of services through better ways of working d. enabling the supply of trainees, students, newly qualified staff and new recruits and their development e. ensuring plans reflect cross organisational/regional/all Wales workforce requirements where appropriate.
2. The workforce: a. have all necessary recruitment and periodic employment checks and are registered with the relevant bodies b. are appropriately recruited, trained, qualified and competent for the work they undertake c. act, and are treated, in accordance with identified standards and codes of conduct d. The workforce: are able to raise, in confidence without prejudice, concerns over any aspect of service delivery, treatment or management e. are mentored, supervised and supported in the delivery of their role f. are dealt with fairly and equitably when their performance causes concern

g. are provided with appropriate skills, equipment and support to enable them to meet their responsibilities to consistently high standards
3. The workforce is provided with appropriate support to enable them to: a. maintain and develop competencies in order to be developed to their full potential b. attend induction and mandatory training programmes c. have an annual appraisal and a personal development plan d. develop their role e. demonstrate continuing professional development f. access opportunities to develop collaborative practice and team working g. work closely together, preventing duplication of effort and enabling more efficient use of resources

REPORT TITLE:	**REVIEW OF MATERNITY SERVICES AT CWM TAF UNIVERSITY HEALTH BOARD – CARDIFF AND VALE UHB ASSURANCE FRAMEWORK**						
MEETING:	**QUALITY, SAFETY AND EXPEREINCE COMMITTEE**				**MEETING DATE:**	**18.06.19**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
LEAD EXECUTIVE:	**EXECUTIVE NURSE DIRECTOR**						
REPORT AUTHOR (TITLE):	**ASSISTANT DIRECTOR PATIENT SAFETY AND QUALITY DIRECTOR OF NURSING WOMEN AND CHILDREN'S CLINICAL BOARD**						

PURPOSE OF REPORT:

SITUATION:

The purpose of this report is to present the Committee with the Cardiff and Vale UHB assurance framework that was developed following publication of the Review of Maternity Services at Cwm Taf Health Board in April 2019. The report can be read here

REPORT:

BACKGROUND:

The Royal College of Obstetricians and Gynecologists was commissioned by Welsh Government to undertake an external review to investigate the care provided by the maternity services of Cwm Taf University Health Board. The review took place in January 2019 and was initially prompted by the discovery of under-reporting of Serious Incident cases by the maternity service. A look back exercise to January 2016 had identified 43 cases for review. In the years leading up to the review there had also been concerns raised following GMC Deanery visits and surveys as well as concerns identified as a result of Healthcare Inspectorate wales unannounced visits in 2015 and in 2018.

In response to a request from Dr Andrew Goodall, following publication of the report, the UHB has completed an assurance framework which provides a position statement with regards to the UHB compliance against the recommendations in the report. This assurance framework can be viewed here in Appendix 1. An overview of the Cardiff and Vale UHB position was presented at the public session of the May 2019 Board.

The Committee should also be advised that Healthcare Inspectorate Wales (HIW) will be undertaking a review of Maternity Services across Wales in the coming months and the UHB is currently responding to a request from HIW for a self-assessment and disclosure of key documentation.

ASSESSMENT:

In relation to the 70 recommendations, 11 were not applicable, the UHB is compliant with 41, partially complaint with 16, and has identified 2 areas where immediate action is required and these are:

- **To mandate and support a full programme if clinically led audit with a nominated consultant lead**. – the Committee should be advised that there are dedicated multi-professional clinically led monthly sessions in place with an agenda and attendance list but governance arrangements in relation to minute keeping and the identification of required improvements needs to be strengthened
- **Ensure that the consultant on call for the labour ward has ownership of all patients in the maternity unit for the period on call. This must involve antenatal ward rounds being undertaken by a consultant –** with the recruitment of additional obstetricians, this will be built into consultant job plans.

The Committee should also be advised that the UHB is working very closely with Cwm Taf UHB, to manage the changes in flow of patients to Cardiff and the Vale which has happened following the concerns that have been raised about maternity services in their area.

RECOMMENDATION:

The Committee is asked to **CONSIDER** the current position of the UHB against the recommendations in the report

AGREE that an improvement plan and progress update is provided to the September 2019 Committee with specific emphasis on the areas of non and partial compliance as well as an overview of the impact, in terms of patient flow to Cardiff and the Vale UHB and how this is being mitigated.

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	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	

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.								

Appendix 1 - Independent Review of Maternity Services at Cwm Taf Health Board – Assurance Framework template

Health Board: Cardiff and Vale University Health Board

Date of Completion: Version 8 10/05/2019

Terms of Reference from review	Recommendations	Where we are (May 2019) Examples of assurance evidence	Areas for Targeted Intervention or Improvement	RAG Green – compliance Amber – improvements required Red – Immediate action
1. To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.	7.1 Urgently review the systems in place for: • Data collection • Clinical validation • Checking the accuracy of data used to monitor clinical practice and outcomes • What information is supplied to national adults	RCOG and Public Health Dashboards in place and reviewed as part of Q&S Meeting Structure 7.1 Main Dashboard - Cal Year.xlsx Stillbirth data triangulated with registrar records / Datix / Euroking. Multi professional Stillbirth Review Forum Monthly to review cases an input into PMRT tool. 7.1 Stillbirth Review Forum Minutes 2019 Consultant Obstetrician, Consultant Neonatologist with a leads role for Each Baby Counts along with Risk Manager for O&G ensures timely and factual completion of cases. Evidence of Risk Manager for O&G investigating data surrounding obstetric haemorrhage by triangulating with blood bank. 7.1 Anonymised running blood transfusion.xls Evidence of joint obstetric/anaesthetic/midwifery meetings for PPH work Evidence of unexpected term admission data collection jointly with lead neonatologist and obstetrician for clinical risk. 7.1 Minutes of meeting to discuss Patient Safety Notice regarding term admission of babies.docx 7.1 Minutes of meeting to discuss term admission of babies July 6.docx Triangulated data checks and reporting of ITU admissions of mothers with Obstetric, Midwife and Anaesthetic Leads for Clinical Risk. Maternity Informatics Support 1wte in post. Monthly Dashboard meetings with senior staff ensure review of dashboard and ability to question / challenge data.	Dashboard information is collected mainly via E3 Maternity System. Some data collection is required by hand with work in progress to make amendments. C&V have raised concern along with other UHBs in Wales in relation to the validity of data being reported by NMPA as certain parameters set by NMPA are not collected as part of the national all Wales Maternity Dataset Data for 2018 requires validation by Maternity Informatics Lead. The Service Manager for O&G is currently looking to provide the Maternity Informatics Lead with some support to enable this to be done. We aim for the support to be in place by July 2019. There is current fragility and duplication of effort for midwives with data entry due to flow changes from CTMUHB which are yet to be confirmed. CTMUHB use a separate Maternity Information System which is not compatible with C&V. This is time consuming for clinical staff and detracts from giving clinical care to women	

		Good working relationship with Wellbeing Software company with a dedicated 24 hour helpline for staff in the event of IT Maternity Data issues. Anaesthetic database of all clinical procedures		
	7.2 Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unity guidelines: • Are up to date and regularly reviewed • Are readily available to all staff, including locum staff and midwifery staff • Have a multi-disciplinary approach • Are adhered to in practice	Work ongoing with Lead Consultant Obstetrician for Antenatal Care and Clinical Supervisor for Midwives (CSfM) to update all obstetric and midwifery guidelines. Currently 61.5% in date, from 17/5/19 compliance will be 68%. Anticipated to be fully compliant by end of year. A programme of work began in Autumn 2017 involving midwives, obstetricians and anaesthetists to ensure guidelines were still fit for purpose and those that weren't needed (eg. Due to national guidance NICE / RCOG) that were lapsed) 7.2 Guideline database Obstetrics.xlsx 7.2 Evidence of Guidelines going out for comment 7.2 Governance News Letters 7.2 Guideline Ratification Guideline An induction programme for locums and new obstetric and anaesthetic staff, which includes: assessment of all mandatory requirements, familiarising with the maternity unit staff, accessing guidelines and process of incident reporting and SUI's. 7.2 Electronic JUNIOR DOCTORS INDUCTION BOOKLET.pdf 7.2 INDUCTION PROGRAMME August 2018.pdf List of clinical triggers for incident reporting placed strategically in various clinical areas for ease of access to maternity staff. CSfM maintains database of all guidelines and updates Clinical Portal with all changes to guidelines as well as emailing update to all staff and highlighting changes in practice in the regular Governance Newsletter. 7.2 Guideline Database Work ongoing by Senior Midwife Manager for Inpatient Services to address updates	Continue projects to ensure all guidelines updated and then remain up to date.	

		required from new NICE guidance for Complex Intrapartum Care 7.2 Draft MPF Minutes 29042019.doc Maternity Professional Forum Meets Monthly to discuss guidelines and ensures multi professional discussion and ratification processes 7.2 MPF Agenda and Minutes 2019 All locum and agency medical staff applying for employment at C&V are vetted by the CD or nominated deputy prior to any employment. All such staff starting employment for the first time will meet the on call consultant.		
	7.3 Mandate and support a full programme of clinically led audit with a nominated consultant lead to measure performance and outcomes against guidelines.	Regular Safety & Quality Sessions (audit) sessions (5 per year for gynaecology and 5 for obstetrics take place. Agenda and attendance sheets available. 7.3 Obs Audit Attendance List 10 April 19.pdf 7.3 Obstetrics Safety Quality Agenda 10 April 19.doc The Clinical Board submitted a clinical audit plan in 2018/19 which encompassed the Tier 1 national clinical audit s and tier 2 audits, identified to meet the quality and safety priorities of the Clinical Board. The Clinical Board participate fully in the National Maternal and Perinatal Audit programme, MBRACE and the National Neonatal Audits. There are identified clinical audit leads for foetal medicine, midwifery and obstetrics. All local clinical audits proposals are authorised by the clinical audit leads to ensure robust governance arrangements around the reporting of these audits. Anaesthetic department hold monthly audit sessions, for which agendas, minutes and attendance lists are available.	There are currently no minutes or actions being recorded by the Clinical Audit Leads and urgent improvement is needed in order to evidence that learning from audit is being put into practice. The Clinical Board will develop a Clinical Audit plan for 2019 / 20 which will address their quality and safety priorities identifying robust governance around reporting arrangements The directorate should explore improvements in the way concerns and themes and trends from RCA feedback is formally captured within the O&G clinical audit meetings Clinical Portal page to be created by the Clinical Audit Lead so that learning from Clinical Audit can be accessed by all members of maternity staff. Creation of an audit newsletter to widely disseminate findings and action points from audit. The Directorate would benefit greatly from having a full time Quality and Service Improvement Midwife in post to ensure that any audit and service improvement project is multi professional Additional administrative support is required for the Directorate as there are only 2 members of staff to support the Senior Directorate Management and Leadership Teams	

	7.4 Ensure monitoring of clinical practice of all staff is undertaken by the Clinical Director and Head of Midwifery: • To ensure compliance with guidelines • To ensure competency and consistency of performance is included in annual appraisal.	All guidelines are accessible to all staff (midwifery, medical and non-clinical) working in maternity services via desktop PC's or Netbooks. Clinical Portal O&G Guidelines Page Attendance at mandatory updates and e learning for midwives recorded in central database held by Practice Development Midwife (PDM) and CSfM. 7.3 Mandatory Staff Training Data 2019.xlsx 7.4 CSfM Database Apr 2018 Apr 2019.xlsx Midwives are expected to demonstrate compliance with mandatory updates at their annual PADR. This is evidenced through the databases maintained by the CSfM team and the PDM 7.3 Mandatory Staff Training Data 2019.xlsx 7.4 CSfM Database Apr 2018 Apr 2019.xlsx Mandatory Training register as above 7.4 CSfM Database Apr 2018 Apr 2019.xlsx 7.4 CSfM Database Apr 2019 Apr 2020.xlsx PADR for O&G Directorate = 49% on 2.5.19 Mandatory online learning for O&G Directorate = 78.55% on 2.5.19 The Clinical Director ensures that all non-training medical staff have an annual job plan and annual clinical appraisal. All medical staff in training have annual appraisal within their ARCP (Annual Review Competency and Progress) All midwives are expected to meet the mandated requirement for 4 hours of clinical supervision each year, 2 of which must be group supervision. In 2018, the CSfMs achieved 99.5% compliance. Anaesthetic team led sessions on Recovery / HDU care	A number of PADRs for midwives have currently expired at the same time. Assurance received from senior midwives that plans are in place and meetings arranged with staff to have a meaningful review. A target of 85% compliance has been set for July 2019.	
	7.5 Agree a CTG training programme that includes a competency assessment, which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum.	C&V have retained the requirement for all midwifery and obstetric staff to complete the RCM/RCOG online fetal surveillance package every three years. This contains	To consider the development of a tool for use at the beginning and end of in house CTG study days to test immediate learning.	

		a competency assessment where staff must achieve at least 80% pass rate. Compliance for CTG updates for midwives held centrally by the Practice Development Midwife. 7.3 Mandatory Staff Training Data 2019.xlsx An annual dedicated whole day in house study day for staff (with study leave given) is in place 7.5 Midwives Mandatory Training Dates 2019.xlsx Twice weekly table top multi professional review (and teaching) of live CTG's takes place within the Skills Room on Delivery Suite. All staff in C&V (medical and midwifery) are expected to undertake at least 5 CTG case reviews annually 7.5 CTG Reviews 2019 Database of obstetric CTG training records is held by Service Manager for Obstetrics. Requirements are as Midwives. New Fetal Surveillance Bundle recently ratified outlining training requirements for medical and midwifery staff. 7.5 Mandatory Training Med Staff 18.xlsx OMNIVIEW Central server provides opportunity for 'FRESH EYES' as part of multi professional safety huddles. Each Baby Counts recommends 4 hourly safety huddles, but this is being completed 2 hourly in C&V.	Welsh national standards for fetal surveillance do not recommend competency assessment. WRP have planned reviews of assurance against both PROMPT and the All Wales Fetal Surveillance Standards for C&V on 28th May 2019. 11 new Huntleigh CTG Monitors have been purchased. Huntleigh are currently supporting 'Train the Trainer' to members of the multi professional team. Once training is embedded, plans are in place to introduce Dawes Redman antenatal CTG analysis with a standard operating procedure being developed. Due for launch and full implementation in July 2019 Central Monitoring recently purchased and installation due May 2019 for Induction of Labour Antenatal CTGs which will also be stored centrally attached to the electronic patient record on E3 Euroking.	
	7.6 O & G consultant staff must deliver: • A standard induction programme for all new junior medical staff • A standard induction programme for all locum doctors	Consultant Obstetrician (College Tutor) leading on this work. Induction programme already in place. See 7.2 for details of induction programme. Rotas are arranged to provide an extra junior doctor when a new locum is working	Obstetric Intrapartum Lead and Directorate Manager to develop a programme of formal induction for locum doctors by end May 2019.	

		Managerial oversight of the medical on call rota is designed to ensure minimum reliance on external locum doctors. Anaesthetic team only use known locums, never external.		
	7.7 Ensure an environment of privacy and dignity of care for women undergoing abortion or miscarriage in line with agreed national standards of care.	C&V have a dedicated Gynaecology Ward (C1) with side rooms for women undergoing miscarriage. (<16+6/40) Women undergoing medical termination of pregnancy 17/40+ are provided with a single room within the high risk obstetric delivery suite A second bereavement room was opened in 2018 with generous donations from SANDS. The room was commissioned following patient feedback for the benefit of women who require close monitoring and are physically unable to be rotated to the bereavement room within the OAU. In 2018, a dignity room was commissioned to support memory making for families and to provide storage of babies in the event that mum and dad don't wish to have their baby with them immediately following delivery but aren't ready to say goodbye. C&V adhere to NICE guidelines for Early Pregnancy Loss Management		
2. Assess the prevalence and effectiveness of a patient safety culture within maternity services including: ○ **The understanding of staff of their roles and responsibilities for delivery of that culture.** ○ **Identifying any concerns that may prevent staff raising patient safety concerns within the Trust.** ○ **Assessing that services are well led and the culture supports learning and improvement following incidents.**	7.8 Ensure external expert facilitation to allow a full review of working practice to ensure: • Patient safety is considered at all stages of service delivery. • A full review of roles and responsibilities within the obstetric team. • The development and implementation of guidelines. • An appropriately trained and supported system for clinical leadership. • A long-term plan and strategy for the service. • There is a programme of cultural development to allow true multi-disciplinary working.	Evidenced formally through minutes of: • Monthly O&G Quality & Safety meetings 7.8 O and G Q and S Meetings Agendas and Minutes 2019 • Monthly Nursing and Midwifery Professional Governance Meetings 7.8 Professional Governance Meetings Agenda and Minutes • Mandatory Training presentations 7.8 Gov Team Pres 2019 V 2 April 2019.pptx • Lunch & Learn programmes • Audit programmes (see evidence in 7.3) • Clinical Board Quality and Patient Safety Meetings 7.8 Clinical Board Q&S minutes • Women's Stories 7.8 OandG QandS Meetings Agendas and Minutes 2019 • Shaping Our Future Wellbeing Strategy • MDT Team Building days	Planned relaunch of Freedom to Speak Up summer 2019	

		Risk assessments carried out at booking, each antenatal and postnatal visit, and on admission for all women. Care plans in place for women with complex needs. Consultant Obstetrician job plans reviewed and agreed. Completed action for 2018/19 7.8 lead roles Sept. 2018 final version.docx 7.8 Copy of MASTER SUMMARY LIVE.xlsx 7.8 Copy of CAVUHB Appraisal Database WOD as at 31st March 2019.xls All of the Consultant Obstetricians have agreed annual job plans – see above Clinical training for midwives includes: • In house Skills to Manage • In house Skills to Lead • In house Being a Leader • RCM Leadership Programme • Multidisciplinary Training in communication and escalation • PROMT training Guidelines: See information in 7.2 above IMTP (Focus on Agnes – Canterbury Model) Senior Midwifery, obstetric and anaesthetic involvement with development of new Maternity Strategic Vision for Wales Within the organisation we have a freedom to speak up process with an e mail and phone number which can be accessed by staff. There are intranet pages with a resource of information and posters across the UHB Staff also raise concerns directly with the Chair via a safety valve process		
	7.9 Develop a trigger list for situations which require consultant presence on the labour ward which much be: • Agreed by all consultants in obstetrics, paediatrics and anaesthetics and senior midwives. • Audited and reported on the maternity dashboard.	Maternity Escalation and Closure Protocol 7.9 Escalation Guideline May 2017.pdf	Escalation Guideline to be amended to include and append the RCOG Guidance “Responsibility of Consultant On Call” Obstetric Team to consider how this may be recorded and monitored	
	7.10 Introduce regular risk management meetings which must be: • Open to all staff	Fortnightly Clinical Risk Meetings, open to all already operating. Scheduled to fit in with trainee teaching times.	Clinical Risk minutes to be made available as PDF on maternity drive accessible to all maternity staff.	

	• Conducted in an open and transparent way • Held at a time and place to allow for maximum attendance	7.10 Clinical risk Governance meeting dates are displayed in each clinical area and shared with all staff via regular Governance Newsletter 7.2 Governance News Letters Weekly Datix review meetings, with Patient Safety staff presence to stream all Datix reports. Evidence via Datix system Monthly Stillbirth Review Meeting open to all – minutes and learning published. 7.1 Stillbirth Review Forum Minutes 2019 Growth Assessment Protocol (GAP) monthly meetings – open to all - minutes and learning published. 7.2 Governance News Letters Themes and trends from all meetings above are collated and published in Governance Newsletter which is displayed in each clinical area as well as being emailed to all maternity staff. 7.2 Governance News Letters Clinical Risk meetings are MDT – evidence in attendance sheets and minutes. 7.10 Clinical risk Neonatal mortality review meetings held quarterly – open to all staff. 7.11 DEATH REVIEW MEETING notes December 2018.docx 7.11 DEATH REVIEW MEETING notes June 2018.docx 7.11 DEATH REVIEW MEETING notes April 2018.docx Midwives are actively encouraged to attend governance meetings. Anaesthetic attend at all governance meetings except Neonatal and O&G Q&S unless specifically invited.		
	7.11 Ensure mandatory attendance at the following meetings for all appropriate staff. Attendance must be recorded and included in staff appraisals. Ensure that meetings are scheduled or elective clinical activity modified to allow attendance at:	Maternity Professional Forum 7.2 MPF Agenda and Minutes 2019 Risk Professional Governance	Consultant Obstetric / Gynaecology Meetings currently clash with Audit e.g. During Obstetric Audit times, consultant gynaecologists hold their consultant meeting and vice versa. This means that for consultants who are both obs/gynae,	

	• Governance meetings • Audit meetings • Perinatal mortality meetings	7.8 Professional Governance Meetings Agenda and Minutes Perinatal Mortality & Morbidity Neonatal Mortality and Morbidity 7.11 DEATH REVIEW MEETING notes April 2018.docx 7.11 DEATH REVIEW MEETING notes December 2018.docx 7.11 DEATH REVIEW MEETING notes June 2018.docx Medical consultant job plans increasingly contain recognised sessions for attendance at management and governance meetings.	they are unable to attend consultant meetings. Reconsider scheduling of Gynae / obstetric meetings and audit in order to improve attendance. There are no formally recorded minutes from either Audit meetings or outcomes / plans to disseminate learning Terms of Reference to be reviewed and updated for all Governance Meetings so that quorum is established and can be demonstrated	
	7.12 Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome.	Evidence of ad hoc debrief sessions after unexpected incidents. 7.12 Debrief Clinical Supervisors for Midwives support staff who have been involved in adverse incident 7.4 CSfM Database Apr 2018 Apr 2019.xlsx 7.4 CSfM Database Apr 2019 Apr 2020.xlsx Multi professional debriefs are facilitated by senior midwifery staff or consultant anaesthetist via C4U Agenda Senior Midwifery Manager on call 24/7 available to staff. 7.9 Escalation Guideline May 2017.pdf 7.12 Senior Midwifery Manager On Call Rotas.pdf	To develop more structured MDT debrief service with agreed terms of reference ensuring inclusion of neonatal and anaesthetic staff where appropriate. Work with the patient safety team to develop structured 'Talk' multi professional debrief initiatives	
	7.13 Identify a clinical lead for governance from within the consultant body. This individual must: • Be accountable for good governance • Attend governance meetings to ensure leadership and engagement	Clinical Governance, Patient Safety and Quality are recognised formally within the Directorate. There is a Consultant Lead Obstetrician (although the RCOG report recommends >1) and identified Consultant Anaesthetists with allocated lead roles for Q&S / Governance within their job plans Risk Midwife Band 7 in post. There is an identified named individual from the patient safety team for the Directorate	The Directorate requires additional support for Clinical Governance to ensure obstetrics, gynaecology and SARC have robust assurances in place	
	7.14 Consultant meetings should • Be regular in frequency • Have a standing agenda item on governance • Be joint meetings with anaesthetic and paediatric colleagues	Consultant Meetings are held monthly and chaired by the Clinical Director. These meetings have a pre circulated agenda. The minutes are distributed with the agenda. Non consultant staff e.g. Leads	Formal joint meetings with anaesthetics / paediatrics not currently in place	

		for the trainees are invited on a regular basis 7.14 Obs Gynae Consultant's Agenda 12 Feb 19.doc Quarterly obstetric anaesthetists meetings.		
	7.15 Educate all staff on the accountability and importance of risk management, Datix reporting and review and escalating concerns in a timely manner. Include this at: • Junior doctor induction • Locum staff induction • Midwifery staff induction • Annual mandatory training	Junior doctor / locum induction – see 7.2 above There are robust procedures in place for new starters within midwifery which include • Midwifery staff induction 7.15 Midwife Induction • Mandatory training 7.3 Mandatory Staff Training Data 2019.xlsx • Governance team presentations 7.8 Gov Team Pres 2019 V 2 April 2019.pptx • Annual induction for Band 5 midwives, Senior midwifery team have introductory session. There is a UHB Incident, Hazard and Near miss reporting policy. This has been recently revised and is available for staff on the intranet. Members of the patient safety team provide education and training on Datix and incident reporting as part of induction and a wide range of leadership courses across the organisation. Bespoke Datix training is provided across the UHB on a regular basis. There is a Datix Online Incident reporting page on the intranet which has a wide range of resources for staff. There is a well embedded reporting culture in the organisation and staff are actively encouraged to escalate concerns through established systems and processes.	The UHB needs to ensure that Locum/bank staff know how to report incidents and escalate concerns appropriately.	
	7.16 Urgent steps must be taken to ensure that consultant obstetricians are immediately available when on call (maximum 30 minutes from call to being present).	All consultants on call for obstetrics are immediately available when on call as defined (within 30 minutes).	A review to be undertaken of home location of all consultants (obstetric/Gynae/anaesthetic/neonatal)who provide on call cover.	
	7.17 Ensure training is provided for all SAS staff to ensure that they are: • Up to date with clinical competencies. • Skilled in covering high-risk antenatal clinics and outpatient sessions.	C&V will have no SAS staff after July 2019.	Although there are no SAS staff in place, the directorate should take this opportunity to review current obstetric working arrangements within antenatal clinic	

	7.18 Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues.	Specific to CTMUHB. Capacity at PCH has been raised as a concern, there are regional contingency planning flow workshop meeting in progress to ensure we support our CT colleagues and ensure stability of services. C&V working with CTMUHB colleagues to determine flow and pathways of care for women who are planning their intrapartum care at UHW.	Regional contingency planning meetings are being held bi-weekly with Planning leads and colleagues across the South Wales Regional Alliance. Urgent actions agreement are required from CTMUHB to ensure that services are stabilised and that C&V can safely accommodate the flow	
3. **Review the RCA investigation process, how Sis are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.** Work is required to address the culture in relation to governance and supporting all staff with their accountability in relation to incident reporting, escalation of concerns and review of Datix in a timely manner.	7.19 Ensure that a system for the identification, grading and investigation of SI's is embedded in practice through: • Appropriate training to key staff members • Making investigations multidisciplinary and including external assessors.	There are nationally recognised 'Never Event' criteria. HoMs in Wales are discussing the variation in Serious Untoward Incident Reporting. Heads of Midwifery Advisory Group are working to obtain a collective consensus of what should be SUI to present / discuss with Executive Nurse Directors and Welsh Government in Summer 2019. All potential Serious Incidents are discussed with the Corporate Patient Quality and Safety Team and terms of reference set within 72 hours RCA and SI Investigations are multi-disciplinary. Investigating Officers are appointed from Obstetrics, Midwifery and where appropriate Neonatal / Anaesthetic 7.19 RCA and SI 2019 7.19 Datix Triggers landscape version 1 October 2016.docx C&V have processes in place for the commissioning of external reviews There is a RCOG trigger list for incident reporting at C&V along with a monthly Dashboard. The Dashboard is reviewed at monthly Q & Pt Safety / Professional Governance Meetings. A number of key staff have completed Root Cause Analysis Training 7.19 List of staff RCA Trained.msg There is a well-established process for the identification and management of SIs. This is understood across all Clinical Boards in the UHB. There is also a well-established RCA training programme which is oversubscribed and has excellent feedback. In the region of 600 staff within Cardiff and Vale UHB have been trained in RCA methodology.	Commissioning of investigating officer for the RCA process external to the UHB is challenging due to commitment and time pressures for clinicians. Welsh Government could learn from NHS England with development of a separate investigation board 'HSIB' independent to Health Boards / NHS Trusts and Heads of Midwifery Advisory Group will be making recommendation to Welsh Government.	

		There is a weekly Concerns meeting led by the Executive Nurse Director and attended by the Medical Director and senior members of the Patient Safety and Patient Experience teams. All new SIs and serious complaints are discussed as well as on-going investigations, inquests and any emerging issues of concerns. The Management Executive is informed weekly of new SIs and any issues of concern in relation to QSE. All SIs are reported to the next public Board meeting. If there are serious concerns with regards to wider services or an SI which affect several patients – the Board and the QSE Committee are kept fully briefed in private sessions until the matter has been fully investigated and concluded. It is then reported in an open and transparent way into the public meeting of Board and/or QSE Committee. A high standard of WG closure assurance is demanded of the Clinical Boards to ensure that all the necessary lessons have been learned and all efforts have been made to prevent the recurrence of a particular issue. Consideration is always given to the instruction of external, independent experts to support as part of the investigation of incidents. In addition, the UHB does from time to time commission an external agency and/or expert to undertake a full review of a service when this is felt to be appropriate.	
	7.20 Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from Sis.	The UHB adopts the Just Culture Guide as part of the SI process to ensure that decisions in relation to staff involved in SIs are fair and consistent across the organisation. The management and support of staff is a central part of the SI process and forms as essential part of the first SI meeting and discussion, following an incident. The new (2017) model of Clinical Supervision for Midwives has been well embedded into practice in Cardiff & Vale UHB as a support mechanism for midwives. 7.20 Evaluations of Group Supervision Jun 17 to Apr 18.pptx		

		Caring for You Charter was signed in 2016 as a joint commitment to promoting a healthy workplace for staff by the head of midwifery and the RCM Health and Safety representative. The C4U programme is multi professional and won a RCM award in 2018. Midwifery staff are strongly encouraged to submit DATIX incident reporting and 'Red Flag' events in accordance with NICE Safer Staffing Guidance 7.8 Gov Team Pres 2019 V 2 April 2019.pptx Learning from governance activities is shared by CSfM team via a newsletter and at mandatory training days. 7.2 Governance News Letters Staff involved in incidents are included in Governance processes throughout and are encouraged to participate in developing their own programme of learning, staff are also encouraged to share learning at mandatory / governance sessions Medical staff are encouraged to reflect on SUI's they have been involved in with their educational supervisors.		
	7.21 Improve incident reporting by: • Delivering training on the use of the Datix system for all staff • Encouraging the use of the Datix system to record clinical incidents • Monitor the usage of the incident reporting system	There is a regular programme of Datix training in place within the UHB. Patient Safety facilitators also provide face to face and/or group training as requested. The Datix system is recognised as the only incident reporting system in the UHB. Staff using other methods such as emails to senior staff etc. are asked to complete and incident form. In addition to this, if an issue is identified as a result of a complaint or a claim or by any other channel, staff are expected to retrospectively complete an incident from. Trends in the reporting of patient safety incidents are reported at each meeting of public Board. Evidence via induction training and checklist. 7.15 Midwife Induction 7.8 Gov Team Pres 2019 V 2 April 2019.pptx Large numbers of staff are involved in reviewing cases and preparing SBAR's for case reviews.	Strengthen the availability of training for all new staff and for bank and agency staff.	

		7.10 Clinical risk Executive report on performance –is taken to the performance reviews and Management Executive meetings Evidenced via Directorate and Clinical Board Q&S minutes 7.8 O and G Q and S Meetings Agendas and Minutes 2019		
	7.22 Actively discuss the outcomes of SIs which individual consultants were involved in their appraisal.	The Consultants are involved in all SI relating to their practice and are formally expected to raise this as part of their appraisal. The content of annual appraisal for consultant staff is set by the responsible officer for C&V.	The Clinical Board Director should take this opportunity to remind consultants that it is their responsibility to raise any SI's related to their practice at their appraisal.	
	7.23 Improve learning from incidents by sharing the outcomes from SIs on a regular basis and in appropriate, regular and accessible format.	All Clinical Boards are expected to discuss outcomes from reported SIs through their well-established Directorate and Clinical board QSE Group structures. Lessons learned are fed back to staff via a range of UHB systems including internal patient safety notices, newsletters, safety briefings and departmental facebook accounts. The Patient Safety team published a quarterly Patient Safety and Quality Newsletter Learning from Serious Incidents is shared within the Clinical Board & Directorate via:- • Directorate Q&S Meetings 7.8 O and G Q and S Meetings Agendas and Minutes 2019 • Clinical Board Q&S Meetings • Corporate QSE Meetings (Where appropriate) • Governance newsletter 7.2 Governance News Letters • Clinical audit 7.3 Obs Audit Attendance List 10 April 19.pdf 7.3 Obstetrics Safety Quality Agenda 10 April 19.doc • Individual (and / or) Group feedback • mandatory training 7.8 Gov Team Pres 2019 V 2 April 2019.pptx • Heads of Midwifery Wales • Undergraduate level in linked Universities • Action plan monitoring		

	7.24 Identify a clinical lead from senior medical staff within the directorate to support the current midwifery governance lead	There is a dedicated obstetric lead for risk and governance within both obstetrics and gynaecology services		
4. **Review how through the governance framework the Health Board gains assurance of the quality and safety of maternity and neonatal services.**	7.25 Appoint a consultant and midwifery lead for clinical audit/quality improvement with sufficient time and support to fulfil the role to ensure: • That clinical audits are multidisciplinary • That there is a clinically validated system for data collection • That the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset • Sharing of the outcomes of clinical audits and the performance against national standards.	There is multi professional attendance at clinical audit sessions **7.3 Obs Audit Attendance List 10 April 19.pdf** The Directorate has invested in Euroking E3 Maternity Information System and is exploring a paper light project later this year. The paper light project will release midwives time to care as they are currently required to write and enter electronic data. All medical staff are required to complete an audit/quality improvement project each year / revalidation cycle to form part of their annual appraisal dataset 7.8 Copy of CAVUHB Appraisal Database WOD as at 31st March 2019.xls Midwifery roles cover these responsibilities. No dedicated role, but individual job descriptions cover evidence of LIPS, service improvement projects, action plan monitoring and audit. 7.25 JD role profile following A4C Jan 17.docx 7.25 LIPS Update_2018_Maternity services for Suzanne.docx O&G has an active R&D portfolio which is multi professional. These include:- • Obs Cymru • ANODE • HOLDS • Pool Study • BUMPES • ELCS QI work • Anaemia working group • UKOSS The appointment of a research Band 7 Midwife in 2019 will ensure that potential studies can be scoped and 5 further studies can potentially be opened within C&V UHB	A Midwife with responsibility for quality and improvement should be appointed to work with obstetric and anaesthetic audit leads to ensure that:- • all audit programmes are multi-disciplinary • midwifery and obstetric audit is undertaken collaboratively • learning from R&D and service improvement projects are embedded and monitored The UHB will participate with the newly formed Neonatal and Maternity Network to develop an All Wales Dashboard for data collection More work is needed to enable midwifery and obstetric/neonatal/anaesthetic colleagues to undertake joint audits. There is variation across Wales with services using different maternity information systems for data collection. Welsh Government should consider investment in a central system which enables maternity information in Health Boards to transfer / be available to view in line with the woman's pathway The Directorate should progress its project to become paper light in 2019/20	
	7.26 Agree jointly owned neonatal and maternity services audits of neonatal service data including: • Neonatal outcome data • Perinatal deaths • Transfer of term babies to SCBU • Babies sent for cooling • Each Baby Counts reporting • MBRRACE reporting • Breast feeding rates • Skin to skin care after birth	The directorate along with neonatal colleagues has designated lead reporters for:- • Each Baby Counts • MBRRACE Maternal Deaths • MBRRACE Neonatal and Stillbirth • Monthly stillbirth forum (multi professional) enables review of MBRRACE reportable cases and input into PRMT Tool	Specialist roles for Bereavement midwife and Infant Feeding are in post however these are historically set at Band 6. Roles such as these should be as Band 7 team leader as there is requirement for clinical audit, teaching and leadership as well as providing clinical care to women and their families.	

	• Neonatal infection • Baby Friendly accreditation • Bliss Baby Charter accreditation	• Lead consultant neonatologist working with midwifery and obstetric colleagues to explore unintended neonatal admissions at term 7.1 Minutes of meeting to discuss Patient Safety Notice regarding term admission of babies.docx 7.1 Minutes of meeting to discuss term admission of babies July 6.docx • Breastfeeding and Skin to Skin Care data collected via Maternity Dashboard and monitored by infant feeding midwives The neonatal unit participates in a number of national audits and benchmarking: • All neonatal deaths are reviewed using PMRT with an external moderator and also at a network level; we contribute to MBRRACE, EBC • We provide Badgernet data to the **National Neonatal Audit Project (NNAP)** which audits a number of key quality outcomes annually including: breast feeding rates, mother-infant separation for term and late preterm babies, necrotising enterocolitis. • Cases of unexpected term admissions are reviewed, but this needs to be formalised • We benchmark with the **Vermont-Oxford network (VON)** which audits our outcomes including infection rates, necrotising enterocolitis, chronic lung disease etc. • We have previously completed the **BLISS Baby Charter Audit** and are currently undergoing a re-audit now we are in the new unit. We review our data regularly and use the audit/ benchmarking to focus QI projects to improve outcomes. We have previously had higher infection rates than we would like which hopefully will improve once all building work completed; current care bundles are being reviewed 2017 data showed unusually high NEC rates- all cases are being reviewed, but 2018 data is improved		
	7.27 Consider extra resource to the Maternity Governance and Risk team to ensure:	Monthly Clinical Risk and Professional Forum is in place for Gynaecology. These	The midwifery management and leadership is very lean when compared to	

	• Workload is manageable • That Datix are reviewed, graded and actioned in an appropriate and timely manner	are multi professional and attended by nursing and medical staff 7.27 Gynae Prof Forum 2019 Weekly DATIX meetings are held to review all DATIX incidents prior to closure / escalating to clinical risk meetings. SBAR communication is prepared and attendance is from the corporate patient safety team, senior midwife and risk midwife. 7.10 Clinical risk Bi weekly multi professional risk meetings ensure all adverse events are reviewed and escalated to RCA / SI investigation process. Rapid review of serious incidents also occurs within 72 hours to determine whether there are concerns with care DATIX Incidents are reviewed and discussed as part of Executive Performance Review with the Clinical Board	other maternity services across Wales and requires additional support and resilience to ensure that Governance is strengthened across the Directorate and to ensure that the role of the Risk Midwife does not become conflicted. The service requires additionality of a Deputy Head of Midwifery and a Senior Midwife for Clinical Governance and Risk Management across the O&G Directorate	
	7.28 Ensure that the executive level lead role for maternity will work with the maternity department and this role is effective and supported. This individual should: • Have a direct progress reporting responsibility to the Board, in particular while the issues raised in this report are being resolved • Understand and facilitate improvement in the reporting of safety issues and clinical risk • Provide a single point of reference for liaison with external agencies • Ensure all reports from external agencies and regulators are channelled through a single pathway to ensure priorities remain focussed.	The executive team undertake regular patient safety walkabouts of the maternity service and provide updates to the Clinical Board /Executive Team. The executive team also escalate any challenges the service is facing to ensure they are addressed in a timely manner There is a defined process for requesting assurance against emerging evidence / national reports let by the Corporate Governance Team. **\7.28 Exec Walkabout 24.5.18.msg**		
5. **Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.**	7.29 Closely monitor bank hours undertaken by midwives employed by Cwm Taf, to ensure: • The total number of hours is not excessive • The Health Board complies with the European Working Time Directive • These do not compromise safety	The service is funded to BR+ compliance (2016) and is undertaking its next 3 yearly review (report expected Summer 19). A number of C&V midwives are enrolled on the C&V bank and provide additional / bank hours where needed. All midwives working in excess of WTD have signed the 'opt out' agreement and retained within staff personal files which can be made available for audit purposes if required	Maternity leave is a challenge in Cardiff and Vale however backfill is provided to recruit at 60%. One output per year from Universities causes service pressures during the summer months however C&V have successfully recruited to all vacancies. There is no increase in commissioning numbers until 2020.	
	7.30 Ensure the Medical Director has effective oversight and management of the consultant body by: • Making sure they are available and responsive to the needs of the service	There is effective communication between the Clinical Director for the service and the Medical Director and Clinical Board Director to ensure that the needs of the service and job planning are effective.	We currently do not have a robust system to ensure that all women admitted within obstetrics and gynaecology are seen by a consultant within 12 hours. Current consultant expansion and review of job	

	• Urgently reviewing and agreeing job plans to ensure the service needs are met • Clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers) • Ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommendation (national standard)	Guidelines are in place to ensure that the most unwell women will be seen within an hour of admission by a consultant via the escalation guideline. The directorate escalated concerns to Welsh Deanery in 2018 due to the lack of trainees in C&V rota. The Deanery have confirmed the rota will be fully staffed from August 2019.	plans is taking account of this recognised clinical risk will look to address this. Appointment of additional O&G consultant's posts is imminent and staff will be in post by August 2019. Improvements are needed to ensure that ward rounds are undertaken by appropriate grades of medical staff and in a timely manner.	
	7.31 Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit it undertaken • Ensure involvement of paediatric staff for all future service design reviews and actions.	A RAG Assessment for community midwives is in use. All women attending the Alongside Midwifery Unit are risk assessed in accordance with the All Wales Pathway for Normal Labour. Women seeking to choose alternative birth plans outside evidence based practice are offered a 'Birth Choices' appointment with either a consultant midwife, senior midwife or lead midwife for the Alongside Midwifery Unit Birth Choices paperwork for women who choose the AMU out of guidance 7.31 Birth Choices Paperwork Service review and development include Neonatal services and Clinical Board approach 7.31 Obs Neonates and Paeds project Board Service Development Meetings (3)	Consider 36 weeks appointment to be completed on Euroking to confirm intended place of birth to predict MLU births	
	7.32 Ensure obstetric consultant cover is achieved in all clinical areas when required by: • Reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved • Undertake a series of visits to units where extended consultant labour ward presence has been implemented • Considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other • Considering the creative use of consultant time in regular hours and out of hours to limit the use of locums	Labour ward cover is provided in teams to ensure that a senior member of the team is always available.	Resident consultant cover on labour ward for 12 hours per day will be achieved Monday to Friday before the end of 2019. Weekend cover will be non-resident except for 4 hours on Saturday and Sunday mornings. This is an absolute requirement for C&V. We will need further new appointments besides the above posts to fulfil this	
	7.33 Actively share and findings of this RCOG review with the Welsh Deanery and urgently encourage them to revisit the Health Board to: • Reassess the quality of induction, training and supervision in obstetrics • Seek assurance on the suitability of this service for trainees • Appoint a named RCOG College tutor to provide support for the trainees currently on the RGH site with adequate time and resource to fulfil this function	College Tutor in post who links with the Deanery CWM TAF SPECIFIC	The directorate would benefit from an audit against RCOG current standards	

	7.34 Allocate all trainees currently in post a clinical and educational supervisor • The role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education • The competency assessments for trainees must be provided in-house under the supervision of the RDOG College Tutor	All trainees at C&V have an educational supervisor. All consultants at C&V receive training on clinical supervision and are formally recognised within these roles by the Deanery.		
	7.35 Undertake a training needs assessment for all staff to identify skills gaps and target additional training	Midwifery training needs are identified via Clinical Supervision 121s or via midwives personal annual development review. All consultant medical staff are required to identify skill gaps and requirements for additional training within their professional development plan within their annual appraisal. All medical trainees are required to complete an ARCP which includes identification of training needs. The Deanery grading for medical trainees is currently pink, due mainly to rota gaps, training and behaviours.	Action plan required to address issues identified by the Deanery.	
	7.36 Clinical supervision and consultant oversight of practical procedures must be in place of all staff including specialist midwives and doctors.	Clinical supervision for midwives is embedded to support midwives in practice. The CSfM are required to be clinically credible leaders. The rota is not part of the rostered establishment which enables the CSfM to be available to midwives who are undergoing a programme of learning and oversee their skills. Examples of midwifery supervision / sharing best practice / learning include:- • Group and 121 clinical Supervision / practical skills support • Lunch and learn • Preceptorship programme for Band 5/6 midwives. • Suturing workshops • Post-mortem consent training • Contraception training • Audit presentations • FGM training Clinical supervision of practice procures for obstetric teams is undertaken by all non-consultant staff and is provided within a recognised framework that allows assessment of competency.		
	7.37 Develop an effective department wide multi-disciplinary teaching programme.	Examples of multi professional learning include		

	• This must be adequately resources and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors. • Attendance must be monitored and reviewed at appraisal.	• PROMPT • NLS / BLS • CTG Training (twice weekly MDT to allow better attendance) • MDT Leadership Day • Audit • Perinatal Morbidity and Mortality Meetings • GAP • Vicarious Trauma Study Day • Annual internal and investment in external ctg study days • Development of HDU / Recovery models for midwives with anaesthetic colleagues in 2019		
	7.38 Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. • This must involve the antenatal ward round being performed by the consultant.	Whilst there are teams and two obstetric consultants within the Obstetric Delivery Unit during the day time, there is no responsibility within the current obstetric job plans to carry out ward rounds within ante and postnatal areas except within Delivery Suite. Anaesthetic and Obstetric teams assume joint responsibility for HDU patients on delivery suite.	Consultant job planning must be reviewed to ensure an antenatal ward round is performed by the on call consultant.	
	7.39 Review the working practice for how consultant cover for gynaecology services will be delivered after the merger. • A risk assessment must be performed to determine the case mix of planned surgery on the Royal Glamorgan site when there is no resident gynaecology cover.	CWM TAF SPECIFIC		
	7.40 Review the skills and competencies of the senior clinical midwives covering for tier 1 doctors to ensure: • Their scope of practice is clearly defined • The Health Board and the individuals are protected against litigation risk for their extended roles.	CWM TAF SPECIFIC		
6. Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.	7.41 Consider the impact of the planned merger on the current culture of the organisation. The Board needs to carefully consider whether the planned merger of two units, both of which are described as having significant issues with their working culture, is likely to compound the problems rather than correct them.	CWM TAF SPECIFIC	Recommendation exclusive to Cwm Taf however C&V are working with CTMUHB colleagues to support patient flow and safety.	
	7.42 In conjunction with Organisational Development undertake work with all grades of staff around communication, mutual respect and professional behaviours. • Staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes.	Multi professional leadership days are being led by Consultant Obstetrician/Consultant Anaesthetist/Clinical Supervisor for Midwives. The days explore roles and responsibilities, values and behaviours and leadership. Midwifery Staff Band 7 are supported to complete enhanced communication courses Support Staff are currently completing values and behaviour training	Enhanced communication / attitudes and behaviours training should be considered for all staff	

		Values and behaviours awareness / women's' concerns / stories are discussed at midwifery mandatory training days Transgender awareness training for O&G staff completed in 2017 The directorate has invested in the appointment of a women's experience midwife who leads concerns / compliments / service user engagement portfolio. Staff named in concerns are referred to their CSfM / Line Manager for support and discussion **7.4 CSfM Database Apr 2018 Apr 2019.xlsx** **7.4 CSfM Database Apr 2019 Apr 2020.xlsx**		
7. Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.	7.43 Undertake an in-depth assessment of the service as it moves into the future with its new ways of working and the likelihood of an increased demand for services. • This can determine the structures and competencies of clinical leadership and governance that will support the service.	Birthrate + workforce assessments ensure that appropriate leadership and management is recognised and aligned with the clinical acuity of the service The senior midwifery leadership and management team comprises of:- 1 wte Head of Midwifery 1 wte senior midwife for in-patient services .60 wte senior midwife for outpatient services .40 wte senior midwife for gynaecology services .90 wte consultant midwife for Physiological Birth 1 wte consultant midwife for vulnerable women and public health	The midwifery management and leadership team is very lean in comparison to all other Maternity Services in Wales and for a Tertiary Unit delivering 5500 births p.a. The directorate would benefit from additional senior governance support and deputy head of midwifery leadership. The senior midwife for out-patient services' role is a split 1wte between gynaecology and midwifery services with no dedicated senior nurse for gynaecology. To enable senior Band 7 midwives to be free to lead, additional support from a Band 5 Rosterpro Admin team would be of great benefit as a great number of clinical hours are lost each week in updating rotas etc. To provide support to become a paper light service and ensure data collection is robust and regularly validated, further IT support is required. The Head of Midwifery does not have a dedicated PA/Secretary. Directorate admin support is provided to the Clinical Director / General Manager / Senior Midwives / Head of Midwifery / Band 7s / key meetings for staff by 1.60 wte. We are currently in the process of appointing for new consultant obstetricians, all of whom will have identified clinical leadership roles within the service. It is recognised that any	

			significant increase in the annual birth rate will require the appointment of further consultant obstetricians to expand the service beyond 68 hours resident cover and provide cross cover of essential routine services, e.g. Antenatal Clinic.	
	7.44 Support training in clinical leadership • The Health Board must allow adequate time and support for clinical leadership to function.	The Directorate supports staff to undertake formal programmes of clinical leadership learning and training. The head of midwifery supports time out sessions for the team with dedicated meetings for the senior team weekly (as service pressures allow) :- • Band 7 midwives are supported to attend clinical leadership programmes such as skills to manage / skills to lead • Band 6 midwives are supported to undertake RCM Clinical Leadership programme (Wales) • The HoM and Consultant Midwives attend the All Wales Midwifery Leadership Think Tank supported by RCM and Welsh Government Annually. • Multi professional staff are supported to attend in house leadership days • Welsh Clinical Leadership Fellows for obstetrics and anaesthetics (currently 3 x anaes, 2 x obs – next year will be 3 + 3) All staff are encouraged to attend MDT leadership training days with supported time. Trainees are encouraged to take a year out of the programme to complete a leadership clinical fellowship. Consultants also have access to attend an Academi Wales Leadership Programme.		
	7.45 Provide mentorship and support to the Clinical Director • Define the responsibilities of this role • Ensure there are measurable performance indicators • Ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service • Consider buddying with a Clinical Director from a neighbouring Health Board.	CWM TAF SPECIFIC		
	7.46 Appoint clinical leads in a structure that supports the service with defined role descriptions and job descriptions and objectives to include an individual response for each of the following: • Governance and clinical quality to include guideline updating. • Data quality • Medical staff education and training • Multi-disciplinary training • Audit	Risk and Governance Midwife Lead midwife and consultant for updating guidelines Lead consultant for Audit. Lead obstetric consultant for medical staff education and training.	Lead midwife for Audit should be considered Research Midwife post to be advertised as key to ensuring R&D studies are progressed and securing income for the Directorate	

	• Risk management • Incident review • Complaints handling	Women's experience midwife: lead midwife for investigating concerns raised in line with PTR Data quality lead by current informatics lead. Supported by Consultant Midwife to review data inaccurate or concerns	Improved links to NWIS / national organisations to improve the quality and accuracy with national bodies. Ensure that the newly appointed consultant obstetricians' job plans which will ensure attendance at Perinatal Morbidity and Mortality meetings and Q&S	
8. Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.	7.47 Develop and strengthen the role and capacity or the MSLC to act as a hub for service user views and involvement of women and families to improve maternity care: • Appoint a Lay Chair as a matter of priority and increase lay membership numbers with appropriate support and resources • Support lay members to engage with women using services in the FMU and RGH and at PCH to assess satisfaction and to identify issues relating to choices. • Enhance the MSLC monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken.	Active MSLC group that meets quarterly. New chair appointed in November 2018 CAV parent voices FB group with 168 members. MSLC includes service users, doula representation, NCT. Now child friendly to increase participation. New posters created to raise awareness and increase participation. MSLC review patient leaflets and are involved in service change and provision (agenda and minutes attached). Social media groups (CAV Voices) access MSLC agendas and minutes for further input if unable to attend meetings. Should any patterns of interests or concerns among MSLC arise, specialists are invited to discuss topic further 2 minutes of your time questionnaires collated monthly with 'You said we did' feedback to MSLC CAV Parent Voices and Maternity Services Facebook pages for directorate to engage with women and ask for opinions re guideline / policy / service change / development of service for women and their families MSLC chair attends performance board meetings at WG 7.47 MSLC		
	7.48 Utilising the role and strengths of the Community Health Council: • Ensure appropriate resources to act effectively as an independent advocate • Ensure that information is available to families regarding its role and contact details • Explore provision of CHC to act as point of contact and provide direct support for women and families, in addition to acting as a conduit referring to other agencies and support • Involve the CHC in the early implementation of the new maternity facilities at PCH and the FMU at RGH so they can be assured regarding the impact on access and satisfaction with maternity services.	PTR leaflets provide further information on CHC and contact details that are located in all maternity units 7.48 CHC All complainants are advised of the role of CHC and throughout the concerns process they are reminded that the CHC can offer support regarding the concerns process if required		

	7.49 Develop the range and scope of engagement with women and families: • Review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback. • As a priority, review and address the monitoring of the outcomes of patient experience as a key part of the governance structure • Feedback the outcomes of all engagement to women and families • Explore methods to hear directly from women and families about their experience including patient stories, diaries, 'mystery shopper' or observation techniques.	Feedback from women and their families is shared via the Women's Experience Lead Midwife and Consultant Midwife through forums such as:- • Mandatory training • Group supervision • Induction programmes for new starters Clinical audit • Professional governance meetings • Quality and Safety Meetings via patient stories • Birth Afterthoughts service • Patient stories are used in a variety of training sessions 7.49 Patient Stories Feedback from women and their families through concerns / RCA investigations is monitored via audit and action plans 7.49 Action plan, Audits & monitoring file Engagement via MSLC Women's experience midwife as a point of contact for families when concerns are raised. Patient stories presented at monthly Q&S meetings. 7.8 OandG QandS Meetings Agendas and Minutes 2019 2 minutes of your time 7.48 2 min time.docx 7.49 Performance Board Report 2017-18.docx Birth Afterthoughts collates themes of patient experience and shares with the clinical board on a quarterly basis	New strategic vision for maternity services in Wales due to launch late 2019. To include national guidance around service user engagement and feedback mechanisms for maternity services in Wales The service could further explore some more diverse methods of listening to our patients' experiences in conjunction with the clinical board.	
	7.50 Continue to work with and build on the community based engagement approaches being suggested by the MSLC • Explore working with external partners, including the CHC and community based organisations.	As above plus:- Consultant midwife for vulnerable women engaged with voluntary sector agencies such as BAWSO		
	7.51 Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety: • Review and enhance staff training on the value of listening to women and families. • Review the process of investigation of concerns, handling 'on the spot' issues and ensure that all responses and discussions are informed by comprehensive investigations and accurate notes • Priorities the key issues that women and families have highlighted to improve the response	The Children and Women's Clinical Board has a well-established QSE Group which considers a range of information across the breadth and depth of the QSE agenda. The standardised UHB QSE agenda template is in use. Minutes of the QSE Group are submitted to each UHB QSE Committee meeting on a 2 monthly basis. There is a robust process in place for the recognition, investigation and	Requirement to provide staff training specifically on dealing with on the spot concerns and embed a structured ongoing training programme	

	• Ensure that promises of sharing notes and providing reports to families are delivered • Clarify the process regarding the triangulation of the range of information sources on patient experience, Sis, complaints and concerns and other data and ensure that there is a rigorous approach to make sense of patterns of safety and quality issues • Review the learning from the Sis in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge.	management of all Sis and this would include any in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge. Directorate:- • Women's experience midwife leads concern response for O&G, sharing outcomes and learning for staff at appropriate forums as above • Actions are shared with operational band 7 team leaders and via professional governance meetings to Senior midwifery management and leadership team • Corporate patient experience team works closely with the directorate to ensure timely compliance and completion. • Works to provide response for other clinical boards where they are leading • Obtaining responses from members of the multi professional team Table top learning (governance process) Action plans created when learning needs for patient safety are identified. Concerns completed in line with PTR. Women's Experience Midwife and risk manager work closely to ensure patterns are recognised and escalated where needed. Investigation process discussed at monthly mandatory study days to encourage no blame culture. 7.8 Gov Team Pres 2019 V 2 April 2019.pptx Close liaisons with concerns department for triangulation of data – fortnightly concerns reports sent with timeframes highlighted. 7.51 example of weekly active concerns list.pdf Women's Experience Midwife to attend monthly band 7 meetings to discuss concerns for emerging patterns as line		

		managers tend to deal with on the spot concerns. Training has been provided for staff focussing upon “on the spot”, informal and formal concerns investigation, resolution and recording All complainants are contacted to listen to their experiences and to agree the questions to be answered as part of the investigation As part of the response complainants receive copies of relevant medical records and staff statements. We offer to meet with people to discuss their concerns response or/ and initially to clarify concerns if required We have a weekly Executive led concerns meeting where triangulation of all concerns (incidents, complaints and claims) can be considered with reference to patient experience feedback, staff raising issues, compliments etc and any “noise”-any areas of concern are discussed and shared with the clinical board where appropriate		
	7.52 Learn from the experience of women and families affected by events: • Respond and work with families in the way they require. • Feed the learning into the design of a comprehensive training and support programme that will give women and families confidence in the skills, expertise, communication, safety and quality of maternity care.	At the outset of any investigation, the family are contacted and given a named point of contact. The family is also asked to consider any questions they may have and are asked about how they would like to receive feedback from the investigation report. Corporate patient safety team provide support to the Directorate and ensure that timescales for completion are progressed / met. Bereavement midwife supports the family who have experienced a loss and there is a named point of contact for the investigation via either Putting Things Right or RCA/SI Process. Learning is shared as above and is incorporated into service development / actions for monitoring A recent initiative has been the development of a dignity room for memory making within delivery suite for women		

		and their families who aren't ready to say goodbye to their baby. Following feedback from a serious incident, a second bereavement room has been furbished and opened within the high risk obstetric unit to enable women who still require additional close monitoring to stay in comfort with her family / partner. Patient kitchens within the postnatal ward and delivery suite were opened in 2018 to provide refreshments for women's partners / families Learning from women's experience is shared at MSLC via Patient Stories IOL video for women in development Patient stories obtained and shared across audit meetings / study days / Q&S Service users invited to be part of service change – reviewing leaflets, signage Projects implemented as a result of patient experience: • IOL video • Visitors policy • Change in signage • Process of assessing SRoM under review • Values and behaviours discussed at study days and including examples of concerns raised in relation to this Development of the Rainbow Clinic to care for women in a subsequent pregnancy after a loss. Involvement of a consultant obstetrician and the bereavement midwife. 7.8 Professional Governance Meetings Agenda and Minutes 7.3 Obstetrics Safety Quality Agenda 10 April 19.doc		
	7.53 Review the communications, support and engagement approach and strategy. • Ensure that the focus is not solely on management of key messages • Demonstrate openness, honesty and transparency, admission of fault and learning from this.	In line with PTR, investigations are open and honest and escalated when breach and causation is identified. As above		
	7.54 Prioritise an engagement programme with families at its heart.	Women are invited to participate in service change via concerns. For example, input into changing guideline,		

	• Women and families affected by events should be part of the improvement, co-design and culture change of the new service.	information leaflets, signage, processes, IOL video As above		
	7.55 Review the level and effectiveness of the bereavement service • Ensure that appropriate support and counselling is available for all families as required • Consider implementing the National Bereavement Care Pathway that has been developed by SANDS in collaboration with stakeholders including women and their families, RCOG and RCM.	The corporate bereavement lead has responsibility for liaising with women who have experienced a neonatal death within the NICU. A full time bereavement midwife is in post within maternity services. Close working relationships with SANDS exist in Cardiff and Vale. SANDS generously support staff with training and refurbishment / development of services for women and their families (See 7.52). Bereavement midwife (seconded Band 6) Dignity room SBRF 7.1 Stillbirth Review Forum Minutes 2019 Bereavement pathway 7.55 Stillbirth Guideline Apr 2019.pdf Teardrop team SANDS bereavement pack	The role of the bereavement specialist midwife should be matched as a Band 7 Substantive Bereavement midwife post (to benchmark against National Bereavement Care pathway). All follow up counselling appointments after a bereavement should be attended jointly by obstetrics / neonatal staff and have a standard format to enable audit. Ty Hafan have indicated they will fund a Nurse Post on NNU	
	7.56 Provide training for staff in communication skills, in particular on: • Empathy, compassion and kindness	Values based recruitment training is in place for staff Values based recruitment for midwives began in April 2019 and will form part of the assessment process for the newly qualified midwife (South East Wales recruitment) in June 2019. Staff are allocated in house training days for values and behaviours		
9. Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board	7.57 Continue with efforts to recruit and retain permanent staff.	**Midwifery** • Active recruitment for experienced midwives and support workers is timely and according to vacancy rates • Active recruitment to backfill maternity leave at 60% is underway • C&V are leading this year's joint South East Wales recruitment for newly qualified midwives. Dates set for June 2019. NQMs due to start October 2019. **Obstetric** Efforts have been made to design clinical fellow posts that will attract high quality candidates external to Wales to include R&D, leadership and governance training. There is current engagement with HEIW to ensure that adequate numbers of trainees are rotating through C&V to ensure robust rota numbers.	National shortage of obstetric trainees with Wales having a significantly higher attrition rate than England. Welsh Government / HEIW should explore the reasons for high attrition rates To become BAPM compliant, the recruitment of a dedicated Neonatal Nurse for transitional care ward should be considered. Concerns regarding lack of 18 months post graduate midwifery programme as there remain challenges with midwifery recruitment due to only one outturn of students annually. HoMAG have requested Welsh Government run a "Work, Train, Live" campaign to improve recruitment.	

			There are only 58 students due to qualify in Summer 2019 to provide newly qualified midwives to all of the South Wales Alliance sites. HoMAG should explore Cardiff Uni selection process and high attrition rates with the Lead Midwife for Education Consider fragility of neighbouring Health Board Services and need to provide support with flow Concerns raised to HEIW in relation to commissioning numbers for midwives, high attrition from Universities this year will result in a possible shortage of new recruits.	
	7.58 Seek expert external midwifery and obstetric advice for support in developing the maternity strategy and use the opportunity of change to explore new ways of working.	There is a clear C&V UHB Strategy 'Shaping our Future Well-Being' which includes the strategic direction for maternal health https://shapingourfuturewellbeing.com/ HoM is Chair of the All Wales Strategic Vision for Maternity Services due to be launched in 2019 Consultant midwives in C&V led 'Midwives Voices' survey for Wales which will inform the new All Wales Strategic Vision Consultant midwives in C&V led 'Your Birth We Care' survey in Wales which helped inform the new All Wales Strategic Vision Consultant Midwives in C&V have an active R&D portfolio and lead to ensure that policy / research and new guidance is informed into clinical practice Consultant midwife and 2 senior band 7 labour ward midwife are named committee members for the development of NICE & RCOG guidance. HoM & Consultant Midwives attend RCM / WG Leaders in Wales Midwifery Think Tank annually which helps inform direction of midwifery strategy in Wales. Q&S 7.8 OandG QandS Meetings Agendas and Minutes 2019 DMT 7.58 Directorate Management Team Meetings.docx	Welsh Government should consider working with NSAG to develop an annual workplan in line with HOMAG	

		7.58 DMT Agenda Week A - 29 March 19.doc 7.58 DMT Agenda Week B - 9 April 19.doc Consultant Obstetrician is currently chair of NSAG and Council member for the RCOG. Consultant Obstetric Anaesthetist is currently on OAA Committee. A number of consultant obstetricians and anaesthetists contribute on a regular basis to national guidance committees and audit systems, e.g. NICE, Each Baby Counts, UKOSS, MBRRACE, PMRT		
	7.59 Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety, including: • Ensuring that length of stay is reduced safely to allow for sufficient capacity in the new merged unit.	CWM TAF SPECIFIC		
	7.60 Monitor the effects of the reduced inpatient capacity to avoid any adverse effects on the safety or quality of the service.	CWM TAF SPECIFIC		
	7.61 Develop a plan to increase inpatient capacity if that is seen to be required.	C&V UHB are working with Cwm Taf Morgannwg UHB colleagues to ensure any additional flow to C&V is managed safely and that there is sufficient resource to do so. Bi weekly regional contingency planning meetings in place Dashboard for all out of area bookings has been developed in order to monitor flow.	Flow changes are increasing immediately following launch of RCOG / RCM external review Urgent requirement for CTMUHB colleagues to determine flow arrangements for C&VUHB to ensure that all women transferring care can be accommodated safely with sufficient resource in place to support them.	
	7.62 Independent Board members must investigate the lack of action by the Executive Team and Board following receipt of the consultant midwife's report in September 2018. • Independent Board members must challenge the executive over the contents of this report • Independent Board members must ensure they are fully informed on the monitoring of planned improvements.	CWM TAF SPECIFIC		
	7.63 Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance.	Data is prepared for Board and sub committees of the Board IM's are encouraged to challenge the data and the Executive response.		
	7.64 Independent Board members should receive training in the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of the services that the Board provides.	Morgan Cole undertook training for the Board on Corporate Manslaughter and Corporate Homicide Act 2007		
10. To make recommendations based on the findings of the review to include service improvements and sustainability. Advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms	7.65 Ensure that criteria for the opening of the new FMU have been agreed by a multidisciplinary maternity guidelines group and that readiness for the merger is assured.	Cwm Taf Specific		

	7.66 Update the risk register and review regularly at Board level.	The Directorate Risk Register is updated monthly and shared at Q&S meetings 7.66 Risk Register 2019 There are corporate plans to refresh all risk registers underway with Clinical Boards and Directorates to ensure that identified risks are not confused with issues. **The Corporate Risk register is discussed at all Board Meetings and where appropriate at the sub committees of the Board**	Every Clinical Board will be asked to develop further the high risks and then a report will be brought to the Board meeting in July	
	7.67 Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service that is responsive to the women and their families and the staff who provide care.	As above 7.58		
	7.68 Consider examining other UK maternity services to seek out models for delivery which could better serve their population regarding: • Methods of service delivery • Consultant delivered labour ward care • The role of and function of a resident consultant • Achieving a balance between obstetrics and gynaecology commitments • Reducing the use of SAS doctors for our of hours service delivery and developing their in hours role	C&V UHB maternity services benchmark against areas of good practice external to the UHB and outside Wales. Examples include:- • Blackpool – Paperlight E3 project • Cornwall – Antenatal CTG electronically stored records • Sheffield – ERAS Pathway • Internationally – Los Angeles for Virtual Reality Analgesia in Latent Phase C&V have hosted teams from Bath, Newcastle, Gloucester and London for PPH project. Medical leadership within the department is constantly looking at other models of care against areas of good practice. Medical staff are afforded opportunities to develop leadership and managerial skills including medical student teaching, leading on audits, being on the TWOGS Committee, undertaking research. Academi Wales Leadership Programme and Wales Clinical Leadership Programme		
	7.69 Identify and nurture the local leadership talent	There are opportunities to develop leadership talent in place within the Directorate, Clinical Board and UHB both formal and experiential. These include:- • RCM Clinical Leadership Programmes (Wales and UK) • Being a Leader UHB Programme • Senior Leadership Programmes • Academi Wales Summer School • Skills to Lead • Skills to Manage • Shadowing		

		• Benchmarking • HoM offers individual 121 opportunities for staff who wish to develop • MSc programmes of learning in management and leadership study (Swansea University) • Professional Doctorate Programmes of study • MSc Modules for midwives undertaking (or preparing for) CSfM roles • Rotation into other areas • Rotation to other UHBs to experience all models of midwifery care • Midwifery engagement and leadership of Research and Development e.g. BUMPES, Obs Cymru, ANODE		
	7.70 Ensure that any future service change for the development process of the maternity service as a whole is inclusive for all staff and service users. • Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision • Consider an externally facilitated and supported process for review • Consider seeking continued support from HIW and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provision.	Cwm Taf Specific		

Appendix 1 - Independent Review of Maternity Services at Cwm Taf Health Board – Assurance Framework template

REPORT TITLE:	**Point Of Care Testing (POCT) ALERT**								
MEETING:	Quality, Safety and Patient Experience Committee						**MEETING DATE:**	June 2019	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	x	
LEAD EXECUTIVE:	Medical Director								
REPORT AUTHOR (TITLE):	**Rachel Rayment, Chair POCT group**								

PURPOSE OF REPORT:

SITUATION:

As reported in December 2019, audit of the WPOCT database continues to reveal several issues (mismatches) which prevent the flow of data into both WLIMS and WCP. There has been a significant improvement in user compliance, with a reduction in incorrect use or manual entry of patient demographics, not acknowledging the POCT result when prompted, and the incorrect use or manual entry of user ID. User Errors are being actively managed by the corporate nursing team and lessons learned discussed at the POCT group.
However, IT issues are now responsible for 40% of the errors. The POCT Dept. were initially advised by the IM&T Dept. to prioritise the use of the NHS number over the patient Case Record Number. However, the 2 most concerning errors are :the NHS number is being scanned instead of the hospital CRN, meaning the result is held up in WPOCT and not relayed to WCP. Audits of the WPOCT database have highlighted that the ; PARIS barcode for the CRN (in PCIC) has a letter on the end and similarly, the result is held up and cannot be transmitted to WCP.Furthermore, it appears that there are some technical issues regarding the use of the PMS ADT feed interface to WPOCT, which require further investigation by the PMS Team. Finally, further development of the integration of the WPOCT database to the UHB Business Intelligence system is required to facilitate dashboard reports to monitor POCT activity, user competence reports and clinical effectiveness for each Clinical Board.

REPORT:

BACKGROUND:

POCT refers to all laboratory type tests that are taken out of the laboratory and performed close to the patient eg INR testing, ROTEM, pregnancy testing, blood gases, urinalysis, blood glucose etc. POCT testing must be as robust as those tests performed in the laboratory and stand up to internal and external scrutiny. We are preparing for external accreditation and are aware that we are some way off at present. The POCT group meets quarterly but membership does not represent all clinical boards and there is not an effective communication stream between users and the governance processes. There is no reporting mechanism for POCT in clinical board Q+S meetings

ASSESSMENT:

IT solutions must be sought at a priority to ensure the data entry error rate is diminished. Clinical Boards should nominate a medical and nursing leads for POCT who should be responsible for POCT in that clinical board, attend POCT group meetings and work with the POCT department to assure internal and external quality assurance of the tests, aswell as the training and practice of the users.

RECOMMENDATION:

1. POCT should be part of the Q+S review for each clinical board.
2. POCT data should be clearly visible on a Business Intelligence dashboard to each clinical board and for the UHB.
3. The POCT group establishes a task and finish group, which reports into the POCT group (which meets quarterly), to establish solutions for the IT/governance issues
4. No new POCT devices will be introduced into the UHB until these problems have been solved

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

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

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

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

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

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

Report Title:	Position Paper – Stroke Rehabilitation Model and Workforce								
Meeting:	Quality Safety and Experience Committee						**Meeting Date:**	18th June 2019	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**	**x**	
Lead Executive:	**Fiona Jenkins**								
Report Authors (Titles):	**Diane Walker, Lead Nurse for Integrated Medicine, Chair of the Stroke Rehabilitation Workforce Group** **Niki Turner, Project Manager to Stroke Rehabilitation Workforce Group**								

SITUATION

Cardiff and Vale University Health Board has a strategy to improve the rehabilitation pathway for patients in our care. To help instill a rehabilitation ethos amongst our teams, the Stroke Rehabilitation Centre (SRC) at University Hospital Llandough is developing a rehabilitation workforce model which could be replicated across the Health Board.

BACKGROUND

Medicine Clinical Board is conducting a reconfiguration of its stroke services towards a Hyperacute Stroke Unit on the UHW site and acute rehabilitation at SRC, UHL. This work involves redesigning the inpatient bed structure, enhancing community support to stroke patients and remodelling the multidisciplinary workforce with prudent use of resources across the stroke pathway.

Through this reconfiguration work there will be a shift of service provision at SRC towards an acute rehabilitation setting. In support of this, the SRC workforce project involves revision of the multidisciplinary workforce and a redefining of the rehabilitation model. It is intended that this model could be reproducible in other settings and specialities, aligning to the Discharge to Assess pathway model recently developed by Medicine Clinical Board.

SRC is a 38-bedded specialist rehabilitation unit with an existing multidisciplinary workforce model which is consultant led, with separately managed nursing and therapy teams. The therapy teams largely operate within individual disciplines. Workforce developments for the whole stroke service intend to configure the multidisciplinary establishment in line with the needs of hyperacute developments which necessitate an increased stroke consultant presence on the UHW site. There is a subsequent need to reconfigure the SRC multidisciplinary team, both to support provision of the optimal rehabilitation model for stroke, and to strengthen multidisciplinary leadership and integration of the team.

Rehabilitation evidence suggests that patients are more likely to have improved outcomes if they experience intensity of practise and maximise opportunity for repetitive task performance individualised towards their personal goals. In support of this, a rehabilitation workforce model which maximises rehab-facing direct patient contact time is promoted and these principles underpin the work being undertaken at SRC to re-focus the model of rehabilitation provided, using patients' time as the currency. Stroke patients are some of our most dependent in the Health Board; SRC can be seen as the flagship service for implementing a new rehabilitation model.

ASSESSMENT
To support the workforce review on SRC, a 'time in motion study' was conducted to identify current rehabilitation provision and individual roles. This found limited integration of multidisciplinary input at point of care and provision of rehabilitation by separate disciplines. In April 2019, an MDT workshop was held with the SRC multidisciplinary team.

4 key questions were explored:

- Time is the most important currency for patients in our care. How can we ensure that we work with patients to help them use it well?
- How do we ensure that each profession and different roles within each profession work to their maximum licence?
- What are the barriers to implementing home first? What do we need to do as an MDT to overcome these barriers?
- What do we need to do to challenge the status quo?

The main themes derived from discussions at this workshop were:

- Patient and family expectations need to be managed, there is a need for education about stroke recovery.
- Patients need to spend their time meaningfully in a way that adds value to them
- More variation is required with regards to how patients access their rehabilitation
- Team members need to do the right thing at the right time
- We need to work differently – culture change is needed and the rehab ethos needs to be embedded and sustained
- The environment needs to be reviewed

Further highlights of the workshop included the recognition of the need for multidisciplinary structural change towards better integration, and the recommendation for stronger therapy leadership. The team identified some quick wins which can be implemented immediately to enhance the rehabilitation provision towards an evidence based model.

ASSURANCE is provided by:

- Monthly Stroke Services Transformation Programme meetings
- Monthly Safety and quality meetings

RECOMMENDATIONS
Immediate actions for SRC to implement include:

- Promotion of the rehabilitation ethos / last 1000 days / "get up get dressed get moving" campaigns, ensuring that rehabilitation is "everyone's business".
- Improved patient and carer education and communication; managing expectations.
- Improved goal setting with patients and their families.
- Reduction in the number of meetings which do not add value to individuals' rehabilitation experience.

A longer term plan which will need support from Medicine/CD&T Clinical Boards and Management Executive includes:

- Defining an operational therapy leadership role, will be crucial to the success of the rehabilitation model. This role would work alongside the nursing lead and consultants,

jointly responsible for the quality of care and for overseeing any cultural changes needed to support the reconfiguration of the workforce at SRC.

- Development of nursing and therapy led beds, providing leadership support to the MDT and allowing the development of an alternative stroke consultant job plan model in the reconfiguration of stroke services.
- As the stroke pathway workforce review continues there will be opportunities to identify and develop advanced nursing and therapy roles rather than following the traditional medically led model.
- Reintroduction of the rehabilitation assistant role to work alongside both the nursing and therapy teams to deliver goal orientated practise and functional rehabilitation.

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:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Update on car parking and sustainable travel**						
Meeting:	Quality, Safety and Patient Experience				**Meeting Date:**	18th June 2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Executive Director of Strategic Planning						
Report Author (Title):	As above						

SITUATION

As previously reported, car parking on our major hospital sites is extremely limited with no medium term opportunities to increase the number of spaces available. In addition to this, in line with the Wellbeing of Future Generations legislation, the health board has a duty to develop and implement plans that increase the use of sustainable and active travel. The benefits are twofold: improving general health of the population by getting more people to be more active (walking to the bus stop, cycling etc); and helping to improve air quality by reducing the number of vehicles on the road in key locations. The Cardiff Public Service Board partners have all signed a commitment to significantly increasing the proportion of our staff who use sustainable travel to get to work over the next five years.

We have already taken action. A park and ride for UHW has now been running for two years which gives people and alternative way of getting to the UHW site.

This paper outlines the additional actions that are being taken, and the impact this will have for patients, visitors and staff.

REPORT

BACKGROUND

As presented in previous reports.

ASSESSMENT

As reported to the Board in March, the Health Charity has agreed to fund the first year costs of a number of initiatives that will support patients, visitors and staff access our sites more easily.

At UHW the park and ride service now runs until 11pm and between 7am and 7pm, the bus now runs every ten minutes rather than every 20. The numbers of people using the service continues to increase steadily.

A new park and ride service will be introduced for UHL, hopefully in July subject to final contractual arrangements. The service will run on a 20 minute loop from the old Toys-R-Us car park to UHL. The location was agreed as being most convenient to serve people travelling to UHL from Cardiff, the Vale of Glamorgan and from the M4.

A shuttle minibus service provided on a loop is also being set up and will run between UHW and

UHL to enable staff to more easily move between the sites during the day. Patients will also be able to use this service (in the future) if it is more convenient to park in the UHW park and ride and travel from UHW to UHL. There is plenty of blue badge parking at both P&R sites.

We continue to move non-clinical functions off our hospital sites where it makes sense to do so, with the final moves from UHW to Woodland House taking place over the summer.

All of these actions mean that staff and visitors have alternative methods to get to UHW without the need to bring their own car onto the site.

For those people who do need to use their car because of disability or restricted mobility, the current actions should mean that there is less competition for the limited car parking spaces, and therefore it is easier to park. We know that there are staff who have chosen not to register their vehicle with Parking Eye and continue to park in visitor and patient car park areas. To address this, the parking time allow will be reduced from 4 hour plus and extension of a further 4 will be changed to an extension of 2 hours (bring the total stay time to 6 hours). Most staff work shifts longer than 6 hours so this will deter staff from parking inappropriately. There will of course be the opportunity for patients to further extend their stay if they need to (such as attending in an emergency) and staff are being encouraged to make sure that they discuss this with patients and visitors so the Parking Eye office can be contacted to ensure a car parking charge notice isn't issued.

We know that there are still a high volume of complaints regarding the issuing of car parking charge notices, although these are declining as people get used to the new system. It is recognised that mistakes do sometimes occur, either by the patient or visitor not familiar with the site and where visitors are allowed to park, or Parking Eye as a result of the automated processes that are used. To date, approximately 40% of the parking charge notices that are issued automatically are cancelled by Parking Eye, and 20% of those issued put the onsite car parking attendants.

Anecdotal feedback received by patients and visitors is that they were not aware that we provide a park and ride service (or that it is free). We are therefore trying to increase the publicity and awareness raising regarding the parking and ride services. We looking at how we make the information more prominent on our website, providing the information on our appointment letters to patients and through improved signage on our site.

We are also developing plans to introduce corporate membership of Nextbikes which would enable all of our staff to use the Nextbikes in Cardiff (which are doubling in volume, and extend out into the Vale of Glamorgan). Under this arrangement, the first 30 minutes of bike rental would be free, and ongoing rental is at reduced cost. We have Nextbike stations at UHW and Woodland House and home to work with the organisation to extend this.

In the medium term, we are planning to develop an improved base for buses and bike racks at UHW through a sustainable travel hub and a business case has been submitted to Welsh Government to secure the capital funding. This will result in an increase in the number of bus routes coming to UHW.

ASSURANCE

ASSURANCE to the committee is provided by
The action taken to increase access to alternatives transport options that reduce the demand for car parking on the main hospital sites.

The Committee is asked to:
Note the content of the progress report.

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

REPORT TITLE:	**CLINICAL AUDIT PLAN**						
MEETING:	Quality Safety and Experience Committee				**MEETING DATE:**	**18.06.19**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**
LEAD EXECUTIVE:	Executive Medical Director						
REPORT AUTHOR (TITLE):	**Head of Patient Safety and Quality Assurance**						

PURPOSE OF REPORT:

SITUATION

The purpose of this paper is to present the UHB 2019 / 2020 Clinical Audit Plan.

REPORT:

BACKGROUND

The National Institute for Health and Clinical Excellence 2002, defines clinical audit as: "A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change."

ASSESSMENT AND ASSURANCE

The NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) is developed annually by Welsh Government and confirms the list of National Audits and Outcome Reviews which all health boards and trusts are expected to participate in. In addition there are a significant number of national clinical audits administered by national professional bodies that are not included within the NCAORP but that provide valuable assurance around the quality of care provision. A copy of the NCAORP can be viewed at https://gov.wales/national-clinical-audit-and-outcome-review-plan-2019-2020 .

The National Clinical Audits are an integral part of the quality improvement process and are embedded within the Welsh Health and Care Standards. The requirement to participate and learn from the audits is a central component of the Delivery Plans developed for NHS Wales.

A formal assurance process is in place for all audits included within the NCAORP. The results of audits should be used as part of the Clinical Board assurance arrangements, however full assurance can only be obtained if the requisite improvements are implemented.

Local clinical audit functions best as part of a planned programme of quality improvement activity. The development of a clinical audit plan should be informed by local quality and safety priorities and should meet the priorities of each Clinical Board, as a result there is recognition that it should be a dynamic plan which will respond to changing priorities throughout the year.

Clinical Boards should have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. Reporting arrangements should be determined to ensure results and improvement plans can discussed in the correct forum. There will be a focus on the Clinical Board governance arrangements around all clinical audits throughout 2019/20, ensuring that the audits are reported through the appropriate forum where requisite improvements can be agreed and monitored.

When deciding on clinical audit activity consideration should be given to recent:

- Serious Incident / Never Events
- Patient Safety themes
- Patient outcomes
- Release of new or revised best practice guidance..

In February 2018 the committee agreed an approach to categorise clinical audits into three tiers, to support a prudent and targeted approach (appendix 1).

- **Tier 1** National clinical audit.

- **Tier 2** Local clinical audit undertaken to address the patient safety and quality agenda,

- **Tier 3** Local clinical undertaken for any other reason including revalidation and CPD purposes.

Tier 1 audits should take priority and Clinical Audit Leads, Directorates and Clinical Boards should prioritise the data collection, reporting and development of requisite improvements around these audits before agreeing the allocation of any resource to Tier 2 or Tier 3 audits.

Tier 2 audits should be developed to give assurance around patient safety issues that have been identified as a result of Serious Incidents, Regulation 28 and other existing patient safety incident themes etc or to give assurance that care delivery is in line with recently published or updated best practice guidance.

Tier 3 audit proposals should be scrutinised by the Clinical Audit Lead and the Clinical Director to ensure they are prudent and offer a benefit to the Directorate and Clinical Board.

Clinical Audit Leads have developed a 2019 /20 Clinical Audit Plan incorporating all Tier 1 and anticipated Tier 2 audits (Appendix 1). There is not an expectation that Tier 3 audits will be included in the clinical audit plans, however the requirement to register and have approved all audits and to report and escalate the results remains imperative.

Progress against the 2019/20 Clinical Audit Plan will be reported to the committee In June 2020.

RECOMMENDATION:

The Committee are asked to :

Approve the 2019/20 clinical audit plan

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

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		

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

Appendix 2 - Cardiff and Vale University Health Board - Local Clinical Audit Plan 2019 / 2020

Clinical Board	Directorate	Tier	Audit Title
PCIC	primary Care	Tier 1 National Audit	National COPD Audit
PCIC	primary Care	Tier 1 National Audit	Acute Kidney Injury
PCIC	primary Care	Tier 1 National Audit	National Audit of Diabetes
PCIC	community pharmacy	Tier 2 Quality and Safety priority	Short Beta Antagonists in asthma patients
PCIC	primary Care	Tier 2 Quality and Safety priority	ANTT
PCIC	Primary Care	Tier 1 National Audit	NATROX
PCIC	NW Locality and CRT	Tier 2 Quality and Safety priority	Falls
PCIC	Localities		National Audit if Intermediate Care
PCIC	Department of Sexual Health		Audit of management of Chlamydia in Cardiff department of Sexual Health
PCIC	Department of Sexual Health	Tier 1 National Audit	National Audit of HIV and Malignancy Services in Centres within South East Wales
PCIC	Palliative Care Services	Tier 1 National Audit	National Audit of Care at the End of Life
PCIC	Palliative Care Services	Tier 2 Quality and Safety priority	Palliative Care Referral response Times
PCIC	Palliaive Care Services	Tier 2 Quality and Safety priority	Anticipatory Prescribing in Palliative Care:
W&C	Acute Child Health	Tier 1 National Audit	National Paediatric Diabetes Audit
W&C	Acute Child Health	Tier 2 Quality and Safety priority	RCPCH Quality in Diabetes Programme
W&C	Acute Child Health	Tier 1 National Audit	National Neonatal Audit
W&C	Acute Child Health	Tier 1 National Audit	MBRACE- UK perinatal mortality reporting (and contributing to Each Babay Counts)
W&C	Acute Child Health	Tier 1 National Audit	Vermont-Oxford Network- benchmarking
W&C	Acute Child Health	Tier 2 Quality and Safety priority	All Wales neonatal network: Neonatal Sepsis Risk calculator (SRC)
W&C	Acute Child Health	Tier 2 Quality and Safety priority	Annual service evaluation against All wales Neonatal Standards reporting to neonatal network
W&C	Acute Child Health	Tier 2 Quality and Safety priority	Review of Necritising Enterocolitis cases
W&C	Acute Child Health	Tier 2 Quality and Safety priority	Review of term admissions
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Knowledge and understanding of Diathermy safety
W&C	Obstetrics and Gynaecology	Tier 1 National Audit	BSGE national audit of complex endometriosis surgery outcomes and complications
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Quality of image optimisation in gynaecology outpatients department
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Use of TVT

W&C	Obstetrics and Gynaecology	*Tier 2 Quality and Safety priority*	Quality of image optimisation in gynaecology outpatients department after teaching intervention
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Hysterectomy methods and complications
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Antibiotic use in gynaecology
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Consenting for fetal tissue
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	evaluation of minitouch
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	evaluation of Resectr
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Evaluation of Transrectal ultrasound in outpatients
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	management of Hyperemesis
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Antenatal routine enquiry audit
Surgery	Dental	Tier 2 Quality and Safety priority	An audit of compliance by UDH OMFS department to new MRONJ protocol guidelines (SDCEP) prior to extractions.
Surgery	Dental	Tier 2 Quality and Safety priority	Re-audit WHO checklist in oral and maxillofacial surgery
Surgery	General Surgery	Tier 1 National Audit	National Lung Cancer Audit
Surgery	General Surgery	Tier 1 National Audit	National oesophago Gastric Cancer Audit
Surgery	general Surgery	Tier 1 National Audit	National Audit of Breast Cancer in Older People
Surgery	Urology	Tier 1 National Audit	National Prostate Cancer Audit
Surgery	Urology	Tier 1 National Audit	Audit of Stress urinary Incontinence I Women
Surgery	Urology	Tier 1 National Audit	Audit of Urethroplasty
Surgery	Urology	Tier 1 National Audit	Audit of Cystectomy
Surgery	Urology	Tier 1 National Audit	Audit of Nephrectomy
Surgery	Urology	Tier 2 Quality and Safety priority	Audit of Scrotal Pain Pathway Audit
Surgery	Urology	Tier 2 Quality and Safety priority	Audit of Consent for day of surgery admission patients
Surgery	Opthalmology	Tier 1 National Audit	National Opthalmology Audit
Surgery	Anasthetics	Tier 2 Quality and Safety priority	Obs Cymru
Surgery	Trauma and Orthopaedics	Tier 1 National Audit	National Joint Registry
Surgery	Trauma and Orthopaedics	Tier 1 National Audit	National Hip Fracture Database
Surgery	General Surgery	Tier 2 Quality and Safety priority	BAETS UK registry of endocrine and thyroid surgery
Surgery	General Surgery	Tier 1 National Audit	National oesophago Gastric Cancer Audit
Surgery	General Surgery	Tier 2 Quality and Safety priority	PQUIP
Surgery	General Surgery	Tier 1 National Audit	National bowel cancer audit
Surgery	General Surgery	Tier 2 Quality and Safety priority	SWORD pouch surgery database
Surgery	General Surgery	Tier 1 National Audit	Pelvic floor national database (mesh rectopexy)
Surgery	General Surgery	Tier 1 National Audit	National Vasular Registry
Surgery	General Surgery	Tier 1 National Audit	National Emergency Laparotomy Audit

Medicine	Medicine	Tier 1 National Audit	National Diabetes in Pregnancy Audit
Medicine	Medicine	Tier 1 National Audit	National Pulmonary rehabilitation Audit
Medicine	Medicine	Tier 1 National Audit	National Asthma Audit
Medicine	Medicine	Tier 1 National Audit	National COPD Audit
Medicne	Rheumatology	Tier 1 National Audit	National Early Inflammatory Arthritis Audit
Medicine	Medicine	Tier 1 National Audit	National Diabetes Inpatient Audit
Medicine	Medicine	Tier 1 National Audit	National Stroke Audit
Medicine	Medicine	Tier 1 National Audit	National Audit of Dementia
CD&T	Podiatry	Tier 1 National Audit	National Diabetes Footcare Audit
CD&T	Audiology	Tier 1 National Audit	National Audiology Audit
Specialist	Cardiology	Tier 1 National Audit	National Heart Failure Audit
Specialist	Cardiology	Tier 1 National Audit	Cardiac Rhythm Audit
Specialist	Cardiology	Tier 1 National Audit	National Adult Cardiac Surgery Audit
Specialist	Cardiology	Tier 2 Quality and Safety priority	National Audit of Percutaneous Coronary Interventions
Specialist	Cardiology	Tier 1 National Audit	National Congenital Heart Disease Audit
Specialist	Cardiology	Tier 1 National Audit	Myocadial Ischaemia National Audit Project
Mental Health	Adult Mental Health	Tier 1 National Audit	National Audit of Psychosis
Mental Health	Adult and Older people's Mental Health	Tier 2 Quality and Safety priority	Care and Treatment Plan Audit
Mental health	Adult and Older people's Mental Health	Tier 2 Quality and Safety priority	Matrics Cymru Compliance with Psychological Therapies
Mental Health	Adult Mental Health	Tier 2 Quality and Safety priority	Patient Own Medication Audit

presented to department QSE
presented to Clinical Board QSE
Presented at Clinical Governance Session
Results escalated to Clinical Board

Complete
Abandoned
Ongoing

Tier 1 National Audit
Tier 2 Quality and Safety priority

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

MINUTES OF THE MEETING HELD ON 13TH MARCH 2019

Present:

Alun Morgan (Chair)	Assistant Director of Therapies and Health Sciences
Bolette Jones	Head of Media Resources
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Judyth Jenkins	Head of Dietetics
Robert Bracchi	Consultant, AWTTC
Mathew King	Head of Podiatry
Nigel Roberts	Laboratory Service Manager, Biochemistry
Kathy Ikin	Directorate Manager, Radiology and Medical Physics/Clinical Engineering
Sarah Wilcox	Pharmacy (Representing Sarah Jones)
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Suzie Cheesman	Patient Safety Facilitator
Stephanie Francis	AWTTC

Apologies:

Sue Bailey	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Rachael Daniel	Health and Safety Adviser
Maria Jones	Senior Nurse, Outpatients
Paul Williams	Clinical Scientist Medical Physics
Lisa Griffiths	Quality Manager, Laboratory Medicine
Andrew Wood	Clinical Director, Radiology and Medical Physics/Clinical Engineering
Scott Gable	Laboratory Service Manager, Cellular Pathology
Sarah Jones	Quality and Safety Lead Pharmacy

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/085 Welcome and Introductions

Alun Morgan welcomed Mathew King to the meeting and introductions were made.

CDTQSE 19/086 Apologies for Absence

Apologies for absence were NOTED.

CDTQSE 19/087 Approval of the Minutes of the Last Meeting

The minutes of the meeting held on 13th February 2019 were **APPROVED.**

CDTQSE 19/088 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 19/051 Hydropool

It was noted that the pool at Rookwood is still closed for repairs.

CDTQSE 19/068 Radiology Dashboard

Work is ongoing to look at the documentation that will feed the metrics on the Radiology dashboard.

Action: Matt Temby/Rebecca Vaughan-Roberts

CDTQSE 19/079 Trans Awareness Session

Alun Morgan reported that there was good representation from Therapies and Laboratory staff at the session.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/089 Patient Story

Stephanie Francis, AWTTC was in attendance to present the project that was undertaken as part of the LIPS course. The project was to identify new medicines which will have an impact on NHS resources so patients receive timely access to treatment.

AWTTC appraises new medicines for use in Wales and supports the All Wales Medicines Horizon Scanning and Forecasting Group. The role of this group is to identify new medicines 12-18 months ahead of launch, which are likely to impact on NHS Wales. This enables both Welsh Government and NHS Wales to plan effectively and make sure medicines are available as soon as possible. The appraisal process is also effective in terms of patients in Wales gaining earlier access to medicines.

AWTTC have had difficulties retrieving the information required to identify high impact medicines. It was agreed that the project would focus on improving engagement with clinical experts including consultants, pharmacists, nurses and

therapists and would focus on medicines relating to cancer. 31 drugs with high impact were identified.

The majority of engagement was through the use of emails.

The LIPS course was highly valuable and the tools and techniques provided by the course enabled the team to explore the AWTTC horizon scanning process. The team identified that Specialist Pharmacists are useful contacts and links. The majority of engagement was through the use of emails however the team identified that face to face meetings were more efficient and productive. The number of cancer medicines considered in 2018 demonstrates an improvement in clinical engagement.

Going forward the team will continue to collaborate with Specialist Cancer Pharmacists and will extend the approach taken in the project around engagement to other therapeutic areas and identify suitable clinical links.

It was suggested that contact is made with the Medical Director's office for advice on how to engage with consultants. Non-Medical Prescribers are also useful contacts and Alun Morgan will send Stephanie Francis a contact list.

Action: Alun Morgan

Other mechanisms for engagement that were suggested included producing a quarterly newsletter or producing infograms that could be linked to the Medical Director's newsletter. Attendance and presentation at Grand Round was also recommended.

CDTQSE 19/090 Feedback from UHB QSE Committee 18th December 2018

The minutes of the UHB QSE Committee held on 18th December 2018 were **NOTED.**

The Mental Health Clinical Board presented their annual report.

The Committee approved the timeframes and approach for the Health and Care Standards. The Executive Members will sign off the standards relating to the Quality, Safety and Experience Committee during week commencing 13th May. Work will be taking place with Independent Members to sign off the files during week commencing 20th May.

The report on Maternity Services Review was discussed.

An update was provided on Medicines Management and the Committee commended the actions and progress made.

It was noted that Cardiff and Vale UHB's adherence to inputting the correct information into POCT systems in terms of patient number and staff ID was poor. The UHB is strengthening the process which Clinical Boards will be asked to sign off at their QSE Groups.

The UHB is making process with the National Clinical Audit Programme and the structures in place. Further work is to be carried out on the fractured neck of femur audits where mortality is satisfactory but aspects of care could be improved on.

CDTQSE 19/091 Health and Care Standards

Nothing further to report.

CDTQSE 19/092 Risk Register

Kathy Ikin reported that a Medical Physics Expert for Non Ionising Radiation has been placed on the risk register and is part of the business case for investment resource in view of the fact that the UHB will be introducing 2 or 3 new MRI scanners this year.

Mathew King enquired whether the foot pathway is on the risk register. It was suggested that he checks the Therapies directorate risk register.

Action: Mathew King

Alun Morgan will write to Nicola Foreman to ask when the new risk register template is likely to be available.

Action: Alun Morgan

CDTQSE 19/093 Exception Reports

There were no issues to escalate.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/094 Initiatives to promote Health and Wellbeing

Judyth Jenkins reported that as part of the National Campaign for Nutrition and Hydration Week, events are being held this week across the UHB.

A pilot is being undertaken for the provision of nursing staff with drinks on 4 wards. Staff will be issued with separate cups from the patients.

The Clinical Board is implementing a group to promote dietary, physical and mental wellbeing. The first meeting of the Group has been held and lots of ideas were presented.

Judyth Jenkins attended the Healthy Weight, Healthy Wales workshop held yesterday.

It was noted that Dr Adam Christian, Laboratory Director for Cellular Pathology has challenged his staff not to use the car during the week of 18th March. Staff are encouraged to use the Park and Ride, cycle, walk or use public transport.

Kathy Ikin suggested whether a summary could be provided for staff of all the work that is being undertaken in relating to health and wellbeing.

Kathy Ikin commented that hydration is an issue for Radiology staff, particularly in the new MRI facility and she is in discussions with estates regarding water stations.

It was noted that the UHB Charity is hosting a number of wellbeing events for staff in the coming months. There is a cycle event being held on 1st June.

CDTQSE 19/095 Falls Prevention

The Health Board Falls Framework document has been produced. Alun Morgan will circulate an electronic version.

Action: Alun Morgan

The Framework now needs to be translated into Welsh.

SAFE CARE

CDT QSE 19/096 Concerns and Compliments Report

From 1st April 2018 to 28th February 2019 the Clinical Board reported 53 formal concerns. This compares to 61 in the same period as last year.

In February 2019, 4 formal concerns were received. This compares to 7 received in February 2018.

Since 1st April 2018, the Clinical Board is reporting 21 breaches in response times. There were 2 breaches in February 2019.

The Clinical Board received 2 AM concerns in February 2019. Since 1st April 2018 the Clinical Board has received 11 AM concerns.

From 1st April 2018 to 28th February 2019, the Clinical Board has received 89 compliments. This compares to 88 received in the same period last year. 6 compliments were received in February 2019.

The key theme for formal concerns received is communication between staff and patients. 22 of the 53 concerns received fall within this category. The breakdown by sub-category is as follows:

- 7 (32%) related to attitude of staff.
- 8 (36%) related to difficulties in arranging/cancelling appointments.
- 7 (32%) related to lack of communication/communication issues.

Helen Jenkins will be discussing with Matt Temby whether the dashboards that have been produced for regulatory compliance can be replicated to demonstrate the Clinical Board's compliance with concerns.

Action: Helen Jenkins

CDTQSE 19/097 Ombudsman Reports

Nothing to report.

CDTQSE 19/098 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 19/099 Patient Safety Incidents

SI Report

There are currently 0 open SIs in the Clinical Board to report.

There are currently 2 IRMER incidents relating to Medicine. 5 IRMER incidents have been reported to HIW. No common themes have been identified. It was noted that the UHB has a good reporting culture, however due to the volume of incidents reported, an inspection from the HIW is likely. Staff training records have been reviewed and the Radiology team are inspection ready.

CDTQSE 19/100 New SI's

A meeting has been arranged to discuss a potential SI.

CDTQSE 19/101 RCA/Improvement Plans

An RCA Report relating to an incident in Children and Women's Clinical Board was received for information and learning purposes. The incident relates to a patient who received an anaesthetic for insertion of a femoral line that was not required. The incident has been classified as a near miss.

CDTQSE 19/102 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 19/103 Regulation 28 Reports

Nothing to report.

CDTQSE 19/104 Patient Safety Alerts

PSA009 Wrong Selection of Orthopaedic Fracture Fixation Plate

This alert has been circulated for awareness particularly for Physiotherapists and Occupational Therapists mobilising patients post fixation.

CDTQSE 19/105 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 19/106 Medical Device Risks/Equipment and Diagnostic Systems

New defibrillators are being rolled out across Clinical Boards.

New gas cylinders which are safer are being introduced in the Clinical Board. Pharmacy and the Finance team are looking at charging mechanisms for roll out to other Clinical Boards.

CDTQSE 19/107 IP&C/Decontamination Issues

The next UHB IPC Group is being held later this month.

The Water Safety Group has raised the importance of flushing as an episode of legionella has been reported within the Health Board. Directorates need to ensure that flushing audits are being undertaken and being recorded. Any areas with sinks that have been changed into storage areas, need to have the sinks removed.

CDTQSE 19/108 POCT

Nothing further to report.

CDTQSE 19/109 Key Patient Safety Risks

Safeguarding

The UHB Safeguarding Group is being held at the end of the month.

Alun Morgan reported that the Clinical Board compliance against the safeguarding mandatory training modules needs to be improved and asked directorates to ensure staff are undertaking the modules.

MCA Act

Nothing to report.

CDTQSE 19/110 Health and Safety Issues

Attendance at the last Clinical Board Health and Safety Group was poor. Sarah Wilcox commented that she is unable to attend on Fridays. Alun Morgan will discuss with Sue Bailey.

Action: Alun Morgan

CDTQSE 19/111 Regulatory Compliance and Accreditation

Matt Temby has commenced work with Quality Leads on developing regulatory dashboards. This is a visual tool that provides assurance on regulatory compliance. The agenda of the Clinical Board Regulatory Compliance Group will be reviewed so that it is aligned to the metrics of the dashboards.

CDTQSE 19/112 Policies, Procedures and Guidance

The Medicines Codes have recently been updated.

The Patient Property Policy is being updated to incorporate medicines.

Kathy Ikin reported that following the implementation of Radiology On Call for Vascular, the UHB Bereavement Policy does not reflect Radiology and therefore an interfacing policy for Radiology will be produced. The Mortuary Team will be linked into the development of this policy.

EFFECTIVE CARE

CDTQSE 19/113 Clinical Audit

Nothing to report.

CDTQSE 19/114 Research and Development

The Clinical Board R&D Group met last week. Arrangements for representation from Laboratory Medicine are being considered as the current R&D Lead sits in Laboratory Genetics. It was noted that discussions are being held with an individual in Haematology who may be interested in taking on the role.

The Group held a discussion on the new process for R&D funding allocations. R&D work undertaken in directorates will need to be evidenced.

The Dietetics department has been successful in a Pathway to Portfolio application linked to the Model Ward.

CDTQSE 19/115 Service Improvement Initiatives

Sion O'Keefe reported that an ideas generation trial 'Hunch Buzz' is being undertaken in Health Records. The objective is to set challenges and themes for improvement. ENT and Gastro will be involved in setting challenges. .Software has been purchased for the trial. The Director of Transformation is sponsoring this trial as part of the Canterbury work.

A generic invite has been sent out from Surgery and Medicine Clinical Boards for workshops relating to Lightfoot however it is unclear what the workshops entail and who are the appropriate individuals to attend. Judyth Jenkins advised that Surgery are focusing on the frail and elderly and Medicine are holding a workshop relating to COPD.

Podiatry is submitting a team for the next cohort of the LIPS project. Their project will explore setting up private practice to address the unmet need in the community. This topic is of interest to other areas in the Clinical Board such as Physiotherapy and Radiology. Kathy Ikin will link in with Mathew King to determine whether it is worthwhile individuals in Radiology participating in this project.

Action: Kathy Ikin

CDTQSE 19/116 NICE Guidance

New NICE Guidance has been issued on MRI prostate imaging. This guidance will extend the time of scanning and will need investment on MRI capacity and reporting. A full impact assessment is being undertaken. It is anticipated that there will not be MRI capacity to implement this until the new scanners are in place in December. The clinical view is that the guidance is implemented in 2020. The National Imaging Board will track constraints in the different areas. A paper is being produced on the costs and clinical impact and Kathy Ikin will submit this to the Clinical Board when completed.

Action: Kathy Ikin

CDTQSE 19/117 Information Governance

Information asset registers need to be updated. Directorates to contact James Webb in the Information Governance Team if they have any queries.

CDTQSE 19/118 Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 19/119 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

The Clinical Board is expecting to receive a report from the CHC relating to Podiatry services but this has not yet been received.

A routine 2 year inspection for Radioactive Waste in Medical Physics is imminent.

CDTQSE 19/120 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

CDTQSE 19/121 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/122 Equality and Diversity

Sion O'Keefe reported that he is part of a working group looking at gender identity from a health records/data quality and information governance perspective.

TIMELY CARE

CDTQSE 19/123 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/124 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

The Clinical Board is anticipating that it will report 0 breaches for patients waiting over 8 weeks and 14 week at the end of March.

INDIVIDUAL CARE

CDTQSE 19/125 National User Experience Framework

The National User Experience Report was received for February. The Clinical Board is reporting a 79% response rate.

STAFF AND RESOURCES

CDTQSE 19/126 Staff Awards and Recognition

The UHB staff recognition awards are being held this Friday.

The NHS Awards are open for nominations. 3 projects will be put forward per Clinical Board.

It was noted that the Physiotherapy walking aid project has been shortlisted in the HSJ Awards.

Standards of eating in restaurant services and the Model Ward work have both been nominated in the Hospital Caterers Association National Awards in the same category of Efficiency and Improvement Award.

CDTQSE 19/127 Monitoring of Mandatory Training and PADRs

This Clinical Board is currently reporting the highest uptake of frontline staff receiving the flu vaccination and has exceeded the UHB target.

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

The following minutes were **RECEIVED:**

Biochemistry Quality Group Minutes 5.2.19
Outpatients and Health Records Quality Group Minutes 4.2.19
Clinical Board Health and Safety Group 15.2.19

ANY OTHER BUSINESS

The Safeguarding maturity matrix has been launched.

DATE AND TIME OF NEXT MEETING

10th April 2019 at 2pm in Room 4.4. 4th Floor, Ty Dewi Sant UHW

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

MINUTES OF THE MEETING HELD ON 10TH APRIL 2019

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Alun Morgan	Assistant Director of Therapies and Health Sciences
Mike Bourne	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Bolette Jones	Head of Media Resources
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Judyth Jenkins	Head of Dietetics
Robert Bracchi	Consultant, AWTTC
Mathew King	Head of Podiatry
Nia Came	Head of Adult Speech and Language Therapy
Catherine Washbrook	Team Lead, Community Dietitian
Sarah Jones	Quality and Safety Lead Pharmacy
Lisa Griffiths	Quality Manager, Laboratory Medicine
Maria Jones	Senior Nurse, Outpatients

Apologies:

Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Kathy Ikin	Directorate Manager, Radiology and Medical Physics/Clinical Engineering
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Suzie Cheesman	Patient Safety Facilitator
Rachael Daniel	Health and Safety Adviser

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/128 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 19/129 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 19/130 Approval of the Minutes of the Last Meeting

The minutes of the meeting held on 13th March 2019 were **APPROVED.**

CDTQSE 19/131 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 19/092 Foot Pathway on Therapies Risk Register

Mathew King will be reviewing the entry and the scoring.

CDTQSE 19/092 New Risk Register Template

Alun Morgan has received no indication of when the new risk register template is likely to be available. It was agreed to raise this at the next Executive Performance Review.

Action: Sue Bailey

CDTQSE 19/114 Podiatry LIPS Project

It was noted that there is an open invitation for Radiology to link in with Podiatry's LIPS Project.

CDTQSE 19/115 NICE Guidance on MRI Prostate Imaging

The paper being produced in Radiology relating to the guidance has not yet been completed. It was noted that the guidance will result in an increase in scanning requirements.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/132 Patient Story

Speech and Language Therapy

Nia Came presented the story of a patient named Elaine. Elaine has dysphagia, a language processing disorder and dyspraxia. She currently attends the Neuropsychiatry service Day Unit where she engages in speech and language therapy and psychology interventions.

Speech and Language Therapy goals focus on remediation, self-management and most importantly acceptance of a new identity by supporting participation in the community and enabling patients such as Elaine to access psychological talking therapies.

As part of the communication project group all members have produced individual videos that illustrate their experiences of life with cognitive communication

disorders following acquired brain injury. They use the Step by Step computer programme and utilise this at home to gain fluency in their presentations. The project is designed to be challenging but outcome measures demonstrate gains for all those involved including improvements with communication skills, self-confidence, participation and wellbeing.

Elaine's video was presented. She has written, produced and is currently editing the video with the support of the neuropsychiatry speech and language therapy service and members of the Communication Group.

Elaine states in her video that she had an MRI scan which reported a large tumour in her brain. Because the tumour was large the only alternative was surgery. The tumour was removed but some damage to the brain has left her with dysphagia. Living with dysphagia day to day has been difficult and has left her with difficulties with writing and speaking. She also finds it hard to understand what people are saying to her, so when talking to people they need to speak very slowly. After the operation she could not speak one word but after a month of speech therapy she started to say single words. She is using a computer programme called Step by Step. She previously worked as a radiographer but has had to give up her job and this has been very difficult.

Elaine spent at least ten hours in self-directed practice re-learning how to produce speech sounds and words for her presentation. The effort and drive is extraordinary and not commonly acknowledged by those aware of the effects of dysphagia.

Dietetics

Catherine Washbrook, Team Lead Community Dietitian attended the meeting to feedback on the patient experience of X-PERT insulin, a charity led diabetes programme. One of the bits missing for pts with type 2 diabetes when they come on to insulin. Patients with Type 2 diabetes may need to commence insulin to ensure adequate glycaemic control. By making some additional and specific changes to their diet and lifestyle almost all people with type 2 diabetes who require insulin may be able to reduce their insulin doses or be able to omit insulin altogether.

It was recognised that this patient group had additional needs around managing their diabetes lifestyle and insulin requirements A Dietitian and Diabetes Specialist Nurse attended the X-PERT insulin training in July 20117 and implemented the programme in November 2017.

The programme explains what diabetes is and how food has an impact and patients take away a detailed resource. The programme runs for 6 sessions.

Session 1 focuses on patients understanding their health results.
Session 2 discusses nutrition and approaches.
Session 3 focuses on carbohydrate awareness, reading and understanding food labels and self-monitoring of blood glucose.
Session 4 raises awareness on fat in foods.
Session 5 patients are issued a Match it diary.

Session 6 focuses on physical activity.

5 programmes have been delivered over the last year and the majority of patients attend up to at least the 4th session. The majority of patients attending the programme have had diabetes of 10 years or more. A patient in the first group had an mmol was over 100 and reduced to 51 at the end of the programme. 48-53 is deemed good control.

Feedback from the course has been excellent. Comments from patients indicate that they did not realise they were eating too many carbohydrates and did not realise the link between carbohydrate intake and insulin requirements. They believed that they needed to eat to maintain blood glucose levels. Patients have also commented that their self-awareness has increased and their confidence to self-manage has increased. They had not realised that they had permission to alter their insulin dose and previously would not have had the confidence to request this.

Approximately 60 patients have attended the course. Current capacity has allowed an increase from 4 to 6 groups a year. Referrals are predominantly from Primary Care. The programme would ideally like for GPs to encourage patients to enrol in the programme at the time when they come onto insulin and the programme to be part of the health pathway. Robert Bracchi stated that AWTTC would like to link in with this programme to look at the savings and cost effectiveness of this programme and the reductions of co-morbidities linked to diabetes. Robert Bracchi will discuss with the AWTTC senior team how it can get involved.

Action: Robert Bracchi

Matt Temby commented that this is a good example of health accountability. He suggested that the programme links in with Media Resources to utilise the skills of the service for materials and also link in with the Communications Team to look at content that can promote the programme on the screens across the UHB.

The Annual Report from Speech and Language Therapy was **RECEIVED**. The report highlights examples of good practice and initiatives being undertaken within the Speech and Language Therapy service.

CDTQSE 19/133 Feedback from UHB QSE Committee 19th February 2019

The minutes of the meeting held on 19th February 2019 are not yet available.

CDTQSE 19/134 Health and Care Standards

Sue Bailey circulated the self-assessments on the 7 standards that the Clinical Board is required to submit and requested comments and any further contributions/evidence.

Action: All

Judyth Jenkins reported that Dietetics have submitted the standard relating to nutrition to Fiona Jenkins.

CDTQSE 19/135 Risk Register

Sue Bailey reported that the Health and Safety Group have been looking at highly flammable materials relating to DSEAR and celluloid film has been identified as being stored the CRI archives. There is also concern of a data breach. Access to the material has been difficult due to the fabric of the building. Sue Bailey and Bolette Jones need to identify what material is being stored and an assessment and decision on where it can be relocated.

Action: Sue Bailey/Bolette Jones

CDTQSE 19/136 Exception Reports

Issues for escalation were raised from the Clinical Board Regulatory Compliance Group.

In Haematology concerns were raised with the number of days that the longest CAPA was overdue. This related to a phlebotomy issue which has now been closed.

Haematology also escalated an issue relating to governance and supervision in phlebotomy and whether current processes are adequate.

The Cellular Pathology ISO Accreditation dashboard reflects challenges around the number of CAPAs and incidents open up to 12 months. The department is developing a log to track the individual cases that are open.

Pharmacy SMPU and UHL Units were challenged to close out their longest standing CAPA. It was noted that there have been a number of changes in their quality team resource and the Clinical Board was asked to approve their quality vacancy. This has been actioned.

A business case is being submitted to the UHB to request an increase in regulatory and quality resources in the Clinical Board.

The Blood Compliance Report is due to be submitted on 30th April and Lisa Griffiths is providing support with completion of the report.

The high volumes of labelling incidents that Laboratory Medicine are reporting has reached an unmanageable level. It has been suggested reporting these on another system e.g. LIMS and grouping the incidents by Clinical Board however the Patient Safety Team have raised concerns that they need to be able to search for individual incidents. An SBAR will be produced for a future meeting of this group recommending that these types of incidents are moved from being reported on Datix to another system.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/137 Initiatives to promote Health and Wellbeing

The Clinical Board has reported the highest uptake of frontline staff in the UHB to receive the flu vaccination and will be awarded with a financial reward from the organisation. It was agreed that Sue Bailey will be responsible for the decision making of how the monies will be utilised. Sue Bailey would like to use the monies for health and wellbeing and promotion that will benefit staff and asked directorates to consider where this will be of benefit in their departments.

Action: All

CDTQSE 19/138 Falls Prevention

Alun Morgan reported that the first meeting of the Community Falls Prevention Alliance has been held.

SAFE CARE

CDT QSE 19/139 Concerns and Compliments Report

From 1st April 2018 to 31st March 2019 the Clinical Board reported 66 formal concerns. This compares to 70 in the same period as last year.

In March 2019, 13 formal concerns were received. This compares to 9 received in March 2018.

Since 1st April 2018, the Clinical Board is reporting 23 breaches in response times. There were 2 breaches in March 2019.

The Clinical Board received 0 AM concerns in March 2019. Since 1st April 2018 the Clinical Board has received 11 AM concerns.

From 1st April 2018 to 31st March 2019, the Clinical Board has received 105 compliments. This compares to 93 received in the same period last year. 16 compliments were received in March 2019.

The key theme for formal concerns for 2018-19 were concerns relating to treatment.

Matt Temby stated that the Clinical Board needs to ensure that it is reporting 0 breaches going forward. Directorates need to identify early where a concern is not related to this Clinical Board and report this back to the Concerns Team immediately. Directorates are to escalate to the Clinical Board if there is any challenge in transferring a concern that sits in another Clinical Board. Also if a concern requires comments from another Clinical Board, directorates are to request the comments as soon as possible. It was noted that the Clinical Board Senior Management Team are willing to provide support and assistance with any complex concerns.

CDTQSE 19/140 Ombudsman Reports

Nothing to report.

CDTQSE 19/141 RCA/Improvement Plans for Serious Complaints

Sue Bailey has been in discussions with the PET Centre who reported a challenging IRMER Reportable incident. The actions are now closed.

CDTQSE 19/142 Patient Safety Incidents

SI Report

The Clinical Board is reporting 3 SIs:

In69239 - the closure form has been submitted to Welsh Government.

In82274 - relates to a choking episode on a ward.

In88890 relates to a patient who had a rare but known complication of a neurovascular procedure and passed away following the procedure.

CDTQSE 19/143 New SI's

Nothing to report.

CDTQSE 19/144 RCA/Improvement Plans

Nothing to report.

CDTQSE 19/145 WG Closure Forms – Sign Off

There were no closure forms to be received.

CDTQSE 19/146 Regulation 28 Reports

Nothing to report.

CDTQSE 19/147 Patient Safety Alerts

There were no new patient safety alerts to report.

CDTQSE 19/148 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 19/149 Medical Device Risks/Equipment and Diagnostic Systems

Tony Powell was not present.

CDTQSE 19/150 IP&C/Decontamination Issues

It was noted that IP&C nurse Yvonne Hyde will be supporting this Clinical Board.

The UHB Decontamination Meeting is being held on Thursday.

CDTQSE 19/151 Point of Care Testing

The Clinical Board submitted a business case for Point of Care Testing to the UHB Business Case Approval Group however this was not approved. The Clinical Board is now assessing the viability of a managed service contract and bringing all costs related to point of care testing into a central budget and to put in place a sustainable point of care testing process. A revised business case will then be resubmitted.

It was also reported that the Point of Care Testing Team are submitting a risk relating to their quality resource.

CDTQSE 19/152 Key Patient Safety Risks

Safeguarding

Maria Jones provided feedback from the UHB Safeguarding Group.

Anti-violence collaboration posters being circulated to raise awareness.

The Safeguarding maturity matrix is being implemented.

This Clinical Board is performing well against compliance with violence and aggression against women mandatory training.

Sarah Richards reported that 94 DOLs have been reported with the majority within the EU.

There will be a re-launch of the Designated Lead Manager (DLM) role in June.

Alun Morgan reported that there has been an unprecedented number of professional concerns being reported in this Clinical Board. No trends are identified. It was agreed that Maria Jones and Alun Morgan will consider setting up workshop format for managers to understand their duties and responsibilities.

Action: Alun Morgan/Maria Jones

Matt Temby noted that there has also been an increase in the number of employee relations cases within this Clinical Board some of which are linked to professional concerns.

MCA Act

Nothing to report.

CDTQSE 19/153 Health and Safety Issues

The Clinical Board Health and Safety Group is meeting next week.

CDTQSE 19/154 Regulatory Compliance and Accreditation

Nothing further to report.

CDTQSE 19/155 Policies, Procedures and Guidance

The Transrectal Ultrasound Guided Biopsy of the Prostate Standard Operating Procedure was **RECEIVED.**

Concerns were raised that the procedure around the labelling of pots is not consistent with the UHB Labelling Policy. This element of the procedure needs to be revised. When the procedure has been revised it was agreed that Chairs Action will then be taken outside of the meeting.

Action: Rebecca Vaughan-Roberts/Sue Bailey

EFFECTIVE CARE

CDTQSE 19/156 Clinical Audit

Nothing to report.

CDTQSE 19/157 Research and Development

The Clinical Board R&D Group has not met since the previous QSE Sub-Committee.

CDTQSE 19/158 Service Improvement Initiatives

Directorates are asked to strongly promote the Clinical Board Innovation Meeting on Friday. All levels of staff are welcome. These are a rolling programme of meetings and Helen Jenkins will re-circulate the dates.

Action: Helen Jenkins

CDTQSE 19/159 NICE Guidance

Nothing to report.

CDTQSE 19/160 Information Governance/Data Quality

There are discussions at Executive level around setting up a UHB Group specifically relating to Information Governance and Data Quality which is likely to include the remit of the current Medical Records Management Group.

DIGNIFIED CARE

CDTQSE 19/161 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Judyth Jenkins reported that HIW has undertaken a review on food in hospitals and this was received from Fiona Jenkins. A report in response to the investigation has been submitted to Len Richards.

The CHC report from their visits to Podiatry has been received. Matt Temby commended Mathew King on his response and suggested strategies to the challenging report.

A WRP Report on radiology processes has been received and it was noted that informal feedback was complimentary of the processes in place.

CDTQSE 19/162 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

The Clinical Board has been involved in working with patients with dementia on testing out an interactive table top tool and feedback has been positive with patients reacting well to using the tool. A bid will be submitted to the Health Charity for assistance with the costs of procuring the tool.

Sensory loss

The guide for Post Mortems is now available in braille in English and in Welsh. It was noted that Dental has an embosser that they are willing for other services to utilise. Helen Jenkins will circulate the contact details.

Action: Helen Jenkins

CDTQSE 19/163 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/164 Equality and Diversity

Keithley Wilkinson has circulated an email relating to the Inclusion project and is seeking volunteers.

TIMELY CARE

CDTQSE 19/165 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/166 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

This Clinical Board is reporting 0 position for 8 week waits in diagnostics and 0 waiters over 14 weeks in Therapies. The Clinical Board thanked all staff involved for their hard work.

It was noted that recent additional support from Therapies enabled the UHB to achieve its RTT targets.

INDIVIDUAL CARE

CDTQSE 19/167 National User Experience Framework

It was noted that the patient experience questionnaires have changed in format and examples of the new questionnaire were circulated for information.

STAFF AND RESOURCES

CDTQSE 19/168 Staff Awards and Recognition

The AHA Awards are being held on Friday. The Podiatry Stance project has been shortlisted.

The Physiotherapy walking aid project has been shortlisted for a HSJ Award.

Nominations are being sought for the NHS Awards. Matt Temby requested oversight of nominations before they are submitted.

CDTQSE 19/169 Monitoring of Mandatory Training and PADRs

At future meetings metrics for mandatory training and PADRs will be presented.

Fire training compliance needs to be improved. Sue Bailey is willing to provide bespoke training to departments.

The UHB Mandatory May sessions are running next month.

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

The following minutes were **RECEIVED:**

Biochemistry Quality Group Minutes 5.3.19
Clinical Board R&D Group Minutes 5.3.19

ANY OTHER BUSINESS

It was noted that Haematology is part way through its UKAS assessment this week. Rebecca Vaughan-Roberts raised concerns on behalf of the Head and Neck Service that patients being seen for neck appointments that require interpreters are having to wait longer for biopsies. Sue Bailey suggested the use of Language Line.

DATE AND TIME OF NEXT MEETING

8th May 2019 at 2pm in Room 4.4. 4th Floor, Ty Dewi Sant UHW

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING

16th May 2019

Seminar Room, Hafan y Coed, Llandough Hospital

Present: Darren Shore, Senior Nurse Manager Adult In-patients (Chair)
Will Adams, Professional Practice Development Nurse
Simina Alexa, SHO Links CMHT
Mark Doherty, Lead Nurse MHSOP/Neuro
Chloe Evans, Interim Team Lead North Crisis Team
Ruth Evans, Integrated Manager Links CMHT
Kate Gregory, Student Nurse
Sarah Howell, Interim Lead CMHN, Gabalfa CMHT
John Hyde, Mental Health Lecturer, Cardiff University
Noel Martinez-Walsh, Integrated Manager Pentwyn CMHT
Bala Oruganti, Consultant Psychiatrist
Natalie Prosser, Professional Practice Development Nurse
Tara Robinson, Senior Nurse Manager Cardiff CMHT
Briony Seaford, Deputy Ward Manager, Hazel Ward
Andrea Sullivan, Concerns Co-ordinator
Joanne Wilson, Directorate Manager MHSOP
Sarah Trench, Lead CMHN, Hamadryad CMHT
Mark Warren, Senior Nurse Manager Criminal Justice & Forensic

Apologies: Jayne Tottle, Director of Nursing Mental Health
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Owen Baglow, Deputy Ward Manager, Oak Ward
Philip Ball, Senior Nurse Manager Vale Locality CMHT
Jayne Bell, Lead Nurse Adult MH
Des Collins, Ward Manager Pine Ward
Natalie Coombs, Deputy Senior Nurse Manager CMHTs
Dan Crossland, Programme Manager
Alison Edmunds, Concerns Co-ordinator
Carol Evans, Assistant Director Patient Safety & Quality
Catherine Evans, Patient Safety Facilitator
Victoria Gimson, MHCB Pharmacist
Natalie Hulbert, Deputy Senior Nurse Manager MHSOP
Robert Kidd, Consultant Psychologist
Mike Lewis, SIMA Trainer
Mary Morgan, Senior Nurse Manager Rehab & Recovery
Annie Procter, Director Mental Health
Natalie Robertson, Principal Physiotherapist in Mental Health

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 - No Closures

GOOD PRACTICE:

3.1 EM

EM had been receiving services from the Drug and Alcohol Team (EDAS/CAU) since 2013. He had three admissions for alcohol detox to Adfer Ward and one planned to Pine ward. He suffered with the effects of long term alcohol abuse, and also from Hypertension and Type II Diabetes. He did not manage his physical health conditions very reliably. It is clear that he wanted to address his problem of alcohol dependency and gave his family (4 children and parents) as the key motivation for addressing his problem drinking, however he struggled to make the lifestyle changes necessary to maintain abstinence.

Very sadly, a telephone call was received from EM's mother to advise CAU staff that EM had been found deceased in his bed at his home address. Cause of death - Fatty cirrhotic liver and alcohol abuse. Coroner's conclusion - Death from natural causes.

Contributory Factors:

Poorly controlled weight, high blood pressure, Diabetes Type II and signs of Liver disease, and an unhealthy avoidance of exercise

Notable practice:

EM was properly advised about the health risks associated with his drug and alcohol use and was cautioned about the importance of his physical health treatments and remedies.

Paris notes reflect non-judgemental and assertive support towards addressing problem behaviours towards alcohol and also clear evidence of physical health monitoring and signposting.

Paris shows that appointments were properly documented, partner agencies (primary care) were alerted at times when blood monitoring showed physical health concerns.

The Service showed flexibility and tolerance, encouraging EM to re-engage – they did not discharge without several calls and letters.

TO CLOSE.

3.2 MK

MK had been known to services since 2010 and had been seen by several CMHT's during this time. MK was also known to the drug and alcohol services. MK had four mental health inpatient admissions, all informally, along with three admissions to Pine ward (Addictions Services). MK's mental health diagnosis was ADHD with recurrent depression for which she had been prescribed an antidepressant. This had recently been reviewed and the prescription supplemented. MK was also prescribed Atomoxitine for her ADHD and Antabuse medication from CAU.

Very sadly, MK was found outside the Knox Road NCP car park collapsed and badly injured. NCP staff called an ambulance, and the police were informed by UHW staff. MK was conscious when found and it is reported that she was attempting to get up and go home, at no point did she allude to her fall being a deliberate act. MK was conveyed to hospital but certified dead the next morning. South Wales police reported that MK had been seen on the top of the car park alone (no third party involved). MK appears to have fallen from the top of the car park and landed on a grassed area. No suicide note was found.

Inquest Outcome: Suicide

At the time of her death MK had been drug and alcohol free and was engaging well with services. MK had been seen by all three services (Ty Canna, CAU and Links) in the days immediately preceding her death, none of whom felt there was any imminent risk to herself or others. All three services acknowledged that MK was vulnerable, but that she was improving. MK had been seen approximately six times in the two weeks prior to her death, and despite describing a low mood, was able to talk positively about the future. MK had not described any suicidal ideation and spoke positively about the future

MK's friend had jumped from the same car park some years earlier and MK often went there to reflect on their friendship.

Notable practice:

Duty worker (Gwilym Griffiths) spent time talking through various options with MK to avoid social isolation and the associated feelings of paranoia.

CAU received a telephone call from MK stating she was low in mood and wouldn't be attending supervision, the HCSW encouraged MK to try and attend, which she managed to do. Staff spent time with MK encouraging her to try and motivate herself to a daily routine; to carry out small tasks and eat well. She was also encouraged to attend all appointments for additional support

Case note entries were comprehensive, for example they reported what was discussed and what activities were planned.

It was agreed that if MK didn't attend for supervision, the team would call her on her mobile. MK was also advised that if she had any relapse with her alcohol, she could contact the team at any time.

Each case note entry suggests that staff spent time with MK encouraging her to look at aspects of her routine she might change to alleviate some of her symptoms. MK was given the opportunity to speak to staff at times when she felt that she needed it outside of her routine appointments.

Issues:

MK had been sexually assaulted and SARC (Sexual Assault Referral Centre) was supporting her. Links Community Mental Health Team CMHT) did not have any interaction with SARC and wondered if information could be shared, subject to consent. SARC would be invited to attend a Team meeting at the Links by the Integrated Manager/Lead CMHN to learn how the CMHT could help clients who are supported by them.

TO CLOSE.

3.3 EK

EK was known to mental health services since her first hospital admission in 1972. EK had a history of taking overdoses though had a long period of stability since 1974. EK reported small overdoses to staff over past few years, inconsistent report of amounts taken and not requiring treatment. EK always informed staff or emergency services of the overdose. EK took an overdose of 16 co-codamol in January 2018 requiring treatment. Utilised and actively sought support from CMHT/Duty Worker.

EK was well known to Gabalfa Community Mental Health Team (CMHT). EK had a diagnosis of schizophrenia. She received a depot injection every 3 weeks which was administered at her home. The patient had several physical health issues including polycystic kidneys, sciatica, hypertension, lung resection for a lung tumour in 2013, asthma and a degenerative spinal disease.

The patient was last seen by her Community Psychiatric Nurse where she reported arguing with a neighbour but declined any help from her CPN in resolving the dispute with her neighbour. The patient appeared well at the visit and was cheerful in mood and wearing make-up. Her medication blister pack was checked and in order. The CPN arranged to contact the patient the following week; following unsuccessful telephone contacts, the CPN called to the home. The CPN was advised by workmen in the street that an ambulance and police had attended the property that morning.
EK had died unexpectedly at her home

Cause of death was identified following post mortem: 1a coronary artery thrombosis, 1b coronary artery atherosclerosis.

Notable Practice:

The patient was reviewed regularly by her responsible clinician who took a holistic view of EK's care. The reviews always considered both the physical and mental state of EK. The clinician always liaised with EK's GP and conveyed any change of treatment in a quick manner.

The CPN/Care Coordinator had an excellent understanding of the patient and showed great effort and detail in every interaction with the patient. The Care and treatment plan was updated in accordance with the patient's needs and strengths on a regular basis.

The patient was very well monitored by her community mental health team and information was shared with the GP in a timely manner.

Conclusion:

There was much discussion regarding physical health monitoring and health promotion. Darren Shore said that the MHCB were committed to the development and practice of physical health care and were advertising for a Senior Nurse for Physical Health Care to provide clinical and professional leadership in physical health within Adult Mental Health at Cardiff & Vale UHB.

Ward Managers are meeting catering staff in the next couple of weeks regarding the choice of food available on the wards. Healthy eating will be promoted.

TO CLOSE.

ANY OTHER BUSINESS

The Job Description for Clinical Lead for Quality, Safety & Governance is being revaluated.

Andrea Sullivan is currently supporting the Clinical Governance structure and is the Clinical Governance Co-ordinator for two days a week.

It was acknowledged that there was no standard practice for sharing RCA/Desk Top Reviews. It was agreed that sharing the document would be helpful in improving practice. Feedback should be encouraged.

Darren Shore requested that more than one or two lines be written in the column of "Good Practice". This should be expanded to include what the Good Practice was in detail and also name the staff.

4.0 DATE OF NEXT MEETING

18th July 2019 at 9.30am in the Seminar Room, Hafan y Coed.

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE held at 1.30 pm, 14th May, 2019 in PCIC Meeting Room 2, Woodland House

Present

Gareth Hayes (GH) (**Chair**)	Clinical Director, Clinical Governance
Anna Mogie (AM)	Lead Nurse, North and West Cardiff
Clare Evans (CE)	Head of Primary Care
Denise Shanahan (DS)	Nurse Consultant
Helen Donovan	Senior Nurse, Vale Locality
Karen May (KM)	Head of Medicines Management
Kay Jeynes (KJ) (Vice Chair)	Director of Nursing PCIC
Matthew McCarthy (MM)	Patient Safety Facilitator
Maria Dyban	Community Director, Clinicl Governance
Nicky Hughes (NH)	Lead Nurse, S&E Locality
Sarah Griffiths (SG)	Head of Primary Care Contractor Services
Stuart Egan (SE)	Trades Union representative
Vince Saunders	Infection Prevention and Control Nurse
Rachel Armitage (RA) (Minutes)	PCIC Quality and Safety Officer

By invitation

Ceri Clatworthy (CC)	Primary Care Pharmacist (for item 6)
Judy Brown (JB)	Safeguarding Nurse Adviser (for item 26)
Suzanne Wood (SW)	Consultant in Public Health Medicine (for item 24)

Apologies

Helen Earland (HE)	Senior Nurse PC
Lynne Topham	
Theresa Blackwell (TB)	Business Manager
Rachel Thomas	Locality Manager, South and East
Rebecca Williams (RW)	Assistant Head Of Workforce (representing Nicola Evans)

Preliminaries		**Action**
05/19/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Chair.	
05/19/002	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
05/19/003	**DECLARATIONS OF INTEREST** GH asked for any declarations of interest – none noted.	
The agenda was re-ordered		

05/19/004 (Agenda item 6)	**PATIENT STORY: MEDICINES MANAGEMENT - PAIN CLINICS EVALUATION** GH welcomed Ceri Clatworthy to the meeting. CC presented a collective evaluation of patient experience of pain clinics. This was a Medicines Management initiative which commenced in May 2018, aiming to improve access to pain management services for patients with persistent pain. It was noted that chronic pain results in a complex picture including social and psychological impacts. Fortnightly clinics were established with 30 minute appointment times. Evaluation was undertaken in March 2019 and the project will continue through 2019/20. GPs refer the patients under defined criteria; the pain clinic will signpost the patients to other supportive schemes and support patients pending referral to secondary care. The evaluation had received an 88% response rate providing overwhelmingly positive feedback. It was highlighted that GPs have become more conversant with the provision of this service and are consequently explaining better to the patients what service to expect. The following points were discussed: • The potential for cluster pharmacists to carry out similar work. It was noted that this was a small scale pacesetter scheme which had been developed in response to CC qualifying as an independent prescriber • The impact on GP practice attendances, noting that the additional time allocated for appointments in this scheme represented an investment rather than a reduction in resource, but recognising that it was about the work being done by the right person with the right time resource • The need to account for non-attenders and people who declined to be referred to the service. It was highlighted that these groups were included in the lessons learnt and there will be further review of how to maintain lists and the booking of appointments, recognising that non-attendances can indicate that people are being invited back to the service too frequently • The significance of psycho-social issues related to pain. The QSE Group **noted** the project evaluation.	
05/19/05 (Agenda item 24)	**DEMENTIA** GH welcomed Suzanne Wood to the meeting. <u>Dementia Plan Update and Dementia Strategy</u> SW provided a presentation on the Dementia Strategy, noting the need for holistic treatment of this condition with which 1 in 3 people will die. It was emphasised that there is both national and local policy and strategy supporting the local strategy. The local strategy has been developed with staff, professionals,	

	service users and carers via extensive consultation and has identified the need to ensure equitability and timeliness of access and that carers need to be empowered and supported. It was highlighted that the prevalence of dementia is expected to increase in the next few years with associated co-morbidities and frailties. In addition, more people will be living alone and will require additional support in the community, including increasing numbers of people with learning difficulties experiencing dementia. It has been identified that there is a need to reduce stigma and share the 6 steps to risk reduction. It was also highlighted that transferring services from secondary to primary care would make them more effective, and that this would require support of a single point of contact, namely the Link Worker that has been appointed to each cluster. In addition, improved links with palliative and end of life care are required in order to ensure a smooth transition across services. SW described the referral process, noting that the aim is to support the whole patient journey, including links to other specialties such as dietetics and speech and language therapy. In describing the possible future service model, SW highlighted Dementia Awareness Week, noting the clear links between the dementia strategy and the PCIC Dementia Plan. The "Read about Me" tool will be promoted, noting that it was developed by local dementia champions. In addition, a charitable bid is under development with the aim of pump-priming care homes with the "This is me" document which is intended to act as a passport; this will be launched on PARIS, which will also be utilised to identify the carers of people with dementia. The following points were discussed: • The need to redesign services with the needs of dementia patients in mind • It was suggested that SW attend MDTs on compassionate communities, noting that most dementia care occurs in community settings. The QSE Group **noted** the update.	
05/19/006 (Agenda item 4)	**MINUTES OF THE PREVIOUS MEETING HELD ON 12TH MARCH, 2019** The minutes of the previous meeting were approved as an accurate record. **Matters Arising** Page 4 Medication Incidents: KJ confirmed that she had reviewed the incidents and that no themes had been identified. Page 4 GP OOH Update: HE to provide update. Page 4 Patient Flow: Agenda item 28.3.	**HE**

	Page 5 GMS Services/Primary Care Capacity and Sustainability: Director of Operations to be requested to provide an update Page 5 CHC Commissioning Group: KJ confirmed that a paper has been submitted to the UHB Executive Director of Finance; direction is awaited. The item is recorded on the risk register. An update will be provided by the Director of Nursing once guidance has been provided by the Executives on how to proceed. Page 6 St David's Hospital: Telephone system testing now occurs at weekends so there should no longer be any associated system failures. Page 6 Audit: the Audit Plan has been refreshed but further updates will be required to build in proactive planning. Page 7 Domestic Homicide Review: RA confirmed that the review related to incidents occurring in 2016 and reported in 2017; on discussion with the Director of Nursing it had been decided that there was unlikely to be any further learning to be derived due to the time interval. The report and learning has been circulated out to Practices.	**LD**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
05/19/007 (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 the CHAP:** All staff are now in post; however, it is necessary to review the establishment noting the impact of a Cost Reduction Programme some years ago. It was noted that the variance between numbers of people attending is difficult to manage, relating also to the rate at which people are being dispersed. It was noted that the CHAP service carries a caseload of 1,000 patients. It was highlighted that there has been no administrative support since Christmas 2018, but a new service manager has been appointed who will review how to improve service efficiency. It was noted that the South and East Locality will be holding a service review imminently, at which a position statement will be presented, noting that there is an urgent need to complete work to reduce the current pressure on the small team. This will enable the development of a service model which will account for the needs of the target population. It was confirmed that the recruitment of staff and review of governance arrangements is in progress. **05/18/008 Risk Register – GP OOH IT issues:** Further update required. **11/18/009 Risk Register - QS&E 020714 CHAP:** See above – items to be combined.	**LD/DJ**

	11/18/009 Risk Register – Risk Escalations to note: Retrospective Assessments It was noted that 3 staff from the Powys project have been redeployed into the team. This had resulted in HR and IT challenges which are being resolved. 82 patients have been returned to the care of the UHB. Action can be removed from the action log. **11/18/023 Tracheostomy Guidelines Updates:** Action completed. **01/19/016 Out of Hours Peer Review – Christmas Transfer of Calls** HE to request that Danielle James and Loretta Reilly circulate the OOH service evaluation. **01/19/008 Risk Register – QS&E160714 Patient Flow**: Agenda item 28.3. **03/19/008 Risk Register – PCIC 280115 GMS Services/Primary Care Capacity and Sustainability**: Risk register has been updated. **03/19/008 Risk Register Risk Escalations – St David's Hospital:** Item to be removed from action log **03/19/013 Domestic Homicide Review – "Janet":** See above, matters arising. Item to be removed from action log. **03/19/024 Pre-analytical sample management** – agenda item 20.	**HE**
05/19/008 (Agenda item 7)	**QUALITY DASHBOARD** GH reviewed the dashboard. The following points were highlighted. **Vacancies:** It was noted that staff retention remains challenging. The Clinical Board has been involved in band 5 recruitment events across the Health Board and is piloting 12-hour shifts in the North and West Locality in response to staff feedback. In addition there is a great deal of workforce succession planning in progress. **Sickness**: It was noted that sickness audits indicate that sickness is being well managed. It was highlighted that there is a lack of access to counselling and that the same credence should be given to mental health as to physical illness. SE confirmed that this has been raised at the UHB Board level Local Partnership Forum as the current provision is far below the agreed standard. There are some all Wales discussions ongoing to attempt to address this. KJ confirmed that she will continue to raise this in all the appropriate forums; meanwhile it was suggested that N&W team members requiring the service could email Steve Curry, Chief Operating Officer, for support and escalation, as he had assisted previously, and that nurses may be able to access support from the Edith Cavell Trust and the Royal College of Nursing. **Interface incidents**: KJ confirmed that she will present an update to the next LMC meeting. It was noted that there will	

	be a pilot roll-out of the Datix system in a GP Practice in the Vale. **Pressure Ulcers:** the numbers reported reflect the reporting mechanism. Final evaluation of the revised process is awaited. **Healthcare Acquired Infections**: KJ confirmed that root cause analyses (RCA) of C. diff cases has now ceased as it had been identified that no further learning was possible. RCA of MSSA was commenced in 2018/19; learning has informed revision of the template which will continue to be used for another year. Regarding E. coli, formal evaluation is awaited with the possibility of an application for a research study to be considered for the Peezy pilot. **Cold Chain breaches:** KJ confirmed that work to improve cold chain breaches is under consideration. **OOH statistics:** formal recognition was given of the improvement in shift fill rates and reduction in escalation. It was highlighted that the current period is Ramadan which adds to the challenge of filling shifts. Nevertheless, the UHB is leading Wales in this area. **GMS Sustainability Framework:** it was noted that the sustainability framework is not an accurate index and that further work is required on capturing data regarding sustainability. SG confirmed that active work is in progress to support fragile practices and that work is under way to develop plans for supporting practices when they need it. While the current sustainability tool is employed nationally and is unlikely to be reviewed until 2020, practice performance measures are locally being made more robust with development of more appropriate triggers to indicate the need to intervene. It was discussed that the Immunisation Co-ordinator is currently absent from work which is having a significant impact on commissioned services and PCIC staff. It was highlighted that Public Health Wales has no contingency for when this practitioner is not at work. CE highlighted that vaccinations queries are affecting the Primary Care team, noting the fragility of having this function funded through the Children and Women Clinical Board and overseen by Public Health Wales (PHW). LC agreed to meet with PHW to discuss arrangements to cover absence of immunisation co-ordinator.. The QSE Group **noted** the Quality Dashboard and the agreed indicators.	**LC**
05/19/009 (Agenda item 8)	**RISK REGISTER (RR)** GH highlighted that the risk register was presented for colleagues to note. In future it will be considered at every alternate meeting; however, risk escalations will be discussed at each meeting.	

	AM reported that the risk relating to the border issue with Cwm Taf Morgannwg Health Board has been elevated. AM agreed to forward the risk escalation. <u>Risks escalations to note</u> *North and West Locality – Individuals with a Learning Disability under significant restrictions to their liberty whilst placed in residential care settings.* It was highlighted that Deprivations of Liberty Safeguards (DoLS) are the statutory duty of Local Authorities although they are funded by the Health Board. It was recognised that there is a significant backlog of DoLS and Best Interests assessments but it was noted that there is a risk that if a judicial review was lodged the UHB would be considered jointly responsible. KJ confirmed that she has raised this issue at the Mental Health and Capacity Legislation Committee which has given assurances that the matter is being addressed. Risk to be added to the risk register and regular updates to be requested from the Local Authorities via AM. The QSE Group **noted** the Risk Register.	**AM** **RA/KJ** **AM**
05/19/010 (Agenda item 9)	**AUDIT** <u>Bi-annual Audit Report - Anticoagulation Monitoring by the Acute Response Team (ART) – July – December 2019</u> KJ highlighted the recommendations of the report regarding the management of all major bleeds, noting that there is no recommendation for management of clots. KJ will feed this back to the Acute Response Team. The QSE Group **noted** the report.	**KJ**
05/19/011 (Agenda item 10)	**DATIX** <u>Current position – Business Unit (BU) queues</u>: RA summarised the BU queues, noting the impact on performance of an incident being held by one managing department for an extended period before being transferred to another incident manager. It was recommended that colleagues check their data as it has been identified that some of the figures reported were inaccurate. MM highlighted that performance relating to review within 7 days is good; it was advised that some District Nursing incidents are being allocated to Primary Care when they should be allocated to the respective Locality. BUs to send reminder to their staff. <u>Datix Update Report:</u> MM highlighted that the majority of SIs remaining open were RCAs for which there is a lack of clarity on who should complete them. JB confirmed that these are being reviewed by the Safeguarding team and a process for managing them is under development. <u>PCIC Interface Incidents Final Internal Audit Report:</u> KJ confirmed that the overall assurance opinion reported in the final Internal Audit report was Reasonable Assurance, which was welcomed. This work will now be supported by a pilot implementation of Datix in the Penarth Health Partnership.	**All**

	The QSE Group **noted** the updates.	
05/19/012 (Agenda item11)	**PHARMACY UPDATE** KM confirmed that funding is being provided to support service continuity and manage the high locum prevalence while improving the availability of the common ailment schemes. It was noted that the oral contraceptive scheme is expected to go live in the summer of 2019. It was highlighted that there has been a further reduction in antimicrobial prescribing of 3.1% from a very low position. The team was formally thanked for its work and thanks were extended for the GP support. The QSE Group **noted** the report.	
05/19/013 (Agenda item 12)	**GMS AND DENTAL SERVICES** Community Dental Service Transfer to PCIC: KJ formally welcomed the Community Dental Service (CDS) to the PCIC Clinical Board as from 1st April, 2019. It was confirmed that CE and her team are developing reporting arrangements. CE confirmed that the new service was discussed at the most recent Senior Management Team (SMT) and the lack of a service manager has been escalated as a risk on the Clinical Board Risk Register. CE recently met with the CDS SMT to agree future governance arrangements. It has been agreed that the overall accountability remains with the Dental Clinical Board; CE will provide updates to the quarterly Dental Governance meetings, which will be chaired by Mick Allen, Dental Practice Adviser. Approval to appoint a Service Manager has been sought. KJ confirmed that there will be a planned audit involving the CDS and a new representative for the decontamination group will be required. CE confirmed that work is under way to appoint a Band 5 nurse to cover decontamination and infection protection and control. Community Dental Services: Collection of Patient Charge Revenue for Vulnerable Adults in Wales – letter from Chair, Welsh Committee for Community Dentists: CE confirmed that Lynne Aston, Senior Assistant Finance Director, will review CDS charges. The QSE Group **noted** the update.	
05/19/014 (Agenda item 13)	**EXPIRED CERVICAL SCREENING TEST VIALS (SAMPLE POTS)** KJ confirmed that Public Health Wales had sent a notification that out of date medium was being used; in response, Lynne Cronin, Nurse Lead Primary Care Development, has addressed this issue with all the Practices involved. One Department of Sexual Health incident has been followed up by the S&E Locality. The QSE Group noted the update.	

05/19/015 (Agenda item 14)	**FRAMEWORK FOR THE MANAGEMENT OF PERFORMANCE CONCERNS IN GENERAL MEDICAL PRACTITIONERS (GPS) ON THE MEDICAL PERFORMERS LIST WALES** GH highlighted the revised Framework for the Governance Team to use when managing primary care practitioner performance issues. It was noted that this will be submitted to the Executive Quality and Safety Committee for ratification. The QSE Group **noted** the Framework**.**	**RA**
05/19/016 (Agenda item 15)	**BUSINESS CONTINUITY** Welsh Government - Preparing Wales for a No Deal Brexit The QSE Group **noted** the guidance**.**	
05/19/017 (Agenda item 16)	**CONCERNS** Death of CC in HMP Cardiff: NH confirmed that staff had attended Coroner's Court for this case, following which a narrative verdict had been reached, with no blame or causation therefore no recommendations for the Health Board. This is viewed as a positive outcome for the staff involved and has generated a lot of learning. Staff were offered a de-brief but had opted to carry that out between themselves. Concerns themes performance summary by Business Unit: the report was noted. The QSE Group **noted** the report.	
05/19/018 (Agenda item 17)	**BUSINESS UNIT QSE MINUTES** KJ confirmed that all BU minutes had been checked prior to the meeting and feedback had been provided as appropriate.	
05/19/019 (Agenda item 18)	**INFORMATION GOVERNANCE** Displaying GDPR Information in Public Areas - Audit Report Recommendation KJ confirmed that the guidance had been re-circulated and positive confirmation has been received from all BUs that it is displayed in appropriate areas. The QSE Group **noted** the update.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
05/19/020 (Agenda item 19)	**RESEARCH AND DEVELOPMENT (R&D)** Eurolyser Cube & test kits: to be deferred to the next meeting. Madeline's Project – KJ confirmed that the project is supported by Cardiff University, Mental Health Clinical Board and Public Health Wales. It was noted that Cowbridge is making efforts to become a dementia friendly town. It was highlighted that the Dementia Action Plan is intended to support PCIC attempts to build dementia into core business. It was highlighted that the	**RA**

	specialist palliative care team has worked strenuously to improve end of life care for people with dementia. Congratulations were proffered to generalists for ensuring that individuals with dementia are cared for without exception and strategies to manage their needs delivered in line with national guidelines. Pathfinder 1 – Pain Clinics and Medicines Management - Increased dedicated prescribing advisor time in practice as part of overall expansion of medicines management resource Note was made of the WG funding to support these projects. Glucometer audit results by Locality: Further work is required to review the audit results. To be deferred to the next meeting. PCIC update on R&D activity: KJ confirmed that AK, GH and KJ will be meeting Professor Chris Fegan, Director, Clinical Research Facility, and the UHB Medical Director, to discuss and increase PCIC R&D activity, noting that Dr Guru Naik, Research and Development Lead, and Dr Anna Kuczynska, Clinical Board Director have developed a plan to support more Practices to undertake R&D activity, while Dr Naik has shared his expertise and guidance with a number of identified Practices. It was also highlighted that there is work under way to make R&D part of the GP Fellowship scheme, and that 2 Nurses from Professor Fegan's team are available to support R&D in primary care. The QSE Group **noted** the update.	**RA**
SAFE CARE		**Action**
01/09/021 (Agenda item 20)	**PRE-ANALYTICAL SAMPLE MANAGEMENT** RA summarised the key points from the inaugural meeting of the pre-analytical sample management task and finish group. It was noted that CE and KJ had already met with the Laboratory Manager to review the improvement of access to phlebotomy services, which needs to be linked with this work. The QSE Group **noted** the update.	
05/19/022 (Agenda item 21)	**POINT OF CARE TESTING** Evaluation of AliveCor device usage, Birchgrove Surgery: to be deferred to the next meeting. Point of Care Testing Group Report from meeting held on 4th March, 2019: The QSE Group **noted** the report.	**RA**
05/19/023 (Agenda item 22)	**MEDICAL EQUIPMENT UPDATE** RA summarised the key points from the meeting of the Medical Equipment Group on 18th April on behalf of Theresa Blackwell, Medical Device Responsible Officer. The QSE Group **noted** the report.	
EFFECTIVE CARE		**Action**

05/19/024 (Agenda item 23)	**INFECTION CONTROL** VS summarised the PCIC position compared with the previous year. It was noted that Yvonne Hyde, Clinical Nurse Specialist in Infection Prevention and Control, will contact KJ regarding the management of additional bacteraemias (HCAI reduction targets). • WHO Hand Hygiene Day 5 May 2019 - Save Lives: Clean Your hands • IPCG Clinical Board Feedback, April 2019 meeting • HCAI monthly update and reduction expectation dashboards • HCAI monthly update and reduction expectation summaries • HCAI monthly update dashboards (Public) The QSE Group **noted** the updates and links to further information.	
DIGNIFIED CARE		**Actions**
05/19/025 (Agenda item 24)	**DEMENTIA** Dementia Plan Update and Dementia Strategy: and Is your health centre dementia friendly? EHE Environmental Assessment Tool These items were covered in minute above 05/19/05.	
05/19/026 (Agenda item 25)	**FREE SANITARY PRODUCTS – LETTER FROM DEPUTY CHIEF MEDICAL OFFICER** The QSE Group **noted** the letter.	
TIMELY CARE		**Action**
05/19/027 (Agenda item 26)	**SAFEGUARDING** Safeguarding update Judy Brown was welcomed to the meeting. The changes to the Safeguarding team were noted. JB highlighted the need to ensure ongoing training to level 2 for anyone in contact with children, families and adults at risk. In addition, all staff are expected to complete level 1 e-learning on domestic abuse. It was highlighted that there is an “Ask and Act” system to support a victim who wishes to report abuse to the Police and it is also possible to signpost to other supportive agencies if necessary. In addition work is under way to develop level 3 themes for adults to cover elements that WG indicate are necessary, including modern slavery, human trafficking, “honour-based” violence, county lines and cuckooing, noting in particular that Cardiff is a target city for county lines gangs, in which all community staff will require training. In addition, training sessions on female genital mutilation and WRAP will be provided for District Nurses. The following points were discussed:	

	• The need for clarity on the expectations for staff and what arrangements will need to be made to release them to do the appropriate training • The increasing prevalence of some of the above issues in community settings • The need for clarity on which elements of level 3 training are required by community-based staff • The MASH welcomes the Clinical Board's approach to managing pressure ulcers • The 2 ongoing adult practice reviews and 7 ongoing domestic homicide reviews • There will be a re-launch of the Designated Lead Manager process to ensure that the Lead Practitioners will be Health Board staff. Staff were advised that safeguarding advice is more quickly accessible by telephone than by email. The QSE Group **noted** the update. 26.2a - d Good working practice principles for the use of Chaperones during Intimate Examinations or Procedures within NHS Wales 26.3 Safeguarding Steering Group Minutes from 28th March, 2019 26.4 Regional Safeguarding Board Newsletter (a – English, b- Welsh) These items were presented for information. The QSE Group **noted** the contents.	
INDIVIDUAL CARE		**Action**
05/19/028 (Agenda item 27)	**TRACHEOSTOMY AUDITS** This item was discussed during agenda item 5, action log.	
05/19/029 (Agenda item 28)	**PATIENT EXPERIENCE** DoSH patient feedback results: NH highlighted that results were initially mixed but became very positive in later weeks. NHS Delivery Framework for 2017-18 – patient experience feedback: KJ highlighted that PCIC had received particularly positive feedback. National Audit of Intermediate Care 2018 by NHS Benchmarking: KJ highlighted that the report presented was a summary of the full report; further work was required to validate the data noting that the audit reflected the national position. The QSE Group **noted** the update.	
05/19/030 (Agenda item 29)	**WELSH LANGUAGE STANDARDS UPDATE** This item was presented for information.	

	The QSE Group **noted** the update.	
STAFF AND RESOURCES		**Action**
05/19/031 (Agenda item 30)	**WORKFORCE UPDATE** The QSE Committee **noted** the updates which had been discussed under item 8, PCIC Quality Dashboard.	
SUB-GROUP REPORTS		**Action**
05/19/032 (Agenda item 31)	<u>Primary Care Business Unit Reports</u> <u>GP OOH Business Unit</u> No report received. <u>Vale Locality</u> No additional issues to report. <u>Cardiff South and East Locality</u> NH highlighted that several residential or nursing homes are of concern, and that the team is soon to lose a Nurse Assessor. <u>Cardiff North and West Locality</u> No additional issues to report. <u>Pharmacy and Medicines Management</u> No additional issues to report. <u>Palliative care</u> No report received. <u>Primary Care</u> No additional issues to report. <u>Clinical Governance Group</u> RA provided a verbal summary of the themes being managed by the Clinical Governance team.	
PART 2:	**ITEMS RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE GROUP**	
05/19/033 (Agenda item 32)	**<u>CMO and CPhO UPDATES</u>** CEM/CPhA/2019/6 — Actavis group pTC ehf and Accord Healthcare Ltd Paracetamol 10 mg/Ml Solution for Infusion CEM/CPhA/2019/6a — Rescheduling of Gabapentin and Pregabilin as Schedule 3 Controlled Drugs CEM/CPhA/2019/007 — Accord Healthcare Ltd., Losartan potassium 50 mg film-coated tablets and Losartan Potassium 100 mg film-coated tablets CEM/CPhA/2019/008 — Sun Pharmaceutical Industries Europe BV-Zoledronic Acid 5 mg solution for infusion CEM/CPhA/2019/009 — Martindale Pharmaceuticals Ltd – Chloramphenicol 0.5% w/v antibiotic eye drops	

	CEM/CPhA/2019/011 Genethics Europe Ltd (distributed by Genesis Pharmaceuticals Ltd.) Prednisolone 5 mg tablets CMO Update 95: April 2019 (a – English, b – Welsh)
05/19/034	**WELSH HEALTH CIRCULARS** WHC (2019) 011 Implementing recommendations of the reiew of sexual health services – action to date and next steps (a – English, b – Welsh) WHC (2019) 015 The National Influenza Immunisation Programme 2019-2020 (a - English and b - Welsh)
05/19/035 (Agenda item 37)	**PATIENT SAFETY NOTICES/INTERNAL SAFETY NOTICE AND GUIDANCE** PSN045/August 2018 Resources to support safer modification of food and fluid/ International Dysphagia Diet Standardisation Initiative Update March 2019 PSN047 Recommendations for Managing Life-Threatening Bleeds from AV Fistulae/Grafts PSN048 Safe Practice Reminder – Pulse oximeters poster
05/19/036 (Agenda item 39)	**NHS ALERTS** MDA/2019/012 Potentially breached sterile packaging of: rectal tubes, Unoversal drainage systems, SimpaVac, sterile suction connecting tubes, sterile connecting pieces, suction handles/sets (FilterFlow™/Deltaflo), oxygen catheters, sterile nasal oxygen cannulas, sterile oxygen connecting tubes, and sterile forceps MDA/2019/013 All T34 ambulatory syringe pumps need a sponge pad fitted to the battery compartment to prevent battery connection issues MDA/2019/014 All Bard urogynaecological mesh – voluntary product withdrawal; implanted devices do not need to be removed
05/19/037 (Agenda item 41)	**UPDATES FROM OTHER GROUPS** Minutes from the UHB Nutrition and Catering Steering Group December 2018 Agenda for the UHB Nutrition and Catering Steering Group April 2019 Agenda for the Nursing Productivity Group Meeting 18th April, 2019
DATE OF NEXT MEETING	
Tuesday, 9th July, 2019, 1.30 pm – 3.30 pm **PCIC meeting room 2, Woodland House** ***FOCUS: Research and Development and Audit***	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 5th April 2019
Venue: Critical Care Resource Room

Attendance:
Carys Fox (CF), Director of Nursing, Specialist Services (Chair)
Jessica Castle (JC), Director of Operations, Specialist Services
Sarah Matthews (SM), Senior Nurse, N&T
Vince Saunders (VS), IP&C Lead
Suzie Cheesman (SC), Patient Safety
Colin Gibson (CG), Clinical Engineer, Rehabilitation Engineering, REU/ALAS
Steve Gage (SG), CB Pharmacy Lead
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Mary Harness (MH), Senior Nurse, Haematology, Immunology & TCT
Sarah Williams (SW), Interim Senior Nurse, Critical Care
Gareth Jenkins (GJ), Service Manager, Haematology
Kevin Nicholls (KN), Service Manager, Cardiothoracics
Helen Scanlan (HS), Interim Directorate Manager, Nephrology & Transplant
Craig Spencer (CS), Consultant, Critical Care
Beverley Oughton (BO), Interim Lead Nurse, Critical Care
Judith Burnett (JB), Interim Senior Nurse, Critical Care
Daniel Farr (DF), Deputy General Manager, Critical Care and Major Trauma
Lisa Higginson (LH), Senior Nurse, Nephrology & Transplant
Mathew Price (MP), Service Manager, Neurosurgery
Sarah Lloyd (SL), Directorate Manager, Neurosciences
Claire Mahoney (CM), Associate Infection Prevention Control Nurse
Keith Wilson (KW), Consultant, Haematology

Present:
Gemma Williams (GW), Personal Assistant, Specialist Services (Note Taker)

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome & Introductions The group introduced themselves one by one.	
1.2	Apologies for absence Received from; Hywel Pullen, Gemma Ellis, Claire Main, Rachel Barry, and Hywel Roberts.	
1.3	To review the Minutes of the previous meeting 14 March 2019 The minutes were agreed as an accurate record. Matters Arising 1.3 GW was not notified of any further changes required. The minutes were approved as an accurate record. Skin Prep Cannulation issue in Theatres – HR will feed back after the meeting	**HR**

	regarding the Clinel Blue wipes and their use. 2.1 Open Serious Incidents (SIs) – 5 closure forms for February. GW will liaise with SC regarding these forms. SC advised they will be presented at a different meeting. 2.2 DHR Report from Safeguarding – Directorates were due to raise awareness/ask the right questions. Staff needed to be made aware of their duty of care. Item 2.3 Healthcare Associated Infections – GW confirmed that she had circulated the VRE Outbreak SBAR. Item 3.1 Feedback from UHB QSE Committee – GW circulated the minutes from the last UHB meeting from SC. Item 3.2 Exception Reports regarding T5 Bathrooms – SM has a meeting next week regarding the roll out of the refurb. Item 4.1 Safeguarding Launch – GW confirmed that she had circulated the Safeguarding Maturity Matrix. Falls Framework – GW confirmed that she had circulated the framework to the group. Blood Gas Readings – Directorates confirmed no further issues regarding unusual readings. NatSSIPS – Representative required for each Directorate. GW will email out to confirm who the representatives are.	**SC** **GW**
1.4	<u>Patient Story – Haematology</u> Clare Ibbs, Paediatric Haemophilia Nurse Specialist presented to the group. A young boy with severe haemophilia A diagnosed < 12 months of age. Bruised easily and diagnosis confirmed. Developed antibodies to treatment inhibitor 6 months after diagnosis. Bleeds were a significant issue. Timeline of events discussed. Left ankle and left elbow pain. Plasma derived PF. Steroid injections ankles and elbows. Muscle wastage. The patient spent approximately 80% of his time in a wheelchair and was frequently in plaster. His health was disrupting his school time. His mum was unable to work as she had to care for him. 8 hourly rFVIII PF. Bleeding 3-5 times a week. Huge cost of treatment. When the patient was 15, he took part in a trial where he was given weekly S/C injections. When he was 17 the product was licensed. When he was on this treatment he only had 5 bleeds over the 2 year period which was a huge decrease. The new drug is called Hemlibra and was given once a week. The patient's quality of life has improved significantly. The patient has not been in a wheelchair since starting the trial and doesn't report any pain. He is also now going to college. His treatment costs £200,000 a year compared to £1.25m previously. The treatment has been life changing for the patient. The group agreed that this was a real success story.	

	CS asked if the patient will have any difficulties when he accesses Adult Services. Clare confirmed that the Adult and Paediatric Services are based all together as it is a lifelong service.	
2.1	Open Serious Incidents (SIs) SC noted that SIs have reduced significantly. There are 12 Open Sis currently. Quite a few are nearing completion. Open Inquests None to be discussed. Patient Safety Alerts No relevant alerts to be discussed.	
2.2	Closure Summary for Serious Incidents • NHS Ref In71721 • NHS Ref In78842 For information - Directorates to review.	**Dirs**
2.3	Healthcare Associated Infections VRE in Haematology VS updated the group. Meetings on VRE have been taking place since February due an increase in VRE in Haematology patients. From January to December 2018 there were 22 Bacteraemia cases against 6 the previous year. There is now an outbreak. Screening patients weekly and this is ongoing. To date there have been 57 screened as positive (colonised not infection). Audits highlighted environment not suitable and VRE isolated in environment. Estates have carried out some remedial work. Some work has taken place on B4 Haem. Next step is looking at the refurbishment. It is planned that Bone Marrow Transplant (BMT) will stay where it is during the refurbishment as no-where suitable to move to. This is a significant risk but the service can't be moved to England or anywhere else in the Health Board. PHW are looking at bringing a pod in to provide positive pressure cubicles so could then decant BMT at the same time. It was suggested that the VRE patients affected should have a duty of care letter stating an apology. It was agreed that this was a good idea. CF to look into this. A patient has also been tested as positive for TB. Meetings are taking place and letters have been sent to patients. A meeting needs to happen with the Bronchoscopy Service and Haematology. Attendees required are; Simon Barry, Keith Wilson, Geraldine Johnson, JC and CF. Also monitoring pseudomonas on B4 Haem. Concern was raised regarding the increase in MSSA across the Health Board but specifically massive increase over the last 11 months in Clinical Board. March figures show 9 cases which is the highest in any month. Increase in CC and B5 so increased incidence meetings taking place. HCAI Report Significant increase in Bacteraemia - 41% increase. The Clinical Board has not met any of its targets apart from Flu. The Clinical Board had a 64.4% compliance	**CF** **GW**

	rate for staff getting vaccinated. CF thanked MH for her hard work. Vince Saunders VS will be rotating to another service. Claire Mahoney will be taking over as the Lead for Specialist Services. CF thanked VS for all of his hard work over the last few years.	
3.1	Feedback from UHB QSE Committee None.	
3.2	Risk Registers with Scores of 15+ CF noted that she wanted to discuss with the group how the risks are being managed and what support the Directorates need. ALAS CG updated the group. CG noted that they are in the process of updating their Risk Register. There is an IT solution with regards to the Wheelchair Replacement programme. They are in the process of replacing it. New server required etc. Money from Welsh Government for this. Haematology MH updated the group. The filtration issue is in the process of being sorted out. Lack of isolation facilities is an ongoing problem. It won't be possible to decrease the risk level without the new build. The Day Centre will be improving its isolation facilities with segregation rooms starting in May. CS correctly pointed out that this has been 25 on the RR for >9 years. The solution sits out with the Directorate and CB, all Execs are aware of the issues and a new build is the only solution. The stem cell issue is now resolved. Expansion and uplift. The situation has improved regarding waiting times and they have appointed a new Consultant. The DVT service did find a room to relocate to but unfortunately due to a sewage leak CD&T are using the room. When it's available they will de-cant into it. In relation to the staffing issue re DVT the permanent second member of staff has helped. The Haemophilia Unit is an ongoing issue due to the inappropriate services. MH will go back to the Haemophilia Centre and discuss the possible solution of using the Children's Centre. Clinical staff not having appropriate areas to work from is still a significant issue. Consultant offices still have leaks from above. The University has loaned some office space. 2 additional risks recently; suitability of haemophilia service in Swansea and difficulty recruiting into the Consultant vacancy, SPR supporting. VRE outbreak needs to be added. Critical Care Nursing capacity is still a concern due to vacancies however they have successfully recruited and there is another round of recruitment events coming up. CF noted that the risk level could now be reduced. 2 Consultants recently started but there is still a deficit. Working on capacity – in October-Feb there has been an increase by 6. Bid to Welsh Government to access Critical Care fund. It's being managed but still a risk. Biggest risk currently is lack of isolation facilities. The Risk Register needs to be updated. Neurosciences Information governance is a long standing issue – issue with patients located in the Cwm Taf region as their notes are held on "Cardiff notes". If admitted locally	

	there is no access to their notes. Trying to discuss with Cwm Taf and not made much progress, SL is working with the Commissioning team. The Neurosurgery emergency admissions database is huge and sometimes falls over. Trying to get a purpose built database. Working with the developing team to build their own. No adequate support with regards to Neuroradiology, WHSSC money given to improve this service. In relation to 36 and 26 week targets – 36 week has made significantly progress but 26 weeks is still an issue. Investment from WHSSC so plan to put in theatre capacity to maintain. Neurophysiology issue with equipment and space - capital bids awarded monies to replace equipment and rolled out in May so risk can now be taken off. Interventional radiologists issue, working with CD&T. Rookwood significant issue with facilities and environment. Water coming through the roof. Issues with the electricity as generators can't cope. Money agreed from Welsh Government to build in UHL; 18 months to 2 years development. Failure to implement revised guidance around sodium valproate. Diverting epilepsy resource to make a meaningful start. Withdrawal of Urology support to spinal service. CF sent latest communication to NM yesterday. <u>N&T</u> HS has reviewed and taken off the safeguarding issue regulation 28 following high risk organs (2 kidneys lost). Only 2 risks that are rated in the 20's; - Suite 19 but refurb is now complete so this can be taken off. CF and JC to visit with VS. - Single handed clinical scientist who supports vascular access service. Submitted a business case with radiology and now starting again. HS will update. <u>Cardiothoracics</u> Huge focus on Cardiac Surgery work but still instability and inconsistency remains. In terms of patients waiting above 36 weeks there are 13 patients at year end. However, there are 70 in quarter 1 so it is still a risk. Working closely with theatres and weekly meetings are taking place. The system is up and running in relation to how patients are being monitored whilst on the waiting list. Working closely with the network. Letter issued to all patients to say this is your point of contact if there are any changes in your condition, this has been shared across the network. Cardiff patients being monitored – patients are flagged up if admitted to another specialty so early notification if something is wrong. 5th surgeon has been appointed. Weekend working now initiated. Directorates to update their Risk Registers where necessary and send to GW and CF. CF noted that she was in the process of appointing a new QSE Facilitator (previous advert had no suitable candidates).	**HS** **Dirs**
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> None.	
4.1	<u>Any Urgent Business</u> <u>Leak in TCT</u> MH noted that the leak is likely to be linked to building work going on outside the unit. Scaffolding may have damaged the roof. Water is still coming in. VS will	**VS**

	visit the area. <u>Antimicrobial Stewardship</u> SG noted that the Antimicrobial Stewardship Group needs a Clinical Board lead. Any nominations to be sent to SG. Laurence Grey is taking over from Federica Faggian as chair of the group. Issue of support staff i.e. Therapists, not being included.	**Dirs**
5.1	Thursday 25th April 2019, 8am, in the Critical Care Resource Room, UHW.	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 14th March 2019
Venue: Critical Care Resource Room
MINUTES

Attendance:

Hywel Roberts (HR), Consultant, Critical Care and QSE Medical Lead (HR) Chair
Jessica Castle (JC), Director of Operation, Specialist Services
Navroz Masani (NM), Clinical Board Director, Specialist Services
Rachel Barry (RB), Lead Nurse, Neurosciences
Sarah Matthews (SM), Senior Nurse, N&T
Vince Saunders (VS), IP&C Lead
Suzie Cheesman (SC), Patient Safety
Colin Gibson (CG), Clinical Engineer, Rehabilitation Engineering, REU/ALAS
Steve Gage (SG), Pharmacy
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Fiona Kear (FK), Assistant Service Manager, Haematology
Mary Harness (MH), Senior Nurse, Haematology, Immunology, Genetics & TCT
Lorraine Donovan (LD), Senior Nurse, Neurosciences
John Martin (JM), Clinical Director, Neurosurgery
Sarah Williams (SW), Interim Senior Nurse, Critical Care

Present:

Gemma Williams (GW), Personal Assistant, Specialist Services (Note Taker)

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome & Introductions HR welcomed everyone to the meeting.	
1.2	Apologies for absence Carys Fox, Jennifer Proctor, Gareth Jenkins, Anne-Marie Morgan, Claire Main, Lisa Higginson, Helen Scanlan, Sarah Lloyd and Keith Wilson.	
1.3	To review the Minutes of the previous meeting 24th January 2019 and the 15th February 2019 Draft Minutes HR requested that the group let GW know of any amendments required for both sets of minutes by close of play today. 15th February 2019 Minutes HR made GW aware of one amendment required in the meeting: Item 4.1 Any Other Business regarding mortality review forms – it should read "Specialist Services compliance has dropped. Now 50% compliance. Problem in Critical Care and Cardiology. Measures now in place in Critical Care. Richard Wheeler, Cardiology, is looking into it but has not got back to HR as yet."	**ALL**

	Matters Arising Not all actions discussed. Item 2.8 regarding skin prep cannulation issue in Theatres. Clenel blue wipes not licensed. HR and TT meeting with the rep from the company who supply the wipes on the 4th April for a risk assessment on their use. HR will feed back after the meeting.	**HR**
1.4	Closure Forms: NHS Ref 900516MAY17 - Drill in Theatres (AP) – John Martin JM updated the group. A patient underwent a neurosurgical procedure whereby an Acracut Desoutter reamer with a perforator (drill) was used during a craniotomy procedure. The perforator failed to disengage from the clutch mechanism and continued to ream and punctured into the brain. The patient was found to have a hemiplegia post-operatively. The consultant in charge felt that the drill bit disengaging was a problem and sent to the manufacturers. They found nothing wrong with the kit. When looking further, it was found that the drill touched a sensitive part of the brain. The person had an abnormal shaped head/with slightly different anatomy. The patient made a significant recovery. Lessons Learned Adherence to the standard technique is essential to ensure that procedures are conducted effectively. Use of the intra-operative Neuro-Navigation is to be mandated where doubt exists about the head morphology. Some of the actions implemented/arrangements for completing outstanding actions: - Use of the intra-operative Neuro-Navigation where doubt exists about the head morphology. - Cranial Perforator Training to be provided by the manufacturer of the device. - Arrangements for sharing and learning – RCA to be presented at set meetings. JC raised concern that information was missing from the closure form in relation to the kit not being faulty etc. SC confirmed that the closure form had previously been signed off and sent to Welsh Government. NHS Ref IN56779 - MI on B4N (GT) – Hywel Roberts HR updated the group. A patient died unexpectedly on a Neurosurgery ward. The gentleman was admitted to the neurosurgery ward for elective surgery to his spine. Posterior cervical decompressive laminectomy of C4, C5 and C6 was carried out under general anaesthetic. The gentleman became agitated overnight. Nurses noticed he had a distended abdomen. The nurses requested a review of the patient whilst also informing the Doctors that an ECG was to be taken due to increased heart rate. Soon after an ECG was taken and given to one of the Doctors to review. Unfortunately the Doctor did not review it at this time as it hadn't been labelled with the patients details. An emergency cardiac arrest call was made for the patient. The decision was made to stop CPR. The care delivery and local problems were discussed, along with the service delivery and organisational problems.	

	Lessons Learned: • Nursing skill mix was inadequate on this occasion. • Inadequate time was made available for weekend ward round due to excessive workload. The problem was not escalated to Consultant staff. • Communication between medical and nursing staff was poor. • Recognition of and response to a "non-neurosurgical" problem (acute MI) was poor on this occasion. • The Critical Care Outreach team was not called even when the referral criteria were met. • No mechanism exists for escalation of nursing concerns if they feel that the trainee medical staffs response is inadequate. Confirmation of some of the actions implemented/arrangements for completing outstanding actions: • The Lead/Senior Nurse to develop a set of standards detailing the appropriate nursing skill mix required to support patients on the neurosurgical wards. • The educational supervisor and practice educators are to develop and submit a plan to attend to the communication challenges associated with this incident between the Doctor and nursing team. • Practice educators and senior nursing team to provide further training to ensure that nursing staff can recognise and respond to acute illness and when the CC outreach team should be contacted. NM noted that wards should be in an environment where anyone can pick up the phone and contact someone with any concerns. RB noted that the incident occurred the weekend before the Nurse Practitioners started working weekends.	
PART 2: SAFE CARE		
2.1	Open Inquests SC confirmed that the cases were all out of hospital acquired injuries. Nothing specific to note. HR noted that Critical Care are trying to tighten up the process whereby the Coroner writes to Critical Care. The point of contact in Critical Care is the Critical Care admin staff. Serious Incidents (SIs) SC updated the group. There were 29 open SIs – this is now down to 14. 12 overdue with Welsh Government. 8 related to pressure damage. Sent 5 closure forms for February which will be presented at the April QSE meeting. 1 closure form with Carole Evans for this month.	**GW**
2.2	DHR Report from Safeguarding Directorates to review the documents embedded in the agenda. Nothing specific for Specialist Services to raise. Directorates need to be aware of organisational responsibilities with regards to safeguarding. JC noted that staff need to be made aware of their duty of care. RB noted that the reporting of sexual abuse was still an issue in Neuro. Common problem that neurologists are made aware of. Working with consultants on this. HR referred to the DHR report noting that the Board refused to supply the review panel with the perpetrators medical history. HR felt that this request could have been responded to, noting that the response could have simply said nothing	**ALL** **ALL**

	relevant to report etc. In future this needs to be discussed with legal and risk.	
2.3	Healthcare Associated Infections HCAI minutes 19.2.19 – for information. IP&C Newsletter for March 2019 – for information. HCAI Report to end of Feb 2019 VS updated the group. March 2019: • C.Difficile – 0. • MRSA – 1 (4 in total this year). • MSSA – 3 • E-coli – 3 • P.aeruginosa - 0. • Klebsiella spp – 0. VS informed the group of a VRE outbreak on B4H raising concern that there was a significant increase in VRE with 22 cases between January 2018 and December 2018, against a background rate of 6. 2 more cases in January and February this year. A number of actions are being taken; - Screening patients weekly. 58 patients screened to date. 25 colonised with VRE which is 47%. Data is ongoing. Screening will carry on. Environmental audits have picked up significant issues in relation to the fabric of wards etc. VRE found in toilet panels, window sills. The whole ward needs refurbishing. Looking to de-cant and keep bone marrow transplant patients where they are. Commode cleaning is still an issue which is a concern. Meeting on Tuesday regarding this. Norovirus also an issue on a number of wards. GW to circulate the SBAR around the VRE outbreak. Discussion ongoing regarding location of de-canting. JC raised concern that Estates may not be linked in with the issues. Jason Roberts, Deputy Executive Nurse Director, has picked this up in relation to their attendance at the meetings. There is another meeting next week. VS will feed back.	**GW** **VS**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee SC received the minutes yesterday. GW to circulate.	**GW**
3.2	Exception reports and escalation of key QSE issues from Directorate QSE groups Haematology – Bone Marrow Transplant Unit MH informed the group that cubicles were being closed for refurbishment, a few at a time and are having to profolax with antifungals. N&T – T5 Bathrooms SM referred to the issue on T5 regarding the inadequate bathrooms. One has been refurbished two weeks ago but IP&C have inspected it and raised concerns regarding the backing boards as they are the same as the previous ones. SM will keep the group updated.	**SM**
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business Regional Audits	

	TH asked if the Clinical Board was engaged with any regional audits. It was noted that some Directorates would be and that it was up to the Directorates to prioritise audits. <u>Pharmacy</u> On 1st April 2019 the classification of Gabapentin and Pregabalin will change to become a controlled drug, Schedule 3, Category C. Full CD prescribing and dispensing regulations apply, and wards must order via a CD Requisition. These medicines are exempt from requirements to store in CD cupboard, but must be kept in a secure locked location. Further information will be shared via Pharmacy Directorate and the Medicines Safety Executive. <u>Safeguarding Launch</u> SC informed the group that Judith Burnett attended the safeguarding launch last Monday. SC referred to the Safeguarding maturity matrix which is now available. The whole of Wales has linked in to inform the document of things that can be improved and things that have been working well in relation to safeguarding. SC will send to GW to circulate. <u>Falls Framework</u> SC noted that the Falls Framework has now been published. SC to send to GW to circulate. <u>Blood Gas Readings</u> HR wanted to raise awareness that he had 2 strange blood gas readings which may have been a gas machine fault. He reported both cases to Datix. Directorates to be aware and report back any issues.	**SC/GW** **SC/GW** **Dirs**
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	<u>Received and noted for information</u> • 2 minutes of your time (Feb 2019) • National Survey Report (Feb 2019) • NatSSIPS minutes 23.01.19 <u>NatSSIPS</u> HR noted that Holly Williams, QSE Facilitator was leading on this, but that she has now left the organisation. Attendance at these meetings has been poor. Directorates were requested to encourage attendance – a rep is required for each Directorate. The next meeting is on the 11th April 2019.	**Dirs**
PART 6: DATE OF NEXT MEETING		
6.1	Friday 5th April 2019, 8am, in the Critical Care Resource room, UHW.	

MEDICINE CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE MEETING
MINUTES

HEALTH & SAFETY FOCUS

Thursday 21st March 2019
9am – 11.30am
Classroom 2, UGF A Block, Main Hospital, UHW

Attendees:
Rebecca Aylward (chair), MCB Director of Nursing
Jane Murphy, MCB Deputy Director of Nursing
Kath Prosser, MCB Quality & Governance Lead
Tara Cardew, Derm/Rheum & Gastro Lead Nurse
Gill Spinola, Derm/Rheum & Gastro Senior Nurse
Derek King, MCB IP&C Nurse
Diane Walker, Integrated Medicine Lead Nurse
Fran Wilcox, Integrated Medicine Senior Nurse
Wayne Parsons, Acute & Emergency Medicine Lead Nurse
Rachael Daniel, Health & Safety Advisor
Suzie Cheesman, Patient Safety Facilitator
David Pitchforth, Integrated Medicine Senior Nurse
Emma Mitchell, Integrated Medicine Senior Nurse
Gemma Murray, MCB Professional Practice Development Nurse
Sue Patchett, C6 Ward Manager
Ian Dovaston, MCB Professional Practice Development Nurse
Sarah Cornes-Payne, Diabetes Senior Nurse

Apologies:
Jane Murphy, MCB Deputy Director of Nursing
Dr Aled Roberts, MCB Clinical Board Director
Sarah Edwards, Gastro Service Manager
Sarah Follows, Acute & Emergency Medicine General Manager
Barbara Davies, Integrated Medicine Interim Lead Nurse

PRELIMINARIES		**Actions**
A1	Welcome and Introductions The group were welcomed by RA, and the group took turns introducing themselves for the benefit of those who had not been in attendance before.	
A2	Apologies for Absence Please see above.	
A3	Flu Champion Special Mention The MCB recognised some of the Flu Champions who have been particularly helpful throughout the last campaign. The MCB presented Sue Patchett with a bouquet of flowers to thank her for going the extra mile during the MCB flu campaign, often taking time out of her busy schedule to vaccinate people in other areas.	
PART 1: HEALTH & SAFETY		

1.1	Feedback from UHB Health & Safety Operational Group RD provided the group with an update, advising that at the last meeting, held on Thursday 28th February 2019, there was no rep for MCB. KP acknowledged this. Martin Driscoll, Executive Director of Workforce & OD, is the new Exec lead for this meeting and will chair going forward. RD advised of H&S presentations being conducted throughout CBs in order to engage staff and encourage them to be more proactive. KP to liaise with Carl Ball to arrange a presentation to occur at one of the MCB's forums asap. Pedestrian safety strategy ongoing, following a staff fracture when van reversed into them. The overall aim is to make all UHB sites safer for pedestrians, particularly UHW. The MCB local priority action plan needs to be updated asap. On a rostered basis, the CBs will be asked to present their plan to the UHB H&S Operational group. RD happy to meet with whichever rep from MCB will be taking this forward.	**KP**
1.2	MCB Health & Safety Report Will be circulated in conjunction with these minutes.	
1.3	Manual Handling and V&A Training Guide V&A training session uptake levels are lower than anticipated. RD advised that the training session is a half hour refresher training, rather than full day. To arrange the refresher training, please contact the Elinor Thorne, Manual Handling trainer directly, and they are able to come to wards and areas rather than staff needing to be released from their ward or unit. RA queried MCB compliance on V&A training. GM advised that she had recently received these figures and will notify senior nurses and ward managers of who needs to be re-trained asap. TC queried a Parasitic acid update. RD advised that this issue is now being tabled at the Water Safety group. TC advised that refurbishments along the Rheumatology clinic corridor, have resulted in one door is being sealed up, so there will be only one access/exit point. TC queried whether this was suitable from a Fire Safety perspective? TC to contact Frank Barrett, Fire Officer, to confirm. GS advised of an incident in which a patient being treated in the capsule room in Endoscopy Unit became unwell with a vasovagal episode. There is no buzzer / distress notification device, only one exit and access point, and the capsule room is a considerable distance from the main clinic area. RD advised that a risk assessment of the room's set up should occur. RA queried whether any other areas that could be utilised, but at present there are none available.	**GM** **TC** **DMT**
1.4	Fire Safety Report Not yet received from Frank Barrett, Fire Officer.	
1.5	Workplace Inspection Update RW advised at the last UHB NMB meeting and was disappointed that during her recent walkabout, some areas looked scruffy and unkempt. DW agreed that this seems DW – can we liaise with Waste and arrange for skips. Mental Health room in EU not in use as the alarm is faulty and resulted in a MH nurse being assaulted. KP – can risk assessment of where you will establish another viable area for assessment? WP confirmed this had been completed.	

	Discussion ensued with regards to arranging a health & safety walkabout with Union representation. RA queried who would be responsible for this, the group advised that Stuart Egan, UHB Lead Health & Safety Rep, should be contacted, and that they should occur annually. WP confirmed that Wendy Roberts conducted a walkabout with SE prior to her leaving her post. KP to contact the directorate or SE for this paperwork.	**KP**
1.6	Exception Reports and Escalation of key H&S issues from Directorates RA confirmed that UHB funding had been sourced to purchase 2 new Hover jacks. Discussion ensued with regards to falls policy wording, DW concerned with incorrect procedure instructions for instances when Hover jack not available. KP will address this at the next fall groups meeting.	**KP**
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP & ACCOUNTABILITY		
2.1	Minutes of Previous Meeting The group were in agreement that the minutes of the last meeting were of an accurate record. All agreed that these were of an accurate record. SC suggested that it would be beneficial for attendee's positions to also be noted on the minutes. RK to ensure that attendee's roles are added ion the next set of minutes.	**RK**
2.2	Matters Arising **Directorate QSE Committee** RA confirmed that she had circulated an email to DMTs advising what structure and format their Directorate level QSE meeting should be adhering to. RA continued that, from May, the expectation is that a member of the DMT will present an item from the directorate QSE minutes at this forum, so we are bringing your discussions to this forum. There will also be an increased effort to maximise management and medical staffing attendance, as this meeting's attendees are mainly the MCB nursing workforce. **Flu Update** The MCB achieved 58% of staff flu vaccination uptake, so did not hit our target. RA reiterated the importance to increased uptake for 19/20. **Pressure Damage Purpose T Audit** RA queried an update. The group were advised that the last Pressure Damage T&F group meeting was cancelled, with the next one scheduled for April. Feedback will be provided at the next meeting. **LIPS Presentation** RA advised that she would like Paula Gallent's LIPs presentation sent to the MCB asap. EM confirmed she would ask PG to do this. **Criteria Led Discharge** RA queried whether any other wards apart from B7 and A1 implementing this. The group advised that these were the only two wards piloting this at present. **Hand Hygiene Audits** Discrepancies are occurring from ward to ward regarding the frequent of audits, with some wards not inputting data and therefore showing as a nil result, particularly East 1 / MEAU. WP will investigate further. **Health and Care Standards** KP advised that the MCB submission must be returned by Tuesday 30th April. KP confirmed that she, RA and JM will be working with lead and senior nurses over the next	**EM** **WP**

	few weeks to complete this work. **Health Promotion** RA advised that she would like three senior nurses to volunteer to be part of this group.	
2.3	Patient Story – Specialised Medicine GS relayed the story to the group, on behalf of Andrew Brown, A7 Ward Manager. A frequent patient on A7, was initially admitted hepatic encephalopathy. The patient was abusive and difficult upon admission, would not comply with treatment and was at level 4 enhanced supervision. He was often confused and absconded the ward regularly. The main difficulty and concern was that the patient was Hep C positive, and was found to be contaminating areas on ward with his bodily fluids. He had ongoing liver management treatment and was on the ward for 12 weeks. Before admission, he was displaying erratic and dangerous behaviour in the flat he lived in, and there was concern for his safety. After his hospital stay, it was deemed unsafe to discharge because of his capacity. A full assessment by social work team established it would be better for him to commence living in assisted accommodation. The patient was later diagnosed with liver cancer and was readmitted. He would continue to abscond or self-discharge, though repeatedly advised against it by staff. After each discharge, he would then heavily rely on his family, particularly his siblings, for support. This resulted in a deterioration of his relationship with his siblings. As he neared the end of his life, ward staff contacted his family during his palliative treatment and this resulted in them being present when the patient passed away. Ward staff helped his family gain closure and the patient have the support he needed from his family one last time. The group were all in agreement this was a moving, poignant patient story, and thanked AB, GS and the team for sharing.	
2.4	Feedback from UHB QSE Committee 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	Directorate QSE Minutes – Exception Reporting WP advised the group of the introduction of the Paramedic Post box, which is a confidential box where Paramedics they are able to write a note with a patient's name and admission date on it, and the EU team will endeavour to provide feedback regarding the patient's progress. WP advised that this has been positively received and is a great reflection tool that helps with closure and shared learning. KP advised that it has been found that some coroners are contacting ward staff directly for witness testimonies for inquests etc. KP asked that if this should happen, please notify KP and SC as well, so that they are able to support the staff and log the incident accordingly. DW queried whether KP/SC could act as central point of contact from coroner to hospital, SC advised that this was unfortunately no longer possible.	
HEALTH PROMOTION PROTECTION & IMPROVEMENT		
3.1	Flu Plan 18/19 CD&T were the highest achieving flu uptake CB year with 70.5%, and SpS CB was most improved. CV UHB staff flu profile 190313-1 final.	
3.2	Diabetes and Improvements with Care/Compliance SC-P, Diabetes Senior Nurse, presented to the group, describing her patient cohort, her team and their ongoing work streams. A copy of this presentation will be provided in	

	conjunction with these minutes. RA queried whether other HBs have taken this approach, with SC-P confirmed no, but that she welcomed the opportunity to share this. Collaborative working with PCIC for Band 7, will review annually to see whether there are grounds to increase the nursing workforce. RA great way of showing that when you focus and fix the quality issues, the financial benefits follow.	
SAFE CARE		
4.1	<u>New SIs</u> None reported for February, 3 so far in March – retrospective healthcare acquired pressure damage incidents. Integrated Medicine In79901 – Unavoidable, health care acquired. Development grade 1 to the heel, evolved to unstageable. Poor arterial flow, evidence of podiatry and vascular input. Vascular condition did contribute. Evidence of improvement needed in the completion and evaluation of risk assessments and the completion of Skin Bundles in line with best practice. Also noted that a Datix was not completed to note changes to the patients skin integrity. In81711 – gentleman admitted from clinic to ward and developed Category 3 healthcare acquired pressure damage. Risk assessments were not completed in line with UHB best practice. Background history of severe lung disease and weight loss which contributed towards this evolving. Evidence of individualised care plan and skin bundles. Timely referral to Dietician and TVN. In80645 – Injurious injury resulting in a fracture from a witnessed fall. Identified that falls risk assessments not fully completed pre fall. Post falls procedures undertaken in line with UHB best practice. In81758 – C Difficile noted on death certificate. Noted that this should not have been reported on the death certificate as the patient was C Difficile Toxin negative. The patient was nursed in a cubicle, with evidence of excellent hand hygiene and bare below the elbow audits both 100%. In86775 – Avoidable healthcare acquired pressure damage. 105 year old patient with pre-existing pressure damage to the spine that evolved into category 3. The patient would normally sleep on their tummy at home but this was not communicated and actioned whilst in hospital. Emergency & Acute Medicine In84549 – Young child presented to EU with Bronchiolitis, deteriorated whilst in the department and went into SVT. Incorrect doses of Adenosine and Digoxin. The Digoxin drug error resulted in the child having three times the recommended dose based on the childs weigh. This resulted in admission to PICU for ongoing monitoring and reversal treatment for the digoxin. No longstanding harm as a result of this error. Lessons learnt, drug calculator for all staff, quiet area for staff to prescribe and check drugs, all staff have undertaken medication management refreshers. In74238 – A patient had a sub-clavian air embolism identified during a CT scan. Investigation found that this was potentially as a result of the drip providing fluids under pressure not being clamped tight enough and being placed on the patient's abdomen when being transferred to radiology as the drip stand was broken on the trolley. No harm calm to the patient as a result of this. All staff have been reminded that all equipment that requires repair is escalated immediately and withdrawn from the clinical area. Any patients receiving intra-venous fluids under pressure and being transferred to another area should have the pressure released and ensure that the fluids are well clamped. In84662 – Avoidable healthcare acquired pressure damage. A patient was nursed on a trolley with a repose for over 24 hours secondary to lack of inpatient bed capacity. The patients skin was not assessed in the first 6 hours of admission in line with UHB best	

	practice.	
4.2	Patient Safety Alerts/MDAs/ISN  ISN 2019 002 - Wrong route medicine ISN 2019 002 Wrong route medicine  MDA-2019-013 Final.pdf MDA-2019-013 Ambulatory Syringe Drivers  PSN 048 - Risk of harm from inappropri PSN 048 Risk of harm from inappropriate placement of pulse oximeter probes	
EFFECTIVE CARE		
5.1	<u>Infection Prevention & Control Update</u> DK provided an overview of this month's MCB IP&C report. A copy will be provided in conjunction with these minutes. The group were advised that there are currently 17 outstanding RCAs with the MCB. DK will send this information to RA so that she can prompt senior nurse teams to ensure these are closed down as a matter of urgency. 0 compliance EU/AU with regards to PVC insertion documentation, which is a significant governance issue. DK is confident that the insertion packs are being used in this directorate as they are being ordered, but no documentation is being completed which is a cause of concern. DK also noted that there is a lack of VIPS scoring being logged within AU, advising that this should be completed at least every 24 hours. DK will email WP so that he can develop an action plan. C4C scores, when received, have been satisfactory, but there are still some issues occurring on A4. DK will conduct an environmental audit on A4 to establish if this is a problem. Finally, DK reported that there have not been any c Dif outbreaks reports in February.	**DK / Senior Nurses** **DK/WP** **DK**
5.2	<u>Point of Care Testing (POCT)</u> RA advised that she required some feedback regarding actions taken in relation to this. FW advised that one of her wards repeatedly reports as non-compliant for key tone, but this is not conducted or tested for on this particular ward. ID advised that staff with new ID badges are unable to conduct testing as the access is granted by badge number (i.e. the number on their old badge). POCT then insist that the staff retrain as they are unable to ascertain that the person in question has completed the necessary training.	
DIGNIFIED CARE		
6.1	<u>Enhanced Care Supervision</u> For noting, published in RCNI magazine.	
TIMELY CARE		
7.1	<u>Delayed Transfer of Care (DTOC) Report</u>	

	Not yet received.	
INDIVIDUAL CARE		
8.1	National User Experience Framework Feedback – 2 Minutes of your Time For noting.	
8.2	Compliments and Trends For noting.	
8.3	Appendix S – Lessons Learnt The group were advised of a claim made in 2014 by a nurse in the Emergency Unit, who was punched in the rib cage, falling backwards and onto the floor. The nurse has filed a claim against the UHB, citing failure to provide a safe system of work and exposing the claimant to injury. The member of staff was subsequently paid £50k in compensation.	
STAFF & RESOURCES		
9.1	Winter Pressures – Staffing Plans to de-escalate of winter beds are ongoing and de-escalation is due to commence from the end of April. From a patient flow and experience point of view, the decision has been made to close Ward C7 North. There is also a need to support Ward B4 Haematology's patient cohort due to an outbreak of VRE, so SpS will utilise the C7 North area as an interim measure.	
ANY OTHER BUSINESS		
10.1	RA advised of the Meet Brian Dolan Q&A session in UHW and UHL and encouraged the group to please attend if possible.	
DATE & TIME OF NEXT MEETING		
	09:00 16th May 2019	

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 12th March 2019, 08:00-10:30 hours
Surgery Seminar Room, A2, UHW

CONFIRMED MINUTES

Present:

Linda Walker	Director of Nursing, Surgery CB	LW
Richard Hughes	Consultant Anaesthetist (Chair)	RH
Helen Luton	Senior Nurse, T&O	HL
Rafal Baraz	Quality & Safety Lead, Anaesthetics	RB
Chris Williams	Quality & Safety Lead, Ophthalmology	Chris W
Mark Bennion	Clinical Governance Facilitator, Perioperative Care	MB
Claire Mahoney	Infection Prevention & Control	CM
Adrian Turk	Pharmacy	AdT
Clare Wade	Lead Nurse, Surgery Clinical Board	CW
Angela Jones	Senior Nurse, Resuscitation Service	AngJ
Oleg Tatarov	Quality & Safety Lead, Oleg Tatarov	OT
Sian Williams	Pharmacy	SW
In attendance:		
Dr James Stewart	Consultant Paediatric Anaesthetist for Item 19/29	JS
Edwina Shackell	PA, Surgery Clinical Board	ES

PART 1: PRELIMINARIES *(Chair)*		**Actions**
19/29	**Patient Story: Perioperative Care In25353** Dr Stewart reviewed the root cause analysis of this case in detail, which related to cortical impairment sustained by an infant due to low blood pressure (BP) during surgery, resulting in severe life changing brain damage, and the child requiring 24 hour care. During surgery, intraoperative blood pressure had dropped, critically in the last hour of surgery when no effective steps had been taken to raise the blood pressure. Dr Stewart described the post-operative timeline, from the time when the patient arrived in the Anaesthetic room, to transfer to PICU after almost 3 hours (due to PICU being busy). X-ray, CT and MRI scans had been undertaken, the latter confirming hypoxic ischaemic brain injury consistent with a low pressure perfusion injury. The anaesthetic chart was presented and explained in detail. It was noted that pre-operative blood pressures ward charts were held separately from theatre and were not available at preassessment. **Lessons Learned** - Achieve a mean BP of 40 - Place less reliance on clinical blood flow indicators - Contribution of epidural to be considered more – it was felt this was not taken into account - Reduce sevoflurane concentration - Reduce Remifentanil - Fluid bolus/vasopressor drugs/inotrope - not given when BP was low in the last hour.	

	Other factors: - Ward charts not easily available. - Preoperative blood results were almost a week out of date. It was not clear whether FBC was done the day before and lost. This was needed to compare with post-operative FBC - Blood gas machine in theatre partially functioning resulting in blood lactate level not being recorded. Only the Registrar could do the blood gas, but did not have a log in. The only way would be to send an ODA to main theatre to do this, which would take 30 minutes, not lightly undertaken. This meant that not all the information was available. - Perfusion parameters not recorded – CVP, CRT, urine output. - 2 hrs 50 mins post op in PICU, most of that time waiting for ventilated bed. - When child went to anaesthetic room, the data was not written down. When the patient transferred to PICU, the stored anaesthetic data was wiped (normally stored for 24 hrs). It was explained in detail how this had become standard practice in order to avoid confusion of data. However in this case the 5 hours data for this child was lost. It was not considered that this would have made a material difference as other observations were recorded in the anaesthetic room. - Neuroradiology cover did slow the diagnosis and slow the involvement of the neurologist. Other causes for brain damage were excluded. Action Plan: - Ensure availability of pre-operative BP - Ensure up to date blood results. - Ensure alternative blood gas machine availability - now addressed. - Avoid wiping anaesthetic machine data until this is recorded in the patient's notes. - Record intra operative parameters, ie CVP CRT if used - Anaesthetist to reflect on the case. This had been completed. - Intraoperative blood pressure education to be presented. Actioned. Dr Stewart was thanked for his presentation. Dr Stewart advised that the recommendations were formulated once the RCA was completed, and initiated 4 weeks after this. Assurance was given that the action plan is in place. Gas machine maintenance had been adjusted, and had increased to twice weekly. Any kit found to be faulty was addressed the same day. It was noted by RB that this case was important and useful for awareness for adult anaesthetists.	
19/30	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
19/31	**Apologies for Absence** Received from Catherine Evans, Gillian Edwards, Andy Jones, Barbara Jones, Ceri Chinn.	
19/32	**Declarations of Interest** None declared.	
19/33	**Approval of the minutes of meeting held 15th January 2019** Accepted as an accurate record.	
19/34	**Matters Arising: To receive Action Log from the above meeting** 18/41 Cefuroxime 50g powder for intracameral injection. Chris W had raised this at Ophthalmology Quality and Safety in December 2019. Both products require mixing by nurses. AdT underlined that a consensus was needed. Chris W advised that despite best efforts, there remained a lack of consensus within the Consultant body. There was some anxiety regarding nurses mixing drugs for eye injection.	

	Incidence of post-operative ophthalmitis over the previous 7 years had been reviewed and was almost zero. There is therefore a reluctance to change practice. Ophthalmitis is a very rare complication and a running audit is kept; there is no problem at present. Is Cardiff and Vale permitted to be an outlier? AdT confirmed that this would be permitted, with the proviso that should there be an issue arising from current practice, the UHB would be criticised. It was noted that NICE Guidance is not mandatory; however AdT highlighted that the Guidance did stipulate not to use the unlicensed version. There is a tension, as the Royal College advises practitioners not to use an alternative to the new licensed drug. ChrisW was clear that this concerns a drug going into the eye, which is the greater risk. The two products are not identical. **Action: to remain on the Action Log.** LW encouraged colleagues to reach a definitive decision, so that practice is clear, one procedure. If the decision is to continue with current practice, a Risk Assessment should be completed. **Update at next meeting: Chris W.** 18/105 Orthopaedic Thromboprophylaxis regimes. NICE Guidance recommends Aspirin, an unlicensed drug, giving rise to the issue of consent. Discussion is ongoing. Ipixoban continues to be used. **Action: to remain on Action Log until April TAAG meeting.** **To be added to the Risk Register.** 18/153 Anaesthetists to be reminded to escalate missing faulty kit via an incident form and the risk register. **Actioned. CLOSED.** 18/163 Ombudsman's Report 201700182L. This had been presented at Surgery Clinical Board 25/1/19 for shared learning. **CLOSED** 19/09 NATSIPPS Report: Q&S Group's concerns to be raised regarding wider UHB compliance at the next NATSIPPS meeting. **Action: MB to raise at the next Perioperative meeting.** 19/15 New "Start Smart then Focus" (SSTF) Audit Tool. Circulated to CDs audit their own practice. **CLOSED.**	**ES** **Chris W** **ES** **Clare W** **MB**
19/35	**Terms of Reference – Review** **Action:** All to review, approve next time.	**ALL**
19/36	**Annual Work Plan 2019/2020 – for approval** **APPROVED.**	
PART 2: PATIENT SAFETY AND QUALITY		
19/37	**UHW CEPOD daytime escalation - for authorisation.** This had been compiled by the CEPOD team, and agreed by the CEPOD User Group. The pilot during recent months had proved helpful for the site manager. One issue remained outstanding issue regarding the non-attendance of General Surgeons at the 08.00 meeting which was being addressed. Data had been collected demonstrating improvement. It had been agreed that this should now be formalised. The algorithm was **APPROVED.**	
19/38	**South East Wales Interventional Radiology On-Call Service** Implemented 4th February 2019. Mr Tatarov explained that Urology had raised concerns regarding out of area patients arriving at Cardiff & Vale (C&V) for nephrostomies. The numbers were currently relatively low, but there was a concern that numbers would increase. These patients arrived very unwell, could not be easily repatriated to the referring hospital, and would remain at C&V for an indefinite period. Patient management issues had not been worked through,	

	resulting in the default for these patients to be placed in Recovery, which was unacceptable. These patients were not currently tracked. However, the concern remained that there would be an increase in the number and acuity of these patients, exacerbated by delays in intra hospital transfer, and that the SE Wales IR On-Call Service had been implemented without inputting resource. In addition, realignment of Cwm Taf would result in patients being sent to C&V instead of Morriston. Without capturing the data, funding would not follow. It was noted that this was comparable to the Vascular Centralisation position. No pre-implementation data set was available. In addition, significant numbers of patients were treated in Radiology where the data was not captured. This presented a major problem for all C&V CEPOD work. The necessity of a Band 3/Band 4 administrator to capture all activity outside of theatres continued to be flagged by Barbara Bahlmann. **Action:** Numbers of patients referred to C&V to be monitored, and discussed at the next Urology Quality and Safety meeting. Colleagues will be asked to report these patients to the Directorate which will monitor. **OT** It was noted that it was essential to capture the delays in intra hospital transfer (which could be up to 8-10hrs).	**Oleg T**
19/39	**Standing Item: NatSIPPS Progress report** It was confirmed that Perioperative was due to meet in March. The process of transferring Perioperative Standards and Procedures onto a NatSIPPS document was a continuous process. It was advised that there was no timeframe for implementing or developing new standards. **Action: MB or Babs Jones to report back next time.**	**MB/BJ**
19/40	**Director of Nursing Q&S Report February 2019** Key issues: 17 open Serious Incidents (SIs) as of 31/1/19, an average of 5 per month, (3 injurious falls, one Pressure Damage) 4 closed with Welsh Government (WG) in month (Target = 5) It was noted that there had been a change in reporting to WG. Grade 3 or above would require an investigation within 5 working days, a referral to Safeguarding, and if Health Care Acquired (HCA), reported to WG. Datix queues increasing. **Action: All to feed back to Directorate teams to review these regularly.** Medication errors – 6 attributed to Surgery Clinical Board (SCB). In common with other Boards, use of Agency nurses was a theme; this was being worked through. There was consensus around the table that many prescriptions were illegible. This should be reported, and not corrected by the ward pharmacist. POVAs involving staff – 3, related to pressure damage. Falls – 39 patient accidents and falls. Allergy status documented 100%. Concerns – 38 open, the numbers were reducing. 77% resolved informally, 84% of which met the response time. 62% of formal concerns were responded to within 30 days. The sterling work of the directorates and the Concerns Team was acknowledged. An investigation was underway regarding a Never Event in theatres week commencing 4th March 2019.	**ALL**

19/41	**Directorate Assurance Reports:** 1. General Surgery & Wound Healing, ENT, Urology & Ophthalmology – report to follow 2. Perioperative Services Key issues: - The expectation is that all implants will move to single use items as actioned in Scotland. In C&V for example, some screws and plates are in sets processed multiple times. Single use Laryngoscope and blades yet to be agreed. The cost implication of single use was significant. - Clinell wipes, CHfW. A system had been introduced to reduce the residue of wipes left on operating tables following cleaning. - HSDU UHW had been approached by Cardiff University to process a custom made needle. - The transfer of ENT to UHL is proceeding. - In87825 Botox – wrong side. RCA underway. - Resuscitation service received negative feedback on the availability of manikin availability. RH noted that this service, being of benefit to the UHB, should be corporately funded. - Pain service – shortage of infusion devices. In discussion with Clinical Engineering. - Lack of exposure to Paediatrics in UHW, Main Recovery since transfer to CHfW. Paediatric training on PCA devices had taken place with the Pain Team. - The Child Health Directorate has no dedicated funded Pain Service. The Pain Team provides cover unfunded which could lead to potential compromise within Perioperative Care. 3. Anaesthetics - Colleagues are encouraged to report shortage of equipment. - Reminders sent regarding Bare Below Elbow. - ISN 2019/001 Clexane shortage shared with colleagues. - ISN 2019/002 Wrong route medication, Oramorph. Circulated. 4. Trauma & Orthopaedics - Increase in number of patients exceeding waiting target for surgery. Quality assurance of patients on the waiting list is undertaken by the Directorate comprising weekly discussions on longest waiters and additional payments to staff to increase capacity. LW advised that there would be a tracker of all patients within the Surgery Clinical Board waiting over 36 weeks, to be tracked by Directorate teams. The challenge was recognised, and would form part of the Quality & Safety agenda. It was noted by Chris W that this would not address the lack of capacity to do the clinical work. - Nursing vacancies. A3L and B6 reliant on agency staff. Staff turnover is increasing, increasing medical outliers in Trauma. Currently 28 WTE vacancies. - RGN vacancy – relying A3Land B6 agency, turnover increasing, 28WTE vacancies. 5. Standardised Assurance Report Form Clare W advised that the model used by CD&T was being explored whereby each Directorate reports annually to this Group. **Action: Clare W**	**Clare W**
19/42	**Exception reports from Directorates/Working Groups** ▪ General Surgery, Vascular , Wound Healing – nil reported ▪ Head & Neck, Maxillo Facial and Ophthalmology – nil reported ▪ Urology – nil reported ▪ Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services. *Clare W to provide narrative re Gastroscope/colonoscope.* ▪ Trauma and Orthopaedics – nil reported	**Clare W**
19/43	**Clinical Board Risk Register – Review** Principle items were noted. All to continue to review and update Directorate registers. All to escalate to Clare W for Clinical Board Risk Register as appropriate.	

19/44	**Alerts and other Safety Notices** NICE Guidance 1. Surgery CB summary spreadsheet – outstanding noted. Individuals to respond. Reminder to be sent. **Action: ES** 2. *NG98: June 2018: Hearing loss in adults: assessment and management* – **Wendy Rabaiotti** 3. *IPG625: August 2018: Transurethral water vapour ablation for lower urinary tract symptoms caused by the benign prostatic hyperplasia* **– Howard Kynaston** 4. *IPG618: June 2018: Laparoscopic ventral mesh rectopexy for internal rectal prolapse*. **Guy Blackshaw** 5. *IPG627: August 2018: Superior rectal artery embolization for haemorrhoids*. **Guy Blackshaw** 6. *NG101: July 2018: Early and locally advanced breast cancer: diagnosis and management*. **Guy Blackshaw** Patient Safety Notice 7. Patient Safety Alerts Summary 8. *PSN046/October 2018: Resources to support safer bowel care for patients at risk of autonomic dysreflexia*. **HL will ensure Ward Manager on A6 has this**. Other wards to seek advice from A6. 9. *PSN047/November 2018: Management of life threatening bleeds from arteriovenous fistulae and grafts (PSN number retrospectively updated).* Not applicable to this CB except Recovery 10. *PSN048/February 2019: Risk of harm from inappropriate placement of pulse oximeter probes.* Corneal abrasions caused by probes, also use correct probes in correct place. 11. *ISN:2019/002 - reissued: Medicines Code for the Safe Administration of Medicines – in response to Oramorph wrong route medication*. **NOTED.** MDAs 12. *MDA/2019/001 (Wales): 30 January 2019: Datex-Ohmeda Aisys CS2 and Aisys anaesthesia devices with software version 11 and version 11 SP)! (Service Pack) – risk of ventilation loss, inadequate anaesthesia and hypoxia or severe hypotension*. Confirmed no machines in the organisation. 13. *MDA/2019/002 (Wales): 30 January 2019: Nellix Endovascular Aneurysm Sealing (EVAS) System – Device recall and enhanced patient surveillance.* Procurement confirmed not purchased. 14. *MDA/2019/003 (Wales): FreeStyle Libre flash glucose sensor – Use of barrier methods to reduce skin reactions to the sensor adhesive.* AdT confirmed that this is seen in patients admitted for brittle diabetes. 15. *MDA/2019/004 (Wales): 30 January 2019: Arjo Minstrel passive floor lift (portable hoist) – risk of spreader bar detachment from lifts WITHOUT a scale.* Not used in the UHB. It was noted that there was no hoverjack maintenance at UHL. There is one which was bought by Health & Safety, managed by Site, and belongs to Patient Access which is not maintained. 16. *MDA/2019/005 (Wales): 31 January 2019: Recall of certain batches of Eurotrol haemoglobin controls due to microbial contamination.* Not in use. 17. *MDA/2019/006 (Wales): 14 February 2019: Orthopaedic implant Head Radial Head and Uni-Elbow: risk of early loosening*. **Action: HL will report back** 18. *MDA/2019/007 (Wales): 14 February 2019: Ophthalmic implant Raindrop Near Vision Inlay – risk of corneal haze*. Not used. 18. *MDA/2019/014: 7 March 2019: All Bard urogynaecological mesh – voluntary product withdrawal, implanted devices do not need to be removed.* OT advised that this MDA had been issued as a result of media focus on vaginal mesh devices. Bard implants had decided to withdraw from the market and withdraw all products. For the UHB the risk is low as Urology have not used Bard devices, so would not expect any to be in stock. Gynae have used them, and purchased one approximately two years ago; it is anticipated that this would have been used. No mesh implants have been used in Urology or Urogynaecology. There will be patients who have mesh who will be	**ES** **HL** **HL**

	anxious, although Bard has advised that there is no risk for those implanted. The company wanted to withdraw from pelvic health, due to a worldwide campaign. OT had provided assurance for the UHB that the risk is low. It is not known what the numbers are, if any, of patients complaining or requesting review. It is anticipated that the number would increase. LW advised that some rectoplexies or abdominal hernia had been seen, handful of cases in the last approximately 2 years. OT felt that the UHB approach had been conservative in the last 5 years, which differed from other regions. NICE guidelines out for consultation is a proposal to continue prevailing practice of offering mesh for women with urinary incontinence, which contradicts current thinking. This should only be used in clinical trials and not in clinical practice. MHRA Field Safety Notice 19. *13 February 2019: Endologix and the recall for the Nellix Endo Vascular Aneurysm Scaling System.* Not used by the UHB. Public Health Wales Briefing 20. 17 January 2019: Hantavirus Infections in Patagonia 21. 23 January 2019: Influenza Briefing (No 4) 22. 30 January 2019: Influenza Briefing (No 5) All of the above were **NOTED**. The Surgery Clinical Board 'Flu vaccine uptake was 60.8%. The outstanding work of the 'Flu Champions was acknowledged. Public Health Link 23. *CEM/CPhA/2019/2: 25 January 2019: Drug Alert Class 2, Action Within 48 Hours, Macleods Pharma UK Limited. Irbesartan 150mg Film-Coated Tablets and Irbesartan 300mg Film-Coated Tablets*. Not used. 24 *CEM/CPhA/2019/3: 4 February 2019: Clarr 4, For Information, Accord Healthcare Limited, Amoxicillin 500mg Capsules BP.* Not used. 25 *CEM/CPhA/2019/4: 13 February 2019: Drug Alert Class 2, Action Within 48 Hours, Actavis Grup Plc Ehf, Irbesartan 300mg Film-Coated Tablets; Irbesartan/Hydrochlorothiazide 300/25mg Film-Coated*. Not used. Welsh Health Circulars: 26. *WHC/2019/001: 17 January 2019: Changes to the availability of gluten free (GF) foods for the treatment of coeliac disease on prescription in England – Implications for Wales*. **NOTED** 27. *WHC/2019/002: 30 January 2019: Update on ordering influenza vaccines for the 2019-20 season*. **NOTED** 28. *WHC/2019/005: 5 February 2019: Maintaining continuity of supply of medicines in the event of leaving the European Union in a 'no deal' scenario.* **NOTED.** Communications from UHB: 29. *Legionnaire's disease – advice.* **NOTED**. 30. *Request to turn off paper reports*. **NOTED.** 31. *Transforming Outpatients Pharmacy Information.* AdT advised that Outpatient Pharmacy on both sites would be closing. A third party partner will be on both sites. All Clinical Boards are requested to move away from paper copies, with the exception of incidence of IT failure. The COP system is available in all areas; support for training is available. Implementation:t UHL in May 2019 and UHW in July 2019. Approved by CHC and WG; cost saving based on VAT saving. Staff released from the dispensaries will be redeployed for patient facing services. Discussion: ▪ Avestin/Lucentis administered on site – will continue to be dispensed by Pharmacy. ▪ Familiarisation with electronic prescribing in Outpatients will be essential. ▪ OT advised that printers have been installed, and training completed, but colleagues did not choose to use the system as it was clunky and slow, adding time to clinic.	

	Colleagues are being asked to use more and more electronic applications, so will now need several applications open, which don't work together. OT asked that this be integrated into Clinical Portal would significantly improve efficiency. ▪ AdT advised that electronic prescribing was mandatory. The alternative is to write to the GP to prescribe medication; this practice is increasing. **Action:** All clinical directorates to raise this with clinical colleagues to ensure awareness. ▪ Drug boxes, raised by Resuscitation Committee. AngJ advised that some wards have 2 or 4 emergency drug boxes. Can this be reviewed by deployed pharmacists?. AdT noted that this would be considered together with all other requests. 32. *UHB Diabetes guidelines 2017* AdT explained that the guidelines had been developed in order to address the challenges of looking after diabetic patients over 16 yrs across the UHB. Key themes: ▪ The number of drugs was increasing. ▪ The overarching theme is a lack of continuity of management. ▪ Challenge of ownership/leadership – the report recommends a national joint standard ▪ Recommendation is o appoint a clinical lead for perioperative diabetes care across the UHB. No guidance is in place across the UHB. The only successful implementation has been in elective orthopaedics. Even there, the challenge remained to implement the guidelines due to the movement of clinicians. NCEPOD report 2018 identified the challenges in crossing multiple specialties. AdT advised that work does need to be done to bring this together, feeding into the prehabilitation pathway. Sian W explained that she had emailed all Clinical Directors, but had not received any response. **Action: Sian W to escalate to Abrie Theron and Caryl Taylor (UHL).** Sian W advised that there were errors on CAVWeb. Much information was incorrect and not in line with any current national guidance. There was concern that diabetics were not being safely managed. Sian had been pressing for audits to be undertaken in order to identify patient outcomes for diabetic patients who may not have been managed in line with guidance, eg was there an increase in SSSIs? <u>Patient Safety Alerts</u> 33. *PSA009/February 2019: Wrong selection of orthopaedic fracture fixation plates.* A review of patients over the previous 18 months had been undertaken. No incidents had been brought to the attention of the Surgery Clinical Board.	**ALL** **SianW**
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
19/44	**Key Messages from Board/ Committees/ Groups** *1. UHB Medicines Management Group Notes 3rd January 2019* *2. UHB Medicines Management Group Notes 7th February 2019* 1. PSA Valproate implementation. It is not believed that any clinician is prescribing this, but patients on this drug were admitted. 2. Hydroxychloroquine retinal monitoring. Ongoing. There is agreement that Optometry can carry out screening, but the scans need to be undertaken in Ophthalmology. 800 patients. Further work is ongoing, funding to be agreed. 3. Financial position Month 10: £0.275m overspend against a budget of £128m. 4. Pathway changes were noted. *3. Standards for prescribers and standards for medicines management* Nursing Midwifery Council standards withdrawn 28th January; now adhere to Royal Pharmaceutical Society Framework.	

	4. Clinical Board IP&C Group – draft Minutes of 4th February 2019. **NOTED** 5. Clinical Board H&S Group. Meeting 13th February 2019 – verbal update 6. Decontamination Committee Minutes 11th December 2018 – **NOTED**. 7. Safeguarding Steering Group Minutes 18th January 2019 - **NOTED** 8. Orthopaedic Infection Quality Improvement Group Minutes 3rd December 2018, Agenda 3rd December 2018. **NOTED.** 9. Resuscitation Report 5 February 2019. **NOTED.**	
19/45	**Medical Equipment Group (standing item)** Minutes of meeting 18th January 2019. NOTED. It was noted that Hoverjacks were now serviced by Clinical Engineering.	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
19/46	**Surgery Clinical Board IPC update January/February 2019** CM provided an update: A5 - Norovirus A recent audit of PC VIPS showed an improvement in overall compliance. Notable improvement in documentation in Anaesthetic charts in theatres. C difficile – reduction of 58% on previous year Staph Aureus - 28% reduction MRSA - increase E Coli – 35-40% increase, biliary related. Klebsiella – no data to compare. IP&C RCA database – RECEIVED and NOTED Falls Report – 13 since April 2018. Pressure Damage Report - 22 grade 3 reported to WG this year.	
19/47	**National and UHB Audit Reports** 1. National Vascular Registry Audit 2018 vascular surgery report . Work to be done with consultants. 2. National Hip Fracture Database (NHFD) Audit https://www.hqip.org.uk/resource/national-hip-fracture-database-nhfd-annual-report-2017/#.XHA3JNJo27E A workstream will be set up with Lightfoot, to look at #NOFs.	
19/48	**LIPS End of Year Progress Report** No groups during last cycle. One group (A5) commencing April 2019.	
19/49	**HIW/CHC visits** HIW anticipated in April.	
19/50	**Transfusion Committee** 1. Minutes of meeting 12th October 2018. Minutes of meeting 9th January 2019 not yet confirmed. Next meeting 5th April 2019. 2. Zero Tolerance Report December 2018 3. Zero Tolerance Report January 2019 4. Traceability Non-Compliance for December 2018 All reports **NOTED.**	
19/51	**Health Care Standards Process for 2019/20** CW will be writing these shortly for submission by the end of April 2019. 6 topics. Surgery Clinical Board is leading on Corporate Pressure Damage.	
PART 5: GOVERNANCE		
19/52	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. Open Sis, No Surprises – discussed at 19/40 above.	

	2. Regulation 28 report & Open Inquests It was highlighted by LW that the Surgery Clinical Board team was not receiving notification of Coroners cases, in staff attending inquests unsupported. **Action: All to escalate if they become aware of a Coroner's case pending**. The Concerns Team had corporately been allocated the responsibility for managing Coroner's inquests; previously this had been robustly managed by the Patient Safety Team. A pending case regarding liver/resuscitation was highlighted to AngJ of which she had not been aware. Tycoplanin and anaphylaxis: RH highlighted anaphylaxis incidents in South East Wales associated with Tycoplanin, principally in orthopaedics. Sian W would liaise with the lead to review this. 3. Serious Incidents: 1. Closure forms sent to WG since 1st January 2018 2. Closed SIs report – please see Director of Nursing Report at 19/40 above. 4. Complaints, Claims and other Concerns 1. All Open Clinical Negligence Claims 19/12/18 – 19/2/19 2 All Closed Clinical Negligence Claims 19/12/19 to 19/2/19. **RECEIVED** and **NOTED** for learning**.** 5. Learning from any closed claims: *Regulation 28 response LR-jb-7238 – Specialist Clinical Board, for shared learning* A patient had deliberately taken their own drugs as well as the administered dose. Patients cannot be forced to hand over their medication, being their property, but nurses do need to be aware of this. 6.Ombudsman's Draft Report Settled week commencing 11th March 2019. All to ensure that Montgomery is followed in terms of informed consent. With regard to this case, it was deemed that there had been inadequate consent procedure, lack of care and treatment post-operatively, and lack of communication with the patient concerning their condition. A patient cannot be consented on the day of surgery; there must be time for a patient to consider the information received. This does essentially constiture a constraint on Day of Surgery Admission and Day Surgery. It was acknowledged by OT that day surgery patients were not consented in clinics as this was not practical. **Action: All Directorates to review their practice of consent for surgery and add any patients to the Risk Register who cannot be consented except on the day of surgery.** Consent for elective sections – **Action: RB to check when consent is being completed.**	**ALL** **ALL** **RB**
19/53	**Domestic Homicide Review November 2017** Action: All to read for learning.	
19/54	**Standing Item:** **Point of Care Testing Group** It was highlighted that the Emergency sign-in option would be removed. AngJ had highlighted this to Ruth Walker and Seetal Sali. It was essential to be able to take blood sugars when responding to a 2222 call. A plan must be formulated.	
19/55	**Patient Surveys:** 1. National Survey Report for Surgery (January 2019) 2. '2 Minutes of your time' (December 2019) **For review and action**	
19/56	**Research & Development**	

	1. Research Governance Group (RGG) Minutes 30th January 2019 2. R&D Leads Meeting Minutes 10th January 2019 Noted.	
PART 6: DATES OF NEXT MEETING **Tuesday, 7th May 2019, Council Room, UHW**		
PART 7: URGENT BUSINESS		
19/57	1. Confidential patient data Picked up by Medical Director. All to be aware.	
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
19/58	**Recent Reports & Communications** Nil received.	
19/59	**Directorate Q&S Agendas/Minutes** Trauma & Orthopaedics, 6/2/19, 12/2/19, 6/3/19 Minutes, and M&M reports. **RECEIVED.**	

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 26th March 2019
8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		
	Welcome & Introductions Cath Heath, Director of Nursing (Chair) Mary Glover, Lead Nurse, Acute Child Health Rachael Sykes, Health & Safety Advisor Michelle Abel, Infection Prevention Control Nurse Matt McCarthy, Patient Safety Angharad Oyler, Clinical Supervisor for Midwives, Obstetrics & Gynaecology Laura Bassett, Risk Manager, Obstetrics & Gynaecology Suzanne Hardacre, Head of Midwifery, Obstetrics Anthony Lewis, Clinical Board Pharmacist Paula Davies, Lead Nurse, Community Child Health Cheryl Evans, Directorate Manager, Obstetrics & Gynaecology Nigel Davies, Clinical Director, Obstetrics & Gynaecology Nia John, Community Paediatrician and Clinical Lead for Quality & Safety, Community Child Health **In Attendance** Kirsty Hook, Board Secretary Claire Ball, Clinical Lead for Specialist CAMHS (observation only) Carl Ball, Case Manager (item 1:1 only)	
	Apologies for absence Meriel Jenney, Rachel Burton, Raj Krishnan	
PART 1: HEALTH & SAFETY		
1.1	**National Obligatory Responses Document – Case Management Team** Carl Ball was welcomed to the meeting to provide a presentation on the launch of the Obligatory Responses to Violence in Healthcare (All Wales Document). The purpose of the document was highlighted and it was noted that each organisation has identified single points of contacts. It was noted that violent warning markers are now being placed on patient notes where necessary and necessary actions that need to be taken forward (this also includes patient's families/carers). These markers are continually monitored. Violence and Aggression training is available through the Health & Safety department. Communication posters are also available if required for all ward areas/patient areas. The processes that should be followed were noted and the actions that can be undertaken by the case management team through the violence and aggression process. It was noted that "capacity" of the patient no longer needs to be proved, just that the act has been done, or intended to be undertaken. Assaults on Emergency Workers (Offences) Act 2018 was noted, and it was highlighted that this covers all persons employed for the purposes of providing or engaged to provide a service.	

	It was noted that on the incident reporting system (E Datix), violence and aggression incidents reported are automatically flagged to the case management team for review and action as necessary. Concerns were raised with regards to the Safe Haven site at CRI, where it was noted that there is only intermittent security cover available as there is CCTV. It was noted that incident reports should be submitted for any issues so that this can be monitored, reviewed and necessary actions undertaken. Discussion ensued with regards to social media violence & aggression and the fact this has increased. It was noted that guidance is available on the H&S internet pages for staff. It was noted that these should still be reported.	
1.2	**Feedback from UHB Health & Safety Operational Group Meeting** Martin Driscoll will be the chair of the group going forward. Consideration to be given as to who the representative should be for future meetings. The DMTs were asked to consider representatives and feedback to the Clinical Board. Discussion ensued as to whether this should be rotated on a 6monthly basis and it was agreed that this would be considered. Concerns were raised with regards to evacuation chairs and the fact that there is a lack of training and number of staff trained in using this equipment. Discussion ensued with regards to the possibility of having the training as part of the e-learning package for all staff. It was agreed that there is a need to ensure that there is a rolling programme for the training and whether some cascade training should be undertaken as a Clinical Board. RS noted that the evacuation mats training is available but only on the manual handling update training. It was noted that the tunnels will not be able to be used and will be TDSI access only. Lone worker device use was discussed, and it was noted that the usage of the devices has increased. It was noted that consideration needs to be given for CAMHS staff having lone working devices. PD agreed to contact Emma Keen in order to ensure that this is considered for the new contract.	**ALL** **PD**
1.3	**To note the latest Health & Safety Report** The report was noted for information. The group were asked to review and look at any open incidents that need action/review. The types of incidents being reported for the Clinical Board include service disruption, V&A towards staff continues to be the highest reported incident. One incident reported to HSE with regards to chemical burns/spillage. The learning point was that gloves should be used at all times when handling the bottles.	
1.4	**C&W Clinical Board Health & Safety action plan** A separate meeting has taken place to review the action plan and a number of changes have been made. This is currently being reviewed in order to for any further changes to be included. It was agreed that this meeting will be brought to the next meeting for noting and sign off.	**CH/KH**
1.5	**To note the latest COSSH Report** The latest position report was noted for information. COSSH risk assessments have been reassessed, and it was noted that these need to be undertaken on a 3 yearly basis.	
1.6	**To note the latest Fire Safety Report** The fire safety report is awaited, and it was agreed that this would be circulated when received.	
1.7	**Workplace Inspections Update** No specific updates to note for this meeting.	
1.8	**Feedback from H&S Staff Side** No updates to report. No staff side representatives in attendance.	

1.9	**Exception Reports and Escalation of key H&S issues from Directorates** Covered as part of item 2.3 **Maternity lifts** Concern was raised that further to recent discussions in relation to the refurbishment of the lifts within maternity, no further information has been received with regards to when the work will commence. CH agreed to follow up with the Estates Department.	**CH**
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story - MP In73270** The investigation was undertaken by Claire Tregidon. CH provided an update on the case of child MP who was booked for the insertion of a femoral line, and received unnecessary anaesthetic. Procedure was abandoned following receipt of test results. Gaps in communication and there being no documented evidence was highlighted as part of the investigation. Recommendations were highlighted as: • Staff reflections • Oncology team to review the process for listing patients for rare procedures to ensure all pre-op requirements are met • Review processes for reporting results (new database may provide the requirements) • Review SOP for apheresis • Incidental finding of timing discrepancy in theatre documentation – theatre department to review process for time changes to anaesthetic machines An improvement plan has also been completed and has been shared widely. All actions have been completed and improvements have been made.	
2.2	**To approve the minutes & action log of the meeting held on Tuesday 22nd January 2019 and note any matters arising** The minutes of the meeting were agreed to be an accurate report. Terms of Reference – informal meeting has been undertaken and a further meeting is being arranged with the concerns team with regards to changes in support and review partnership working in order to receive key themes and trends. It was agreed that representation from the DMT's should also be included.	
2.3	**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 Report** • Maternity Vision is planned to be launched on 7th May • GBS guideline is now in place for receipt of IV antibiotics on MLU in line with prudent maternity guidelines • X7 RCA's which require sign off, 5 of which are included in the agenda for sign off • X1 Grade 1 pressure area reported • X1 patient fall report, reported but no harm received. • X1 Medication incident was reported in SARC, x3 medication incidents reported in maternity • Peer Review model is being developed for Supervision for Midwives • MSLC minutes will be shared at Directorate Q&S Meetings for information • PROMPT training rolling programme continues • Archiving of birth registers are being reviewed • 3 midwives training in Hypnobirthing. AH organising a meeting with community teams to discuss enhanced parent education to incorporate yoga & hypnobirthing.	

	• Monitoring process in place for all out of area women. An increase of bookings from ABUHB continues. Monthly booking dashboard in place to monitor activity from out of area. • PACS and RADIS implementation will impact on the move to the new unit • Gaps remain on the medical rota and recruitment is ongoing. Issues have been highlighted with a long term locum which has impacted on consultants required to be resident. Band 7's have formally raised concerns with regards to the gaps on the obstetric rota and this is being reviewed. **ACH Report** • X4 ongoing RCA's in progress. MP RCA has been through Directorate Q&S, Theatre and Anaesthetic Teams • X1 Grade 3 pressure sore noted, 15yr old admitted with pressure sore from TCT. • X2 MSSA report in January/February • Nutrition week was highlighted well across the CHFW • Positive roll out of medicines "druggles" across NICU • Issues highlighted with regards to syringe drivers in PICU and further meetings are taking place • Recruitment is ongoing and very positive open day for nursing, however it was noted that there is a lack of posts for graduates across wales. • Compliance of Legionella Flushing has been reviewed and new documentation is now being used. **CCH Report** • X4 ongoing RCA's. x1 complex medication error, x1 ongoing with regards to community acquired pressure ulcer and there is a significant amount of learning to come from the RCA. X1 Child Death in the community has been reported as an SI and the investigation is ongoing, x1 fact finding investigation is being undertaken with regards to an information governance breach and was retrieved by a member of the public. • SBAR – Access to notes request and the requirement to redact the notes has been completed as due to the volume of requests and lack of support this is now becoming unmanageable. It was agreed that this would be brought to a future meeting for noting. • Audit has been undertaken on patient experience and the feedback has been very positive. • X1 V&A incident reported, support is being provided to the member of staff however it was noted that the correct process was not followed with regards to access of the records prior to the visit. • Within CCNS it was noted that there are a significant number of vacancies which is impacting on current workload. Work is being undertaken with MPS in order to review way forward. • X2 senior consultant retirements are being reviewed as to cover and recruitment. This has also had an impact on the increased neurodevelopment work. Concerns were highlighted with regards to gaps in Audiology and it was agreed that this should be included as part of the Directorate Risk Register • Children's Rights work is continuing and the Youth Board input has been very positive and some participation work has commenced.	**PD**
2.4	**RTT Update – Long Waiting Patients (36 weeks and 52 weeks)** **O&G Position** Zero breaches reported and on plan to continue for year end **Acute Child Health Position** Zero breaches reported for February and a plan is in place with regards to endoscopies cases for the end of March. **CCH Position** Primary Mental Health reported 51.8% for March. S&LT currently at 13 weeks, OT at 11 weeks and Physiotherapy at 6 weeks. Neurodevelopment is currently at 35weeks and Community Paediatrics at 26weeks.	

2.5	**Directorate Business Continuity plans** Work is progressing across all Directorates. Further work is now required with regards to working through the escalation processes and cross over requirements needed within the Clinical Boards.	
2.6	**Update on CAMHS Repatriation** C&V CAMHS service repatriates from Cwm Taf Health Board from Monday 1st April 2019. TUPE process has been progressed for staff and advice has been sought from HR with regards to management of staff and recruitment process for a number of posts have commenced. There are a number of pressures within the nursing service, medical vacancies and psychology vacancies are being progressed. Significant demand and capacity work has been undertaken and this has highlighted significant gaps in service which will impact on RTT targets Final clarification of the management structure for CAMHS has been highlighted specifically within Emotional Wellbeing service. There has been a significant amount of work that has been undertaken with regards to governance processes and work continues to ensure shared learning and robust processes being implemented across the service.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients/Staff** • Pamper Days are being undertaken in the CHFW by Noah's Ark • Re-launch of Safer Pregnancy Campaign is being undertaken • Smoking Tannoy has been implemented within Antenatal Clinic in order to highlight the non-smoking policy across the UHB.	
SAFE CARE		
4.1	**Update on Serious Incidents& Update on CB E-datix performance** Report noted for information. Details of the reported SI's were noted. It was noted that work continues with regards to closure of incidents and was agreed that support from the patient safety team is available if required in order to review some of the longer standing open incidents. Concerns were highlighted with regards to specific individuals that may require support in closure of a number of incidents. CH and MM agreed to review incidents and what further support can be offered in order to move some of the incidents to closure. Discussion ensued with regards to the trigger list and whether this can be reviewed.	**CH/MM**
4.2	**RCA's/SBAR's for noting and agreeing actions** **RCA & Action Plan TW** Case involved 13yr old transferred from Neville Hall Hospital who was in established renal failure on admission. The patient died following a cardiorespiratory arrest prior to permacath line insertion. The RCA highlighted no documented management plan from NHH, there was a delay in referral and subsequent treatment. Incidental learning was highlighted with regards to retrospective entries in the notes and times not documented. It was noted that the date and time of referrals made, along with advice should be documented in the notes. It was noted that once the referral was received, the Paediatric Oncologist acted appropriately and the significance of the diagnosis was recognised. It was noted that as part of the recommendations Neville Hall Hospital have been asked to review the case management prior to admission to the CHFW. With regards to the actions required from Cardiff & Vale UHB, an action plan has been produced and this has been shared widely. All actions have been completed and changes have been embedded into practice.	

	It was noted that since this case, a patient flow co-ordinator has been piloted for a trial period of 3 months and this has made a significant difference to the flow of patients across all areas. A further case has now been submitted to review options of extending this role.
	
	The RCA investigation will now be shared with the family. Contact will also be made with the patient safety team at NHH in order to understand the plans that are in place with sharing of their investigation outcome with the family. MM noted that a closure form will now completion for submission to Welsh Government.
	
	J L-W 278370
	This case relates to an intrapartum stillbirth. The root cause was identified as incorrect assessment of fetal wellbeing using intermittent auscultation resulting in a failure to detect fetal hypoxia in the presence of infection during labour and inappropriate monitoring of fetal movements via a sonic aid auscultation.
	
	Lessons learned
	Supportive training is required to ensure intermittent auscultation of the fetal heart rate is conducted appropriately
	
	Incidental learning
	• Low PAPP-A was found at JLW combined screening. Low PAPP-A is independently associated with adverse outcomes in pregnancy;
	  o Growth restriction
	  o Pre-eclampsia
	  o Preterm birth
	  o Stillbirth
	• The national recommendation for women identified with low PAPP-A should be offered Obstetric Led Care with serial Growth Scans and the OU considered an option for place of birth.
	• An electronic telephone contact sheet was not completed. Hand written documentation has been written on the printed electronic recorded completed on 15th November 2019 (For the five calls made to the AMU by JLW an electronic telephone contact record was completed on three occasions. The remaining two contacts are hand written on the printed contact record).
	• Multiple changes of equipment delayed transfer to delivery suite
	
	Recommendations
	• FIGO IA should be adopted in the monitoring of low risk pregnancies during labour and birth
	• Additional training for the assessment of fetal movements
	• All Wales Normal Labour Pathway review to include descriptive account of palpation of contractions and fetal movements.
	• Consider the introduction of amino sense pads
	• Upgrade of the telephone contacts package within Euroking to record a comprehensive assessment for all telephone calls made to the maternity unit
	• The Midwife in Charge of the AMU should be required to provide one to one care for women in labour
	• Review the evidence to support the introduction of a fresh ears system
	• When Advise of sought be the name midwife providing intrapartum care a bedside review should be undertaken by 2 midwives
	
	It was agreed that changes would be made to the dates included within the SBAR and this can now be shared with the family and a closure form will be completed for submission to Welsh Government.
	
	SB 280808
	This case relates to an Antenatal intrauterine death.
		MM
		
		LB/MM

Root causes

1. Major fetal anomaly affecting fetal kidneys and possibly heart.
2. Placental changes (delayed villous maturation), which may or may not be linked with the renal abnormality, that is associated with an increased risk of late fetal loss but not growth restriction.

Lessons Learnt

- This is a case of a rare abnormality, which sadly ended in fetal demise at 38 weeks. However there were no indications that this was likely, based on the serial growth of the baby, and assessment of liquor volume and umbilical artery Dopplers.
- The actual baby birth weight was 630g less than predicted (21%) but demise was thought to have occurred some days previously, which will have resulted in a lower weight at birth and the accepted error in scan is 15%.
- In the future, acknowledging that where the abdominal circumference is increased by a fetal anomaly, although the EFW may still be accurate, the ability to detect IUGR may be reduced compared to serial measurements of abdominal circumference in a baby without an anomaly. (There was no mention of stillbirth in any documentation, which with background risks of 1 in 200), may have been appropriate.

Incidental Learning

- The GAP-GROW scan calculator was applied in this case, which in retrospect was not appropriate. This software should only be used where normal growth is expected to have occurred between the last scan and birth.

A number of recommendations were made to include

- All entries in the notes should be signed and dated and ideally a stamp with GMC or NMC number used.
- Where possible, EFWs should be plotted on the customised GROW Chart for all women who have had a growth scan, by the reviewing clinician. If thought to be inaccurate due to fetal abnormality, this can be documented on the chart.
- Final plan for mode of delivery should be made and documented on the Green intrapartum care sheet by 37 weeks for women receiving consultant led care.
- The possibility of stillbirth in all pregnancies and especially in those with a fetal abnormality should be shared with parents
- Acknowledging that where the abdominal circumference is increased by a fetal anomaly, although the EFW may still be accurate, the ability to detect IUGR may be reduced compared to serial measurements of abdominal circumference in a baby without an anomaly.
- This and the general accepted error in all growth scans (+/- 15%) should be mentioned to parents and documented by the responsible clinician.
- The GAP-GROW calculator for difference in scan EFW and birthweight should be used with due caution and not in cases of fetal demise.
- Appropriate provision should be made to minimise disruption and loss of antenatal clinic capacity around the festive period.

The SBAR was approved for sign off and it was agreed that learning would be shared with the staff involved and also the family. It was agreed that the closure form will be completed for submission to Welsh Government. **MM**

VK 268569

The SBAR relates to an early neonatal death. It was acknowledged that the case is currently incomplete as further information is awaited from neonatal consultant which is being progressed.

Root causes

- Failure to recognise an unusual abnormal pattern of an Antenatal CTG.

- Failure of Obstetric junior registrar (ST3 doctor), to seek advice from a consultant in presence an abnormal CTG and multiple risk factors in line with the escalation and chain of command guidance.
- There was a failure to fully risk assess the whole clinical picture prior to the decision for induction of labour as VK had a number of risk factors- concerns of oligohydramnious by the community midwife, missed ultrasound growth scan, tailing off growth and an abnormal antenatal CTG.
- Lack of availability of senior obstetricians (Senior Registrars and Consultants) in ward areas such as OAU, Induction bay and antenatal wards, which led to junior staff making inappropriate management plans outside of guidance.
- Delay in recognising the urgency of transferring VK to labour ward and prioritising patient care.

Lessons learned
- Training and testing for competency in fetal monitoring amongst senior staff working in maternity is required. A pragmatic system going forward needs to be put in place in a timely manner.
- US capacity in ANC needs to be improved.
- Lack of senior obstetric staff in ANCs and other Ward areas needs to be addressed urgently.

Incidental Learning
Women who receive antenatal care elsewhere and present without documentation should be booked under consultant led care.

Recommendations
- All documentation must clearly include name, signature and grade of member of staff documenting.
- Consultant Obstetricians' presence in all the ANCs to provide cross cover.
- Consultant Obstetricians' presence in high risk areas such as OAU, IOL bay and antenatal wards
- Junior medical staff should escalate concerns and high risk cases to consultant obstetrician using the escalation guidance and chain of command.
- Consideration should be given for RM7 delivery suite midwives to be able to administer Terbutaline via a PGD.
- Consideration of CTG competency testing of obstetricians and Band 7 Midwives to equip the unit to recognise such rare abnormal fetal heart rate patterns.
- The escalation and chain of command guidance should be used when it is not possible to obtain a senior review.

It was noted that an audit is being undertaken and concerns have been highlighted with the college tutor in relation to feedback to junior medical staff involved. Discussion ensued and it was agreed that actions required from the medical staff should be documented in order for this to be shared for implementation and assurance to be provided to the Clinical Board on the shared learning. LB/SH agreed to review. **LB/SH**

LA 267115
This case relates to an antenatal intrauterine death. The root cause of baby's death was a placental abruption. All actions have been completed and the case was noted for information and lessons learnt.

Lessons learned
- The level of review of high risk antenatal inpatients patients was discussed, the new consultant hours will aid senior review and enable equally spaced CTG's if twice daily.
- A multidisciplinary team discussion should take place and include the family in such complex cases.

Incidental Learning
- The challenge of USS antenatally was highlighted although this did not directly impact on this patients care as alternative arrangements were made.
- It was not clear who prescribed LA low dose Aspirin at her appointment on the 29.01.18, although this was felt to be appropriate in line with the local guidance for small for gestational age. It would require prescribing by medical staff as it does not fall within the remit of the midwives PGD.

Recommendations

- Prescription of anti platelet therapy (aspirin) for women with a previous SGA fetus should be made by medical staff and documented in the AN notes.
- All high risk obstetric patients should be reviewed and/or their management plan discussed with a Consultant Obstetrician when they first attend an obstetric led ANC and this should be clearly documented in the notes.
- More timely follow up and management of abnormal results taken at ANC. In the case of suspected urinary tract infections consideration to prescribing antibiotics where there is a high suspicion of infection from patient symptomatology and abnormal urinalysis.
- A Guideline on referral criteria for uterine artery Doppler assessment between 20-24 weeks gestation for women at high risk of SGA within the antenatal services.
- Appropriate Radiography support for the Rainbow ANC.
- New local Guideline on Management of the SGA fetus to include guideline on appropriate Doppler investigations for preterm SGA and term SGA.
- When a patient requires to attend different ANC the consultant obstetrician with overall responsibility needs to be identified. This may change during the course of a pregnancy.
- High risk patients with SGA should be reviewed where possible by the most senior obstetrician at the ANC especially if the USS findings are abnormal.
- Any high risk antenatal patient admitted from the ANC should be discussed with the on call Obstetric Consultant.
- In cases of severe extreme early onset IUGR admitted for extra fetal monitoring a timely multidisciplinary team meeting should take place with the neonatal team and the family.
- Any patient transferred to the Delivery suite with abnormal CTG findings irrespective of gestation should have an urgent review by a senior obstetrician.
- The time and date on a CTG tracing should be correct and the monitor adjusted accordingly before commencing a CTG.
- Any Obstetric Consultation should be documented in the notes.
- Abnormal antenatal CTGs should not be reviewed in isolation. An abnormal antenatal CTG requires a senior obstetric review of the patient.
- Consideration should be given to introducing CTG analysis as recommended by RCOG Guideline No 31.
- Consider the wider implications of Consultant Obstetricians filling junior staff rota gaps on patient care.

EH 268142

This case relates to an unexpected neonatal unit admission. All actions have been completed and the case was noted for information and lessons learnt.

Root causes

The root cause of baby's admission to neonatal unit was suspected sepsis and the placental histology showed Chorioamnionitis. Although this baby was admitted to neonatal unit the investigation has found that the suspected sepsis was recognised and treated in a timely manner.

Lessons learned

- CTG's should be reviewed in full taking into consideration any clinical risk factors. For this case, E-J H was a Primigravida and therefore labour was likely to be slower than a multiparous woman. Suspected sepsis was evident from admission and the decision to induce/ augmentation labour should consider this risk factor when interpreting the CTG. In the presence of maternal sepsis earlier intervention is likely.
- A drop in the fetal baseline rate and reduced variability can be as significant as a raise of the fetal baseline rate and may indicate fetal distress.
- There is no recognised fetal heart pattern which is specifically associated with sepsis.

	Recommendations • Ensure all midwifery and obstetric staff are up to date and compliant with the Welsh Government / Welsh Risk pool and Cardiff and Vale UHB standards for fetal heart / CTG training. • Clear guidance is required to state when women on the sepsis pathway should be reviewed to evaluate the effectiveness of the actions taken and any further investigations required to include blood results. • CTG cases with suspected sepsis should continue to be used for teaching to increase knowledge and understanding of CTG's in the context of suspected sepsis.	
4.3	**Infection Prevention Control Update** Report noted for information. There were no specific issues to note for this meeting. It was noted that clinical board representation is required at the UHB Water and Safety Group and all were asked to consider appropriate representation. O&G Scope process is ongoing with Surgery Clinical Board	**ALL**
4.4	**Safeguarding** There were no issues to note for this meeting.	
4.5	**Patient Safety / MDA Alerts (internal/external)/WHC** • Drug Alert Class 4, For Information, Accord Healthcare Limited, Amoxicillin 500mg Capsules BP • PSN048 - Risk of harm from inappropriate placement of pulse oximeter probes • Internal Safety Notice 2019/002 - Wrong route medicines administration • PSN048/February 2019 - Risk of harm from inappropriate placement of pulse oximeter probes • MDA/2019/007 - Ophthalmic implant Raindrop Near Vision Inlay – risk of corneal haze • MDA/2019/006 - Orthopaedic implant rHead Radial Head and Uni-Elbow: risk of early loosening • PSA009 - Wrong selection of orthopaedic fracture fixation plates • MDA/2019/011 - Multi parameter patient monitors: Carescape B450, B650, B850, B20, B40, B20i, B40i, B125, B105, Dash 3000,4000,5000, Solar 8000M/i, 9500 – risk of loss of patient monitoring • MDA/2019/012 - Potentially breached sterile packaging of: rectal tubes, Unoversal drainage systems, SimpaVac, sterile suction connecting tubes, sterile connecting pieces, suction handles/sets (FilterFlow™/De • MDA/2019/013 - All T34 ambulatory syringe pumps need a sponge pad fitted to the battery compartment to prevent battery connection issues • MDA/2019/014 - All Bard urogynaecological mesh – voluntary product withdrawal, implanted devices do not need to be removed • MDA/2019/015 - enFlow® IV fluid and blood warmer - risk of unsafe levels of aluminium leaching from the device All the patient safety notices were noted for information. It was noted that all notices have been shared widely across all areas and there were no exceptions to report for the Clinical Board.	
4.7	**Medication Safety Metrics – January 2019** Noted for information. 100% compliance is being reported and progress continues to be positive.	
DIGNIFIED CARE		
5.1	**Latest Cleaning Scores Report** Noted for information. Ground floor at St David's Children's Centre also need to be included. Reviews are being undertaken with regards Delivery Suite in order to understand what further actions need to be undertaken in order to further improve.	

INDIVIDUAL CARE		
6.1	**Patient Feedback Video** Deferred to next meeting.	
6.2	**Update on latest 2 minutes of your Time feedback** Processes continue across all areas. There were no specific issues to highlight for this meeting.	
STAFF AND RESOURCES		
7.1	**To note any exceptions/issues relating to staff/resources** Covered as part of Item 2.3	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
8.1	**C Section SSI Report – Quarter 3 2018** Shared for information and onward dissemination as appropriate.	
8.2	**Medicines Safety Executive Newsletter – February 2019** Noted for information.	
8.3	**Manual Handling & Violence and Aggression Training Guidance** Noted for information and onward dissemination.	
8.4	**Paediatric Medicines Safety Update** Noted for information. It was agreed that a similar process would be reviewed for Obstetrics & Gynaecology and plans are also in place and progressing within Community Child Health.	**O&G DMT**
8.5	**Changes to Controlled Drug status of Gabapentin and Pregabalin** Noted for information and reiteration of the processes that need to be followed. It was noted that this has been disseminated widely across all areas for compliance.	
ANY OTHER BUSINESS		
	No items to note.	

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 23rd April, Meeting Room, Clinical Board Offices, Lakeside**

Future 2019 Dates

Tuesday 28th May, Meeting Room, Clinical Board Offices, Lakeside (IP&C FOCUS)
Tuesday 25th June, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)
Tuesday 23rd July, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 27th August, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 24th September, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)
Tuesday 22nd October, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 26th November, Meeting Room, Clinical Board Offices, Lakeside (IP&C FOCUS)
Tuesday 17th December, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)
Tuesday 28th January 2020, Venue to be confirmed
Tuesday 25th February 2020, Venue to be confirmed
Tuesday 24th March 2020, Venue to be confirmed (H&S FOCUS)