Bundle Quality, Safety and Experience Committee 17 September 2019

Agenda attachments

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1	STANDING ITEMS
1.1	Welcome and Introductions *Susan Elsmore*
1.2	Apologies for Absence *Susan Elsmore*
1.3	Declarations of Interest *Susan Elsmore*
1.4	Minutes of the Committee meeting held on 18 June 2019 *Susan Elsmore* 1.4 - Draft QSE Minutes JUNE final version for NF 2.docx
1.5	Action Log - 18 June 2019 *Susan Elsmore* 1.5 Action Log June v3.docx
1.6	Chair's Action taken since the last meeting *Susan Elsmore*
1.7	QUALITY GOVERNANCE
1.8	Patient Story *Meriel Jenney*
1.9	Clinical Board Assurance Report: Children and Women - Maternity Report *Meriel Jenney* 1.9 - C&W Assurance Report - Maternity.docx
1.10	Youth Thematic Review *Meriel Jenney* 1.10.1 - Appendix 1 - Youth Thematic Review Recommendations CH 19 Aug.xlsx 1.10 - SBAR - HIW Youth Thematic Review -August 2019.docx
1.11	Cwm Taf Maternity - Cardiff and Vale Lessons Learnt *Meriel Jenney* 1.11.1 - Appendix 1 -Cwm Taf Maternity Assurance framework from CandV Version 13 30th August 2019.docx 1.11 - Cwm Taf Maternity - Cardiff and Vale UHB Lessons Learnt-update September 2019_.docx
1.12	Gosport Review *Carol Evans* 1.12 - Gossport Inquiry v1 draft.docx
1.13	Ombudsman Annual Letter and Report *Angela Hughes* 1.13 - Ombudsman Annual Letter QSE Report August 2019 v2.docx
1.14	Putting Things Right Annual Report *Angela Hughes* 1.14.1 - Appendix 1 - Putting things right Annual Report 2019.pdf 1.14 - PTR Annual report QSE Report August 2019.docx
1.15	POLICIES FOR APPROVAL
1.15.1	Parental Infusion Pumps Policy 1.15.1 - Parenteral Infusion Cover Report.docx 1.15.1.1 - Parenteral Infusion Pump Policy_2018 v1.doc
1.15.2	Research and Governance Policy

1.15.2 - Research governance policy covering form 050819.docx

1.15.2.1 - DRAFT RESEARCH GOVERNANCE POLICY 240419 for RGG.DOCX

1.15.2.2 - SR-RG-019 UHB457 Research Goverance SOP v1.pdf

1.15.3 Framework for Management of Performance Conerns in General Medicine Practitioners on the Medical Performers List Wales

1.15.3 - Covering Report - Framework for Manage of Performance Concerns.docx

1.15.3.1 - Framework for Performance Concerns CV UHB v5 FINAL no TRK.docx

2 THEME 1: HEALTH PROMOTION, PROTECTION AND IMPROVEMENT

2.1 Diabetic Retinopathy - Patient Recall

Ruth Walker

2.1 - Diabetic Retinopathy paper QSE August 2019 vers 2.docx

3 THEME 2: SAFE CARE

3.1 Centralisation of Endoscopy Decontamination

Verbal Update - Fiona Jenkins

3.2 Update on Stroke Rehabilitation Model and Workforce

Fiona Jenkins

3.2 - Stroke Rehab Model and Workforce Report.docx

4 THEME 3: EFFECTIVE CARE

4.1 National Audit Update

Stuart Walker

4.1 - National Clinical Audit - Sept QSE 20190903.docx

5 THEME 4: DIGNIFIED CARE

5.1 Health Inspectorate Wales Activity Update

Carol Evans

5.1 - HIW Activity update September 2019 -QSE v1.docx

5.1.1 - Appendix 1 - EUAU HIW Improvement Plan.xlsx

5.2 HIW Primary Care Contractor Activity

5.2 - SBAR - HIW Primary Care Contractor Activity.docx

5.2.1 - HIW Appendix 1 GMS August 2019.docx

5.2.2 - HIW Aug 2019 Appendix 2 GDS.DOCX

5.3 Carer Measures

Angela Hughes

5.3 - Carers annual report QSE AUGUST 2019.docx

5.3.1 - Carers_Report_2018_2019_FINAL.pdf

6 THEME 5: TIMELY CARE

6.1 Delivery Unit Report: Impact on Long Waits

Steve Curry

6.1 - 2019-09 DU Long waits report QSE.docx

6.1.1 - Review of Impact of Long Waits - CVUHB report FINAL (002).pdf

6.1.2 - 2019-08 Action plan DU review Long waits (Final) Appendix 2.docx

7 THEME 6: INDIVIDUAL CARE

No items to report

8 QUALITY, SAFETY AND EXPERIENCE COMMITTEE GOVERNANCE

9 ITEMS RECEIVED FROM CLINICAL BOARDS QUALITY, SAFETY AND EXPERIENCE SUB-COMMITTEES

Minutes from Clinical Board Quality Safety and Experience sub-Committee - Exceptional Items to be raised by the Assistant Director of Patient Safety and Quality
Carol Evans

9.1 Clinical Diagnostics and Therapeutics - May and June 2019

Steve Curry

9.1.1 - CD&T - Minutes 8.5.19.docx

9.1.1b - CD&T - Minutes 12.6.19.docx

9.1.1c - CD&T - Mins 10.7.19.docx

9.2 Mental Health - June 2019

Steve Curry

9.1.2 - MH Mins - 20.06.19.doc

9.3 Primary, Community and Intermediate Care - May 2019

Steve Curry

9.1.3 - PCIC QSE Group mins May 2019 KJ.docx

9.1.3.1 - PCIC QSE Group mins July 2019 KJ.docx

9.4 Specialist Services - April and May 2019

Steve Curry

9.1.4 - Spec Services final Minutes QSE 25.4.19.doc

9.1.4.1 - Spec Services Final Minutes QSE 16.5.19.docx

9.1.4.2 - Spec Srvices Minutes QSE 06.06.19.docx

9.5 Medicine - May 2019

Steve Curry

9.1.5 - Medicine CB QSE Minutes 16.05.19.docx

9.6 Surgery - May 2019

Steve Curry

9.1.6 - SCB Q&S Minutes 2019 05 07.docx

9.7 Children and Women - April 2019

Steve Curry

9.1.7 - C&W QSPE Minutes 23.04.19.docx

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

Susan Elsmore

11 Review of the meeting

Susan Elsmore

12 Date and time of next meeting:

Tuesday, 15 Octover 2019 at 9.00am
Coed y Bwl, Ground Floor, Woodland House, Heath

AGENDA

QUALITY, SAFETY & EXPERIENCE COMMITTEE
17 September 2019 at 9.00am
Coed y Bwl, Woodland House, Heath

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 18 June 2019	Susan Elsmore
1.5	Action Log from 18 June 2019	Susan Elsmore
1.6	Chairs Action taken since last meeting	Susan Elsmore
1.7	**Quality Governance**	
1.8	Patient Story –	Meriel Jenney
1.9	Clinical Board Assurance Report: Children and Women – Maternity Report	Meriel Jenney
1.10	Youth Thematic Review	Meriel Jenney
1.11	Cwm Taf UHB Maternity – Cardiff and Vale Lessons Learnt	Meriel Jenney
1.12	Gosport Review	Carol Evans
1.13	Ombudsman Annual Letter and Report	Angela Hughes
1.14	Putting Things Right Annual Report	Angela Hughes
1.15	**Policies and Procedures:** 1. Parental Infusion Pumps Policy 2. Research Governance Policy 3. Framework for the Management of Performance Concerns in General Medical Practitioners (GPs) on the Medical Performers List Wales	
2.	**Health Promotion, Protection and Improvement**	
2.1	Diabetic Retinopathy – Patient Recall	Ruth Walker
3.	**Theme 2: Safe Care**	
3.1	Centralisation of Endoscopy Decontamination	Fiona Jenkins Verbal
3.2	Update on Stroke Rehabilitation Model and Workforce	Fiona Jenkins
4.	**Theme 3: Effective Care**	
4.1	National Audit Update	Stuart Walker
5.	**Theme 4: Dignified Care**	
5.1	HIW Activity Update	Carol Evans
5.2	HIW Primary Care Contractor Activity	Carol Evans
5.3	Carer Measures	Angela Hughes
6.	**Theme 5: Timely Care**	
6.1	Delivery Unit Report: Impact of Long Waits	Steve Curry
7.	**Theme 6: Individual Care**	
7.1	No items to report	
8.	**Quality Safety and Experience Committee Governance**	
9.	**Items Received from Clinical Boards Quality Safety and Experience Committee**	
9.1	Minutes from Clinical Board Quality Safety and Experience Sub Committees – Exceptional Items to be raised by the Assistant Director,	Carol Evans

	Patient Safety and Quality	
9.1.1	Clinical Diagnostics and Therapeutics – May and June 2019	Steve Curry
9.1.2	Mental Health – June 2019	
9.1.3	Primary, Community and Intermediate Care – May 2019	
9.1.4	Specialist Services – April and May 2019	
9.1.5	Medicine – May 2019	
9.1.6	Surgery – May 2019	
9.1.7	Children and Women – April 2019	
10.	**Items to bring to the attention of the Board/Committee** Nothing to report	Susan Elsmore
11.	**Review of the Meeting**	Susan Elsmore
12.	**Date and time of next Meeting: 15 October 2019 at 9.00am, Coed y Bwl, Ground Floor, Woodland House, Heath**	Susan Elsmore

UNCONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 18 June 2019 COED Y BWL, WOODLAND HOUSE, HEATH, CARDIFF CF14 4TT

Present:		
Susan Elsmore	SE	Committee Chair and Independent Member – Local Government
Michael Imperato	MI	Independent Member - Legal
In attendance:		
Jessica Castle	JC	Director of Operations, Specialist Services Clinical Board
Steve Curry	SC	Chief Operating Officer (*for part of meeting*)
Peter Durning	PD	Interim Executive Medical Director
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		Executive Director of Public Health
Christopher Lewis	CL	Deputy Director of Finance (attending *for Bob Chadwick, Executive Director of Finance*)
Navroz Masani	NM	Clinical Director, Specialist Services Clinical Board
Paul Rogers	PR	Directorate Manager for the Artificial Limb and Appliances Service (ALAS)
Ruth Walker	RW	Executive Nurse Director
Geoff Walsh	GW	Director of Capital, Estates and Facilities (*attending for Abigail Harris, Executive Director of Strategic Planning*)
Mike Bond	MB	Director of Operations – Surgery Clinical Board
Glynis Mulford	GM	Secretariat
Apologies:		
Gary Baxter	GB	Independent Member - University
Robert Chadwick	RC	Executive Director of Finance
Abigail Harris	AH	Executive Director of Strategic Planning
Dawn Ward	DW	Committee Vice Chair and Independent Member – Trade Union

QSE: 19/06/001	**WELCOME AND INTRODUCTIONS** The Committee Chair welcomed everyone to the meeting and gave a special welcome to Dr Navroz Masani, Clinical Director of the Specialist Services Clinical Board; Jessica Castle Director of Operations, Specialist Services and Paul Rogers Directorate Manager for the Artificial Limb and Appliances Service (ALAS). The Committee Chair noted that the meeting was not quorate and confirmed that in view of this any decisions made by the Committee would need to be ratified by the Board, through her Committee Chairs	**ACTION**

report, when it met in July 2019. The Committee Chair also advised those present that she would need to leave part way through the meeting to attend the launch of the Joint Learning Disabilities Commissioning Strategy and so the Independent Member – Legal would Chair the remainder of the meeting.

The Executive Director for Therapies and Health Science advised that as the Executive Lead for learning disabilities she would also like to leave the meeting to attend the launch if it was permissible.

19/06/002 **APOLOGIES FOR ABSENCE**

Apologies for absence were noted.

19/06/003 **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 was received and noted:

- Michael Imperato, Independent Member (Legal) declared a conflict of interest in respect of the Infected Blood Inquiry. The declaration was formally noted, and it was agreed that Michael Imperato would leave the meeting when agenda item 1.12 was discussed.

19/06/004 **MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON 16 APRIL 2019**

The Committee reviewed the Minutes of the meeting held on 16 April 2019.

The Committee Resolved - that:

a) the minutes of the meeting held on 16 April 2019 be approved as a true and accurate record.

19/06/005 **COMMITTEE ACTION LOG**

The Committee reviewed the Action Log and noted that reports on Ophthalmology services and Car parking were on the meeting agenda. The following verbal updates were received in relation to the remaining items:

QSE19/04/025 – Items to be brought to the attention of the Board: It was confirmed that the Annual Quality Statement and the key findings arising from the Annual Health and Care Standards assessment had been brought to the Board's attention through the Committee Chair's report presented at the May Board meeting.

QSE 19/04/020 – Endoscopy Decontamination Patient Notification Exercise: It was confirmed that a report would be scheduled for the September meeting of the Committee. PD

QSE 19/02/010 – Gosport Independent Panel Report: The Executive Nurse Director confirmed that a report would be brought to the September meeting of the Committee. RW

	QSE 19/02/008 – PCIC Clinical Board Assurance Report: The Director of Capital, Estates and Facilities confirmed that the Business Case for the development of the Ely Hub had been developed. It was also noted that an interim solution to relocate staff was being put in place. **QSE 18/135 - Ombudsman Annual Letter**: The Assistant Director of Patient Experience confirmed that the Ombudsman's Annual Letters for 2017/18 and 2018/19 had been received and would be put on the agenda for the Committee meeting scheduled for September. **QSE 18/155 – CD&T Minutes:** The Director of Capital, Estates and Facilities confirmed that refurbishment works had commenced and a business case for the replacement of the Bone Marrow Transplant Unit was being developed. The Committee Chair requested that an update be put on the agenda for the Committee meeting scheduled for September. **The Committee Resolved – that**: a) the action log and the verbal updates be NOTED.	AH GW
19/06/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** The Committee Chair confirmed that Chair's Action had not been taken since the Committee meeting held in April 2019. In line with requirements set out in the UHB's Standing Orders, the Chair confirmed that the Committee had met in private following the public meeting held on 16 April 2019. It was noted that at the private meeting safeguarding, the recent Healthcare Inspectorate Wales' (HIW's) letter regarding the findings of the unannounced inspection of the Assessment and Emergency Units on the University Hospital of Wales site, and the UHB's response were discussed. The Executive Nurse Director confirmed that the UHB had submitted all the information requested to HIW and this information had been accepted along with the Improvement Plan. It was noted that the report would be published on 28 June 2019.	
19/06/007	**PATIENT STORY** The Chair invited the Clinical Director and Director Operations of the Specialist Services Board and the Directorate Manager for ALAS to start their presentation. The Director of Operations introduced the patient story explaining that the Specialist Clinical Board would like to take the Committee through the story of conjoined twins who had moved to Cardiff from Senegal, and tell the story of how, through the work of ALAS, they were given greater mobility and their quality of life improved. The Directorate Manager of ALAS explained that: • the twins were born in Senegal and given their disability their father had sought to find a specialist hospital somewhere in the World that would be able to separate the twins.	

- a paediatric surgeon in Great Ormond Street agreed to examine the twins but it was found that they could not be separated due to their complexities and heart issues.
- due to the girls needing specialist medical care the twins father sought asylum in the UK, and in 2018 the family moved to Cardiff.
- once settled in Cardiff the twins were referred to the Posture Mobility Service. The complexity of the twins condition and needs were outlined and it was noted that they included complex posture issues; life limiting conditions; heart defects; a fused pelvis and a central arm that was in a difficult position from a posture perspective.
- the twins needed specialist seating to help with their posture and to aid respiration. A full assessment was undertaken by the Posture and Mobility Service and using specialist equipment a suitable postural seat was developed.
- the seat was a success but due to the twins being constantly photographed and filmed when they were taken out, the father requested that the seat be rotated to give the girls some privacy. After some technical difficulties a way of rotating the seat was found but it was clear that solution was not suitable for the longer term.
- to help address the social issues and manage the reaction that members of the public had to the girls the ALAS team contacted social services, Ty Hafen and the BCC. The BCC produced a fascinating article on the twins with the idea that if the public had more information about them they would be less curious and more tolerant.
- the twins' postural needs are reviewed regularly to take account of their growth and any changes to their needs.

The Executive Nurse Director, stated that the Patient Story demonstrated how the UHB was able to provide bespoke services and highlighted the extent of the skills of its staff. The role that ALAS had played in seeking ways in which to drive down the stigma of the twins' disability was acknowledged and the importance role that all UHB staff had in this respect was emphasised.

The Executive Director of Therapies and Health Science advised the Committee that she had recently had the privilege of visiting a specialist school in Cardiff, and she had been impressed at the amount of specialist equipment that had been made available to the young people through ALAS. It was noted that ALAS was providing bespoke child friendly services too many young people and helping them fit into normal family life.

The Clinical Director advised the Committee that many of the adaptations and equipment issued by ALAS were invented and developed on the ALAS unit based on the Treforest site. The unique, innovative and specialised work of the ALAS team was emphasised.

The Executive Director of Public Health asked whether any of the inventions were patented and it was confirmed that some were, but the legal loopholes often meant that it was a difficult process that often outweighed the benefits. The Executive Director of Therapies and Health

	Science confirmed that arrangements were in place to ensure the best use of Research and Development. The Committee Chair confirmed that as Cardiff County Council's asylum lead the patient story was close to her heart, and stated she had been overwhelmed by the energy that the ALAS team had put into meeting the needs of the twins and their family. The Committee Chair asked a number of questions related to the quality of the service: • what is the frequency of review for the twins: it was confirmed that reviews were annual but the family could request a review at any time. • how well were the links with social care working: it was noted that relationships worked well but that challenges did arise due to some gaps in service provision The Executive Nurse Director asked if formal pressure damage assessments were undertaken by the team. In response, the Directorate Manager confirmed that the primary concern when undertaking any seating assessment was the management of pressure. It was confirmed that regular pressure assessments were undertaken and information on the signs of pressure damage to look for given to all service users and their families. It was also noted that a pressure care pathway was in place, with plans to roll the pathway out across all ALAS services. The Executive Nurse Director advised that the pressure damage assessment tool was changing and confirmed that she would contact the directorate manager to talk about this. The Committee Chair advised the Directorate Manager that she was happy to provide the ALAS service with support in her role as Chair of the Quality, Safety and Experience Committee as well as her Cabinet role with the County Council. It was noted that with improvements to neonatal services the UHB needed to be mindful of the growing demand for the services of ALAS and other specialities. Committee Members agreed that the Patient Story was an excellent example of where UHB services had gone the extra mile. The Clinical Board Director confirmed that the Posture Mobility Service was unique as it was the only service in the UK to have a team that included clinicians, nurses, health scientists, a factory, specialist workshop and a research facility. **The Committee resolved that:** **a)** the Patient Story be NOTED.	RW
19/06/008	**SPECIALIST CLINICAL BOARD ASSURANCE REPORT** The Director of Operations for the Specialist Services Clinical Board introduced the Assurance Report, which provided details of the arrangements, progress and outcomes in relation to the Quality, Safety and Patient Experience agenda over the previous 12-months.	

It was confirmed that the top five risks on the Clinical Board's risk register as at March 2019, were:

- Insufficient Critical Care capacity to meet demand.
- Haematology - Lack of isolation cubicles and appropriate filtration on Ward B4H.
- Neurosciences – Sustainability of services at Rookwood Hospital due to infrastructure issues.
- Neurosciences – Continuity of neurovascular service.
- Cardiac Surgery waiting list - ability to meet 36-week RTT, ability to treat urgent patients.

The discussions that followed focused on the capacity of the Critical Care Service. It was noted that:

- in 2018/19 six additional critical care beds had been commissioned through winter plan monies and that this money was likely to be recurrent. It was confirmed that the funding of the additional beds had relieved some of the capacity pressures, but further work was ongoing through a capital group and operational planning group.
- there was a plan to move the post anaesthetic care unit and free up a further six spaces on the main floor of the critical care facilitates.
- the need for further work in relation to the critical care infrastructure was confirmed and the recently reported findings of a review undertaken by the Royal College of Anaesthetists were outlined; It was noted that the findings highlighted by this review included infrastructure, workforce and relationship issues.
- several of the findings highlighted by the review were not for the Critical Care Service to address alone as they spanned a number of Clinical Boards, hence a UHB approach was required. It was noted that one such issue was care of the deteriorating patient across the two main hospitals.
- developments, such as the Major Trauma Centre, would have a further impact on the areas of concern highlighted by the review. The Critical Care services ability to cope with the predicted flu epidemic was also highlighted.
- the review team from the Royal College of Anaesthetists had noted that the Critical Care risk had been on the Clinical Board's risk register at a rating of 25 for some time, and had reported that the service had become accustomed to practices that were not acceptable, for example not reporting all incidents on DATIX, and was too accepting of certain types of risk.
- next steps in relation to the Royal College review, were to be discussed by Management Executive. It was noted that the Clinical Board had prepared responses to the review findings that were helpful and that responses had also been received from the Consultant Body in Critical Care and the Clinical Director within anaesthetics.

- the Royal College of Anaesthetists would be undertaking a further visit in six months' time to review the UHB's response to their recommendations and had intimated that a referral to HIW may be made if the response was not felt to be sufficiently robust.
- during the period between the Royal College of Anaesthetists being invited to undertake the review and the findings being reported there had already been significant improvements made by the Clinical Board.

The Committee Chair asked for confirmation of the steps that the Clinical Board had taken to address the findings in relation to the normalisation of risk and the risk score having been 25 for such a long period of time. In response, the Clinical Director confirmed that all steps to mitigate the risk had been taken, and advised that short, medium, and long-term plans were in place and had been shared with Welsh Government.

The Executive Nurse Director stressed the important of incidents being reported through the formal process, as otherwise the Board was not sighted of the risks being managed at an operational level.

The Committee Chair confirmed that it was important to ensure that the Royal College of Anaesthetists report and the related improvement plan was brought to the Committee for discussion. It was noted that the Chief Executive Officer had made it clear that he wanted a robust improvement plan in place as soon as possible as some of the relationship and multi-disciplinary team issues would need a robust OD approach.

The Chief Operating Officer advised the Committee that the main issue was critical care capacity but improvements had been made over the previous 12-months as a result of the Chief Executive's negotiations with Welsh Government. It was noted that the UHB was fundamentally constrained by its estate.

The Committee Chair highlighted that the Clinical Director had raised concern in relation to the critical care services ability to respond to a major incident or flu epidemic and asked for the Chief Operating Officer's views on this. The Chief Operating Officer advised that there were very few critical care units in the UK with as many beds as the UHB and confirmed that there would be a networked response to any critical incident, and advised that contingencies were in place to respond to an epidemic, of for example the flu.

The Clinical Director stated that he recognised that contingencies were in place but noted that the recommended that the optimum occupancy rate for critical care beds was 75%, with most UK NHS organisations running at 85%. However, the UHB was running at occupancy levels of between 95% and 110% occupancy.

The Executive Nurse Director confirmed that the discussion highlighted the importance of there being a clear understanding of what the issues were and having a robust plan in place to address them in the short, medium and longer term.

It was noted that due to timing issues only one of the high-level risks highlighted by the Clinical Board had been fully discussed. It was confirmed that issues in relation to haematology and Rookwood Hospital had been discussed by the Committee previously.

The Executive Nurse Director highlighted that the report referenced never events, incidents and other issues of important issues that the Committee needed to be made aware of and thanked the Clinical Board for its openness and transparency.

The Director of Operations advised the Committee that it was important that Members were aware of the issues in relation to the waiting times for cardiac surgery. It was noted that:

- cardiac Surgery was one of the areas where there was difficulty ensuring the right level of capacity on week days in order to maintain the number of cardiac surgery operations needed to eliminate the 36 week wait, and to reduce the overall volume of patients on the waiting list. It was confirmed that some of the risk was being mitigated by weekend working and that plans were in place to manage those patients on the waiting list and identify any patients at risk.
- while urgent patients were being seen there remained a bulk of routine patients who were having to wait much longer than they should. It was noted that plans were in place to avoid the UHB slipping back to the position it was in previously.

The Executive Nurse Director enquired as to how confident the Clinical Board was that things would improve. In response, the Director of Operations confirmed that the message was positive but there was a concern in relation to how much could realistically be done over the next 6-months to stop the situation from deteriorating further.

The Chief Operating Officer confirmed that the cardiac surgery wait had been escalated in line with the UHB's formal performance escalation processes. It was noted that the Chief Executive Officer and the Chief Operating officer were fully sighted of the issues and were meeting with the Clinical Board on a regular basis to discuss and seek a way forward on this matter.

The Committee Chair asked whether the Cardiac Surgery risk score should be higher. The Chief Operating Officer confirmed that the risk score would be reviewed outside of the meeting. It was agreed that if progress was not evident by the end of the calendar a paper focusing on cardiac surgery waiting times should be brought back to the Committee for discussion. **SC**

The Committee resolved that:

a) the Specialist Clinical Board's Assurance report and the progress made to date be NOTED.

b) the content of the Assurance Report be APPROVED, subject to the Royal College of Anaesthetists Report on Critical Care being brought to the September 2019 meeting of the Committee together with the improvement plan developed in response to the recommendations made.

c) if progress in relation to Cardiac Surgery waiting times was not evident by the end of the calendar year a paper should be brought back to the Committee for consideration.

	The Committee Chair confirmed that as the meeting was not quorate the approval of the Assurance Report would need to be ratified, through her Committee Chair's report, by the Board when it met in July. *[The representatives of the Specialist Services Clinical Board left the meeting]*	**SE**
19/06/009	**QUALITY AND SAFETY IMPROVEMENT FRAMEWORK** The Assistant Director for Patient Safety introduced the report confirming that it provided a high-level overview of the progress made in relation to the implementation of the Quality, Safety and Improvement Framework 2017 - 2020. It was noted that the UHB's Annual Quality Statement, due to be published on 25 July 2019, provided a summary of the progress made in 2018-19. As part of discussions: • The Assistant Director of Patient Safety and Quality confirmed that work to develop the next strategy for the period 2021 to 2024 had started and it would be brought to the Committee in April 2020 for approval. • The Independent Member – Legal asked for some background information in relation to 'Cyber bullying in young people' that had been highlighted as an area of focus in 2019 to 2022. In response, it was confirmed that this had been an area of concern highlighted by the work of the Mental Health Clinical Board. The Assistant Director of Patient Safety and Quality advised that responsibility for the delivery of a number of the actions set out in the Framework sat with specialist leads and Clinical Board and not the Patient Safety Team, therefore she did not have all the details in relation to why cyber bullying was an area of focus. • The Executive Director of Public Health noted the importance of any work in relation to cyber bullying being linked to the UHB's Suicide Plan and the emotional mental health work that the Children and Women's Clinical Board were leading on as part of the UHB's integrated health and social care work. • The Independent Member – Legal confirmed that 'cyber bullying' was a major issue and had featured as an important factor in a number of recent inquests. The need for the UHB to be ahead of the curve in relation to this matter was noted. • funding for a mental health consultant nurse post had recently been agreed and that the post would have a particular focus on suicide issues. • conversations regarding the issues aligned to male suicides and suicides in young people were taking place in partner organisations. The Executive Nurse Director advised that the Quality and Safety Improvement Framework report demonstrated that a lot of work was being in relation to the quality and safety agenda. The importance of ensuring that the work was closely aligned to the UHB's Strategy was acknowledged. **The Committee resolved that**:	CE

a) progress with implementation of year two of the Quality, Safety and Improvement framework, the main high-level achievements for 2018/2019 and areas for focus for 2019-20 be NOTED.

19/06/010 **PATIENT EXPERIENCE FRAMEWORK AND IMPROVEMENT INDICATORS**

The Assistant Director of Patient Experience introduced the report, which provided a high-level overview of progress in relation to the implementation of the refreshed Patient Experience Framework 2017 - 2020. As part of discussions it was confirmed that:

- steps were being taken to ensure that patient experience was central to the delivery of the UHB's Strategy.
- a key priority for the Patient Experience Team was ensuring that there was a clear governance framework around volunteers and carers and ensuring alignment across all strands of the work that the Team was leading on. It was also noted that there needed to be a focus on capturing the experiences of those groups of patients and service users that were less vocal and seldom heard.
- the Putting Things Right Annual Report would be considered at the meeting scheduled for September. It was also confirmed that the Carers Report would come to the Committee for noting. **AH**
- the Public Services Ombudsman for Wales had recently been granted new powers and a report outlining these would be prepared for the September meeting of the Committee. **AH**
- the work that the Patient Experience Team had undertaken with the Clinical Boards was important and key to getting the approach to care and treatment right. The importance of putting patient experience at the centre of the conversations being held in relation to the transformation agenda.
- the Executive Nurse Director would be meeting with the Chief Executive Officer and the UHB Chair to discuss a refresh of the mechanisms for bringing the patient voice to meetings of the Board.

The Executive Director for Therapies and Health Science drew the Committee's attention to the fact that patients were less happy with the care and treatment provided over the weekend. It was agreed that there was a need to investigate the reasons for this.

The Committee Chair suggested that consideration be given to Patient Safety Walkarounds being scheduled for the weekend. In response, the Executive Nurse Director confirmed that the Patient Safety Walkaround process was being refreshed and would be brought to a Board Development Session for discussion. **RW**

The Assistant Director of Patient Experience confirmed that steps were in place to investigate and better understand the reasons for patients being less happy over the weekend.

The Committee resolved that:

a) progress with implementation of the Patient Experience Framework and Improvement Indicators, the main high-level achievements for 2018/2019 and areas for focus for 2019-20 be NOTED.

19/06/011	**ESSURE (ISSUES WITH THE FAILIURE OF THE PROCESS)** The Executive Nurse Director introduced the report, which provided an overview of a patient notification exercise that was undertaken when it became apparent that the outcomes of some patients who had undergone the ESSURE procedure (hysteroscopic sterilisation), were unclear. It was confirmed that the paper was being brought to the Committee to provide assurance that the ESSURE issue had been identified, fully investigated and necessary action taken. The Committee was advised that: • it had been identified that not all women who had undergone the ESSURE procedure had been checked to ensure that they were sterile. This issue escalated when one of the patients became pregnant. • 45 women had undergone the procedure and the UHB had been unable to contact or had not received feedback from only three of the 45 women. The UHB had taken all possible steps to contact and engage with the three women. • going forward all incidents where 'patient notification/recall' work was required would be brought to the Committee for scrutiny. • the lead clinician and Clinical Board had highlighted the issues with the ESSURE procedure, demonstrating openness and transparency It was noted that the UHB no longer performed the procedure and confirmed that all Clinical Board's had been reminded of the process to be followed when they wished to introduce new procedures. The Executive Director of Public Health advised the Committee that there were other patient notification exercises in the public health arena that would be appropriate to bring to the Committee for information. **The Committee resolved that**: a) the contents of the report and the outcome of the patient notification exercise be NOTED. *[Michael Imperato, Independent Member- Legal left the meeting prior to discussions in relation to the next item starting*] *It was noted that the Committee was the only Independent Member present to hear the next item.*	FK
19/06/012	**INFECTED BLODD INQUIRY UPDATE** The Executive Nurse Director confirmed that the paper provided the Committee with an update on the activity undertaken by the UHB to support and engage with the Infected Blood Inquiry. It was confirmed that a cohort of 150 patients predominately individuals under the care of the Haemophilia Centre had made enquiries and these individuals were being supported to review their medical records. The Executive Nurse Director confirmed that:	

- in general the UHB had been able to provide individuals with all of their records.
- as at May 2019, 81 individuals had approached the health board to request their records and as a result 84 Subject Access Requests (SAR) had been facilitated. It was noted that some individuals had up to 17 volumes of notes and so ensuring that they got access to the information that they need was a big exercise.
- in three cases it had been evident that medical records had been destroyed in line with the requirements of the Data Protection Act and in a further two cases it had not been possible to provide complete sets of medical records referencing all episodes of care; although records of all blood products administered to patients had been available and provided.
- the UHB had been in contact with the patients and their families and had provided help and support to them. It was confirmed that the UHB may still be able to provide some of the information that the patients and families required because of the testing arrangements. It was confirmed that the timing of testing was a very strong theme emerging form the inquiry.
- four days of hearings would be held in Cardiff during July 2019. It was confirmed that the majority of the infected or affected Welsh individuals called to give oral evidence would do so during this week. The Executive Nurse Director confirmed that she and the UHB Chair hoped to attend the hearings.
- the UHB had applied for Core Participant Status but the Solicitor to the Inquiry had requested further information to support the application.

The Executive Nurse Director advised that it was important that the Committee was made aware of the volume of work involved in relation to the Inquiry and the fact that there could be some reputational issues arising from the hearings because of the connection with the clinician who had been pivotal to this work.

The Committee Chair asked the Executive Nurse Director to ensure that staff involved in the inquiry work were properly support.

The Executive Nurse Director advised the Committee that the UHB was not disagreeing or challenging the views and opinions of the patients and families involved. The Committee Chair confirmed that she was content with this stance. (*to be ratified by the Board*) SE

The Committee resolved that:

a) the approach being taken to respond to the Infected Blood Inquiry be NOTED.

[Michael Imperato, Independent Member- Legal re-joined the meeting]

The Committee Chair agreed to move the agenda around to accommodate the need for certain individuals in attendance to leave to attend other meetings.

19/06/13 **OPHTHALMOLOGY REPORT**

The Chief Operating Officer introduced the item and welcomed Mike Bond, Director of Operations for the Surgical Clinical Board who led on the presentation. Committee Members were:

- reminded that around a year ago some work was undertaken to develop a plan for Ophthalmology as the volume of individuals requiring access to the service was a problem across Wales.
- advised that there was a high level of risk associated with long waits as an individual's eyesight could deteriorate quickly.
- informed that when steps were taken previously to develop an Ophthalmology Plan it had been difficult given the various groups and stakeholders with an interest. It was confirmed that a prioritised plan was developed based on discussions with a range of stakeholders and interested parties.
- provided an update on progress against the priorities set out in the Ophthalmology Plan (the Plan). It was confirmed that when developing the Plan a number of key factors had to be considered, such as:
  - the imbalance in capacity and demand.
  - service complexities.
  - sub speciality work.
  - high volume of work.
- informed that attempts to address the Ophthalmology waiting times had been made over several years with limited success.
- provided with an outline the steps taken by the UHB over the previous year to reduce the Ophthalmology wait, which included an overview of the areas that needed to be taken into consideration and the level of risk aligned to these, namely:
  - capacity and demand.
  - clinical leadership
  - recruitment and workforce
  - RTT
  - patient safety
- described the approach taken to develop and embed a community model and highlighted the importance of a clinically led approach was emphasised.
- confirmed that a Clinical Director was in post and was starting to provide sound clinical leadership, already resulting in good progress in relation to glaucoma.

In response to a question in relation to the approach taken by the service to ensure there were no breaches of waiting time targets, it was confirmed that there had been a focus on managing capacity, the management of follow-up, additional resources, critical pathways and engagement. Communication with patients.

	The Chief Operating Officer confirmed that while progress had been made there was more to do, and highlighted that to ensure further progress there needed to be a focus on: • identifying the best way to ensure people were seen at the right time and in time • ensuring clinicians decide the priority cases and not systems • understanding and appropriately managing risks. The need to move to an outcomes base approach to delivery was discussed. The Executive Director for Therapies and Health Science confirmed that: • she chaired a national group for eye care. It was also noted that each health board had been required to identify an executive lead for eye care in order that a local eye care group could be established. • regional working was recognised as being needed and steps were being taken to regionalise ophthalmology. It was noted that opportunities for a regional approach to the treatment to cataracts was also being explored. • the first pathway to go live with a regional approach was the glaucoma pathway. • the technology to enable regional working would soon be in place but some operational preparations were needed to ensure a state of readiness. • national data showed that the UHB was still the lowest discharger to primary care for cataracts. It was noted that there was a need to ensure that data reflected the local and tertiary situation separately. • primary care optometrists were willing to pick up cataract follow-ups. The Committee Chair confirmed that there was clear evidence of improvement and highlighted the importance of moving services out to the community as this was aligned to the transformation agenda. The Executive Nurse Director asked that a copy of the presentation be sent to the UHB Chair. It was also agreed that a short update report, that included benchmarking data, whould be brought to the meeting of the Committee scheduled for December 2019. **The Committee resolved that:** a) the Ophthalmology presentation be NOTED. b) a short update report, that included benchmarking data, should be brought to the meeting of the Committee scheduled for December 2019.	**SC**
	The Executive Nurse Director confirmed that the work on the incident related to outsourcing was progressing well and a report would be taken to the Board in due course.	**RW**
19/06/014	**CAR PARKING UPDATE REPORT**	

	The Director of Capital Estates and Facilities introduced the paper and outlined the improvements made to the park and ride facilities as a result of the Health Charity Board of Trustees agreeing to fund the first year costs of a number of initiatives. It was confirmed that: • the UHW the park and ride service operated until 11pm, with the bus running every ten minutes rather than every 20. • a new park and ride service would be introduced for UHL, in July subject to final contractual arrangements. • steps were being taken to introduce a shuttle minibus service that would run between UHW and UHL between 7am and 7pm. • parking at UHW continued to be an issue, and the amount of time for free parking was to be reduced to two hours due to the system being abused by staff. • a high volume of complaints regarding the issuing of car parking charge notices had been received. It was noted that Parking Eye had cancelled approximately 40% of the parking charge notices issued automatically as well as 20% of those issued by the onsite car parking attendants. The Executive Nurse Director confirmed that the information provided in the report demonstrated that issues and concerns raised by patients and staff had been considered and acted upon. The Committee Chair advised that there was further need to publicise the Park and Ride service and the steps taken to address issues raised by patients and staff. It was confirmed that avenues for publicising the service would be explored. The Executive Director of Public Health highlighted the importance of sustainable travel and reminded the Committee that the UHB had signed up to the Healthy Travel Charter. **The Committee resolved that:** a) the Car Parking update report be noted.	**GW**
19/06/015	**HTA CAPA PLAN CLOSURE LETTER** The Executive Director of Therapies and Health Science provided an overview of the report outlining the action plan that was in place, the monitoring mechanisms and the proposed Quality Led Governance approach. It was confirmed that: • since the paper had been drafted that the HTA had agreed to Tom Hockey taking on the role of Designated Individual (DI). • the remaining 'in progress' actions were in final stages of completion and included the transition to the new DI, final approval of the Service Level Agreement with the WIFM, and completion of the database development for tissue management. • the CD&T Clinical Board was fully committed to on-going sustainability of the remedial actions delivered to ensure continued regulatory compliance in this service.	

	• the Clinical Board have developed a Regulatory Compliance Dashboard, which is used to drive improvement through the Clinical Board Regulatory Compliance Group. • as the Licence Holder she would ensure close oversight of the situation. **The Committee Resolved that**: a) the closure of the HTA inspection findings, the action plans, the intended monitoring mechanism through CD&T governance structures and the proposed Quality Led Governance approach be NOTED. *The Committee Chair asked Michaels Imperato to Chair the meeting from this point as she had to leave for another meeting.*	
19/06/016	**POLICIES AND PROCEDURES FOR APPROVAL** The Director of Therapies and Health Science provided an overview of the policies and procedures that were being brought to the Committee for approval, these were the: • Ionising Radiation Risk Management Policy • Exposure of Patients to Ionising Radiation Procedure • Exposure of Staff and Members of the Public to Ionising Radiation Procedure • Radioactive Substances Risk Management Policy • Radioactive Substances Risk Management Procedure It was noted that the policies and procedures had been subject to review by the relevant professional groups **The Committee Resolved that:** a) due to the meeting not being quorate the approval of the policies and procedures would be referred to the Board for ratification in July.	**SE**
19/06/017	**STROKE REHABILITATION MODEL AND WORKFORCE** The Director of Therapies and Health Science introduced the report. It was confirmed that: • the Medicine Clinical Board was conducting a reconfiguration of its stroke services towards a Hyperacute Stroke Unit on the UHW site and acute rehabilitation at SRC, UHL. It was noted that this work involved 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. • the reconfiguration of services would result in the SRC caring for acute patients and not just those considered to be sub-acute and as a result the staffing model would need to be re-evaluated.. • immediate actions for SRC to implement included:	

- 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.

- The longer term plan would need support from Medicine/CD&T Clinical Boards and Management Executive as it would include:
  - defining an operational therapy leadership role to ensure the delivery of a rehabilitation model.
  - development of nursing and therapy led beds
  - reconfiguration of stroke services.
  - reintroduction of the rehabilitation assistant role to work alongside both the nursing and therapy teams

It was noted that the stroke work had been started in response to concerns raised in relation to the quality of service**.** The Independent Member - Legal asked whether there were clear deadlines for the commencement and completion of the work outlined in the report.

The Executive Director of Therapies and Health Science confirmed that the Stroke Strategic Group was overseeing the work and a project plan with milestones and deadlines was in place. It was agreed that it would be helpful if an update could be brought back to the September meeting of the Committee to confirm the deadlines and the timeframes for delivery of the key pieces of work.

It was confirmed that the Model and Workforce Plan would need to be agreed by management Executive before they were brought back to the Committee.

The Independent Member – Legal asked whether more detailed priorities themes and priorities had been identified and developed as the ones contained in the paper were very high level and obvious. In response, the Executive Director of Therapies and Health Science confirmed that she would ask the project team to provide further information.

It was confirmed that the Hyperacute Stroke Unit was not resource neutral and so a decision by Management Executive would be needed. The Deputy Director of Finance advised that until the financial aspects of the development were confirmed it would be difficult to confirm timescales.

The Executive Nurse Director confirmed that there had been a reduction in incidents and complaints related to the SRC and this was positive.

The Committee Resolved that:

a) the recommendations set out in the report be NOTED.

	b) a further update setting out deadlines, timeframes and further detail in relation to priorities be scheduled for the September meeting of the Committee.	FJ
19/06/018	*[there was a five minute comfort break at this point in the meeting. The Executive Director of Therapies and Health Science left the meeting]* **COMMITTEE EFFECTIVENESS REVIEW FEEDBACK** The Director of Corporate Governance confirmed that all Committees of the Board had been supported to undertake an effectiveness review, and provided an overview of the process and the action plan that had been developed in response to the findings of the self-assessment It was noted that the findings arising from the self-assessment process were fairly consistent and these were outlined. The Director of Corporate Governance confirmed that a common theme arising from the self-assessment process was the need to improve the committee administrative processes. In response to a question raised by the Executive Nurse Director, it was confirmed that there was no narrative to support the responses to the self-assessment. The Director of Corporate Governance confirmed that she would give further consideration to the suggestion that each Committee had an annual workshop to discuss its workplan and the operational issues related to it. The Executive Nurse Director advised that it was important that the Chair, Executive lead and Director of Corporate Governance discussed and agreed the work plan as it was important to align the work plan with reporting arrangements required by, for example Welsh Government. **The Committee resolved that**: a) the results of the Committee Effectiveness Review for 2019 be NOTED. b) the action plan for improvement to be completed by March 2020 in preparation for the next Effectiveness Review be APPROVED (*it was confirmed that this would need to be ratified by the Board due to the meeting not being quorate).*	
19/06/19	**HEALTH AND CARE STANDARDS SELF-ASSESSMENT** The Assistant Director of Patient Safety and Quality introduced the report and confirmed that as lot of information was contained in the paper, and that a high level of assurance was provided. It was confirmed that as specialist groups were owning the standards and embedding them, Clinical Boards had been asked to undertake a self-assessment against only seven of the Health and Care Standards. Assistant Director of Patient Safety and Quality It was noted that each self-assessment was multi-factorial and considered a number of components relating to the individual standard. To reduce variation between Clinical Boards a scoring matrix had been developed for each standard with definitions aligned to four scores:	

- Getting Started
- Progressing Towards the Standard
- Meeting the Standard
- Leading the Way

It was confirmed that:

- as the process was now working smoothly a self-assessment would be undertaken at the start of the year and an improvement plan developed, with an update brought to the Committee in December. This revised approach would replace the routine reporting to the Committee.
- the work in relation to carers needed to be fully reflected in the Health and Care Standards self-assessments.
- the UHB's Health and Care Standards process had been subject to review by Internal Audit and a rating of 'Reasonable' assurance achieved.

The Committee Resolved that:

a) The progress made against each of the Health and Care Standards be NOTED.

b) the Corporate Priorities for 2019/20 be APPROVED. (*it was confirmed that this would need to be ratified by the Board due to the meeting not being quorate*).

19/06/020 **CWM TAF UHB MATERNITY – CARDIFF AND VALE LESSONS LEARNT**

The Executive Nurse Director confirmed that following the presentation delivered to the Board in May it had been agreed that the detail of the self-assessment would be brought to the Committee for further consideration.

The Executive Nurse Director advised that there continued to be a lack of clarity from Cwmtaf UHB in relation to the number of births that were expected to come to Cardiff. It was noted that the current figure was circa. 200 and that further conversations with Cwmtaf were being progressed. The importance of the service having a full understanding of the demands on it and the impact on planning was emphasised.

It was confirmed that:

- that the UHB's concerns in relation to the lack of clarity had been escalated to the South East Wales Regional Planning Group, Chaired by the Director General of NHS Wales.
- weekly 'exec to exec' meetings were taking place to discuss flow, patient safety and quality.
- steps to secure additional consultant cover were progressing well. Two issues related to consultant workforce t were noted as being red in the self-assessment report, which needed to be urgently addressed. The Chief Operating Officer provided a summary of the

	progress made in relation to recruitment and confirmed that the Clinical Board should be able to progress at pace. • It was important that the UHB clearly articulated as what point it would be unable to safely mange the flow of patients from Cwmtaf was noted. The Independent Member – Legal confirmed that the UHB and not just Cwmtaf was subject to public scrutiny in relation to maternity services and therefore the UHB needed to be seen to do all that it could to ensure safe services. **The Committee Resolved that:** a) the current position of the UHB against the recommendations in the report be NOTED b) an improvement plan and progress update should be provided at the September 2019 Committee meeting 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.	RW
19/06/021	**POINT OF CARE TESTING (POCT) ALERT** The Interim Executive Medical Director confirmed that: • WPOCT database continued to reveal several issues (mismatches) which prevent the flow of data into both WLIMS and WCP. It was confirmed that there had been a significant improvement in user compliance, with a reduction in incorrect use or manual entry of patient demographics. • he was confident that there were no patient safety issues but there were issues in relation to traceability of who did the POCT, when and where and these issues were in the main due to poor IT connectivity. • POCT was a process that cut across Clinical Boards and therefore the group overseeing was made up of representatives from across the UHB. The Interim Executive Medical Director confirmed that given this there was a need to make POCT a standing item on Clinical Boards Quality and Safety meetings. **The Committee Resolved that:** a) POCT should be part of the Quality and Safety review for each clinical board. b) POCT data should be clearly visible on a Business Intelligence dashboard to each clinical board and for the UHB. c) The POCT group establish a task and finish group, which reports into the POCT group (which meets quarterly), to establish solutions for the IT/governance issues d) No new POCT devices would be introduced into the UHB until these problems had been solved	

	e) An update be brought back to the December meeting of the Committee. (*it was confirmed that these resolutions would need to be ratified by the Board due to the meeting not being quorate*).	SE
19/06/22	**CLINICAL AUDIT PLAN** The Interim Executive Medical Director introduced the UHB's Clinical Audit Plan for 2019-20. It was noted: • that the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) was developed annually by Welsh Government and confirmed the list of National Audits and Outcome Reviews which all health boards and trusts were expected to participate in. • the UHB would take part in 36 national audits. • in February 2018, the Committee agreed an approach to categorise clinical audits into three tiers, to support a prudent and targeted approach, • 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. • a number of national audits were coordinated by the Patient Safety Team, but the team had no capacity to take on further work. • a number of diabetes audits had not been included in the plan; the Executive Director of Public Health confirmed that she would follow this up outside of the meeting **The Committee Resolved that:** a) the clinical audit plan for 2019-20 be APPROVED. (*it was confirmed that this would need to be ratified by the Board due to the meeting not being quorate).*	
19/06/023	**ITEMS RECEIVED FROM CLINICAL BOARDS QUALITY SAFETY AND EXPERIENCE COMMITTEE** The following minutes from Clinical Board Quality Safety and Experience Sub Committees were noted: • Clinical Diagnostics and Therapeutics – March and April 2019 • Mental Health – May 2019 • Primary, Community and Intermediate Care – May 2019 • Specialist Services – March and April 2019 • Medicine – March 2019 • Surgery – March 2019	

	• Children and Women – March 2019
19/06/024	**ANY OTHER URGENT BUSINESS** No items of urgent business were raised.
19/06/025	**DATE OF THE NEXT MEETING OF THE QUALITY AND PATIENT SAFETY COMMITTEE:** It was confirmed that the next meeting of the Committee was scheduled to place on17 September 2019 at 9am, Woodlands House, Heath, Cardiff

ACTION LOG

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

JUNE 2019 MEETING

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 19/06/13	Ophthalmology Report	A copy of the presentation to be sent to the UHB Chair		S Curry	**COMPLETED**
Actions In Progress					
QSE 19/06/007	Patient Story – Co-joined Twins	To talk to the Directorate Manager (ALAS) regarding the change to the pressure damage assessment tool		R Walker	Verbal Update for September meeting.
QSE 19/06/008	Specialist Clinical Board Assurance Report	To bring back to Committee a paper on cardiac surgery waiting times if progress was not evident by end of Calendar. As meeting not quorate to be ratified by Board in July	17.12.19	S Curry S Elsmore	On agenda for December meeting
QSE 19/06/009	Quality and Safety Improvement Framework	For the next strategy for period 2021 – 2024 to be brought to Committee in April 2020	14.04.20	C Evans	To be added to agenda 14.04.20
QSE 19/06/010	Patient Experience Framework and Improvement Indicators	Putting Things Right Annual Report to be considered at next meeting. Public Services Ombudsman outlined new powers on agenda for September meeting. The Patient Safety Walkabout to be brought to Board Development Session for discussion.	17.09.19 29.08.19	A Hughes R Walker	On agenda for September meeting. *(Item No: 1.14)* See action (QSE 18/135) To be brought to August Board Development meeting

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 19/06/011	Patient Notification Exercises: ESSURE (Issues with the Failure of the Process)	To provide a report to the Committee on Patient Notification exercises in the public health arena relating to Cardiff and Vale population.	17.12.19	F Kinghorn	To be added to agenda for December meeting.
QSE 19/06/012	Infected Blood Inquiry Update	Chair confirmed she was content with the stance that the UHB was not disagreeing or challenging the views and opinions of the patients and families involved	25.07.19	S Elsmore	Within Chair's report to the Board on 25.07.19. To continue to align with the UHBs commitment to the Blood Inquiry Charter.
QSE 19/06/13	Ophthalmology Report	A short update report including benchmarking data to be brought to Committee	17.12.19	R Walker	On agenda for December meeting.
QSE 19/06/14	Car Parking Update Report	To address issues raised by public and staff and to explore avenues for publicising the service	17.09.19	A Harris	Very proactive social media campaign has been launched for the start of the P&R to UHL.
QSE 19/06/16	Policies and Procedures for Approval	Due to the meeting not being quorate approval of the policies and procedures would be referred to Board for ratification	25.07.19	S Elsmore	Within Chair's report to the Board on 25.07.19.
QSE 19/06/17	Stroke Rehabilitation Model and Workforce	An update to be provided setting out deadlines, timeframes and further detail in relation to priorities	17.09.12	F Jenkins	On agenda for September meeting. *(Agenda item: 3.2).*
QSE 19/06/20	Cwm Taf UHB Maternity – Cardiff and Vale Lessons Learnt	Improvement plan progress update to be brought to next meeting emphasising non and partial compliance. To provide an overview of the impact in terms of patient flow to Cardiff and Vale UHB and how this is being mitigated As meeting was not quorate, the resolutions would be ratified by the Board	17.09.19 17.09.19 25.07.19	R Walker S Curry S Elsmore	On agenda for September meeting. *(Agenda item: 1.11).* Verbal update for September. Within Chair's report to the Board on 25.07.19.
QSE 19/02/10	Gosport Independent Panel Report	A report to be brought to future meeting	17.09.19	R Walker	On agenda for September meeting. *(Agenda item: 1.12).*
QSE 19/04/020	Endoscopy Decontamination –	To bring a paper to a future meeting once the new procedures have been	17.09.19	S Walker	Verbal update for September meeting.

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
	Patient Notification Exercise	embedded A paper regarding centralisation to be brought to September meeting.	17.09.19	F Jenkins	On agenda for September meeting. *(Agenda item: 3.1).*
QSE 19/02/008	PCIC Clinical Board Assurance Report	Concerning the mobile units in the Ely Hub and Splott Clinic. Would discuss issues with the Director of Planning		R Walker / A Harris	B4H consists of two areas. The segregation rooms and the general ward area. The segregation rooms are due for completion next week w/c 5th Aug. We are due to take water samples on 2nd Aug which will take 10 days for results to come through. Therefore handover of this area is scheduled for w/c 12th Aug providing results are good. The actual day of the move back in is still being discussed with all parties. (service board, Infection control, Dis Cap) General Ward area is due for completion 23rd of Aug, with occupation w/c 26th Aug.
QSE 18/135	Ombudsman Annual letter	Present update	17.09.19	R Walker	On agenda for September meeting. *(Agenda Item: 1.13).* Awaiting QSE & Board decision.
QSE 18/155	CD&T Minutes	Update on refurbishment works on the Bone Marrow Transplant Unit	17.09.19	A Harris	Matters arising for September meeting.
Actions referred to committees of the Board					
QSE 19/04/020	Endoscopy Decontamination – Patient Notification Exercise	To bring a paper to a future meeting once the new procedures have been embedded	TBC	F Jenkins	To be brought to a future meeting of the Management Executive. This will be done when the clinical board has completed this work, currently still

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
					underway.

Report Title:	**CHILDREN AND WOMEN CLINICAL BOARD ASSURANCE PAPER**								
Meeting:	**QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE**						**Meeting Date:**	**17th September 2019**	
Status:	**For Discussion**		**For Assurance**		✓	**For Approval**		**For Information**	
Lead Executive:	**Executive Nurse Director**								
Report Author (Title):	**Director of Nursing Children and Women's Clinical Board**								

SITUATION

The purpose of this report is to provide assurance to the Executive Committee that Quality, Safety and Patient Experience (QS&PE) is the driver for the shaping and delivery of services across the Clinical Board. The report will provide an overview of the patient safety and quality agenda over the preceeding 12 months and highlight the achievements, progress and planned actions of the Children and Women's Clinical Board in our aim to continually improve and develop this very important agenda.

Children & Women's Clinical Board links with all elements of the strategy but in the previous 12 months has made progress to align specifically with avoiding harm, waste and variation and delivering outcomes that matter to people.

BACKGROUND

During the financial year 2018/2019, The Children and Women's Clinical Board comprised three Clinical Directorates with associated clinical services and specialties. The Clinical Board delivers a number of highly specialised services to both the South East region and wider all Wales population and has responsibility for universal services which support the health, well-being, education, development and Public Health amongst the population of children, young people, parents, families, women and their partners. This includes partnership and safeguarding priorities. The services also provide primary and secondary care services to the local Cardiff and Vale population. The Clinical Board has a budget of £98.127m and a current workforce establishment of 1770 WTE. 58% of which are Part-Time.

Services are structured through the three Directorates detailed below:-

- Obstetrics and Gynaecology
- Acute Child Health
- Community Child Health

In addition to the above, within the last 12 months Specialist CAMHs and Cancer Services have transitioned to the Clinical Board.

Due to the high volume of activity and diversity of the services provided, risk in the Clinical Board is high and therefore there are robust risk management arrangements in place to mitigate

any risk to our service users and staff.

In summary, the Children & Women's quality, safety and patient experience aims are:-

- To ensure that there is a process in place to continually review the quality and safety risks and take action to constantly mitigate that risk.
- To maintain a culture of improving quality, safety and patient experience across all teams.
- To ensure a positive culture of staff engagement, development and the understanding of everyone's responsibility for the delivery of safe effective care.

This report provides assurance of the progress being made within the Children & Women's Clinical Board with regards to:-

- The Welsh Government Quality Delivery Plan for the NHS in Wales
- The Clinical Board's Operational Plan
- 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

ASSESSMENT

Quality, Safety and Patient Experience is the highest priority for the Children & Women's Clinical Board which has a robust and well attended quality and safety committee with strong representation from Midwifery, Medical, Nursing and Allied Health Professional staff from both within and external to the Clinical Board.

Meetings are held every month with every third meeting dedicated to Health and Safety. The Clinical Board has also established a Serious Incident meeting where any open serious incident is discussed in detail, progress with individual investigations and action plans are widely shared. This meeting also serves as an additional forum for sharing outcomes and lessons learnt and detailing how responsive actions have been embedded into clinical practice.

All of the committees detailed have terms of reference which are reviewed regularly to ensure that they continue to be fit for purpose.

Annual self-assessments against the Health and care standards continue.

The Clinical Board Risk Register is monitored at Directorate and Clinical Board level a minimum of once per month and more frequently as risks are realised or escalated. The risk register is a standing agenda item on the Directorate and Clinical Board QS&PE committee agenda.

Currently the highest risks within the Clinical Board are detailed below:-

Risk	Action to Manage or Mitigate
Expected increase in activity associated with the South Wales	Full engagement with South Wales Plan meetings and process.

Plan in Obstetrics, Paediatric and Neonates. Insufficient capacity, workforce and process to manage this activity and escalation.	Work Programme remains a high priority for C&W Clinical Board. We have increased our Midwifery workforce by 18 wte to manage the additional activity predicted. These midwives have been appointed and will soon commence in post. There are plans to establish antenatal clinics in CTMUHB for women who choose to birth at CAVUHB from October 1st 2019. The commissioning of T2 Unit facility for the Obstetric and Maternity Unit in place for Q3. There are currently no agreed plans relating to Neonates and Paediatrics.
Insufficient PICU capacity particularly over winter months. Staffed to PICU standards for 6 beds	Nursing resource is used flexibly where possible to ensure adequate staffing to meet demand. Transfer out of UHB is available if no available beds following clinical assessment where appropriate. Business Case has been approved by WHSCC to commission a 7th Bed. We have recruited to support this. Staff will commenced in post during the Autumn.
Lack of Senior Medical Cover of Obstetrics Assessment Unit	There are interviews scheduled early September to appoint an additional 4 Obstetricians to mitigate this risk. Consultant cover provided from Delivery Suite where possible
Significant increase in demand for our CAMHS service in the past 6 months has impacted on the Part 1 Performance.	A formal action plan is being developed in response to the recommendations cited in the report from the delivery unit received on the 17th July. An independent report into SCAMHS has been commissioned and the report is awaited. This will also inform the improvement plan developed.

Staying Healthy (Theme 1)

The Children and Women's Clinical Board strives to positively promote the health of our staff and the well-being of our patients.

Within Maternity Services the 'safer pregnancy campaign' has been embedded into everyday practice. This campaign promotes a healthy lifestyle for pregnant women including diet, exercise, vaccinations, awareness of fetal movements, alcohol, and the importance of attending antenatal appointments etc. There are significant positive outcomes. The clinic has an 83% attendance rate 403 women attended in 2018 with 28% following the healthy pregnancy pathway. Only 16.5% of women gained more than 10kgs of weight at 36 weeks compared to 41.5% in 2016/2017.

We also have a dedicated team of midwives and support workers known as the "Seren team" to provide and encourage breastfeeding. Our initiation rates are circa 60%.

We have established a Women's Wellbeing (FGM) service in Cardiff which is the first and setting the direction for the rest of Wales to follow.

We work closely with Public Health Wales to reduce smoking in pregnancy and increase referral to smoking cessation agencies. The table below demonstrates our progress to date:-

- % of women who smoke during pregnancy

	2016/17	2017/18
Co Monitoring	45.5%	83%
Smoking in pregnancy	13.6%	15.8%
Gave up during pregnancy	21.4%	27.9%

Healthy eating advice and education is offered within the clinic. All women receive serial scans together with an oral glucose tolerance test. A birth choices appointment is offered at 36 weeks

Future developments for 2019 include:-

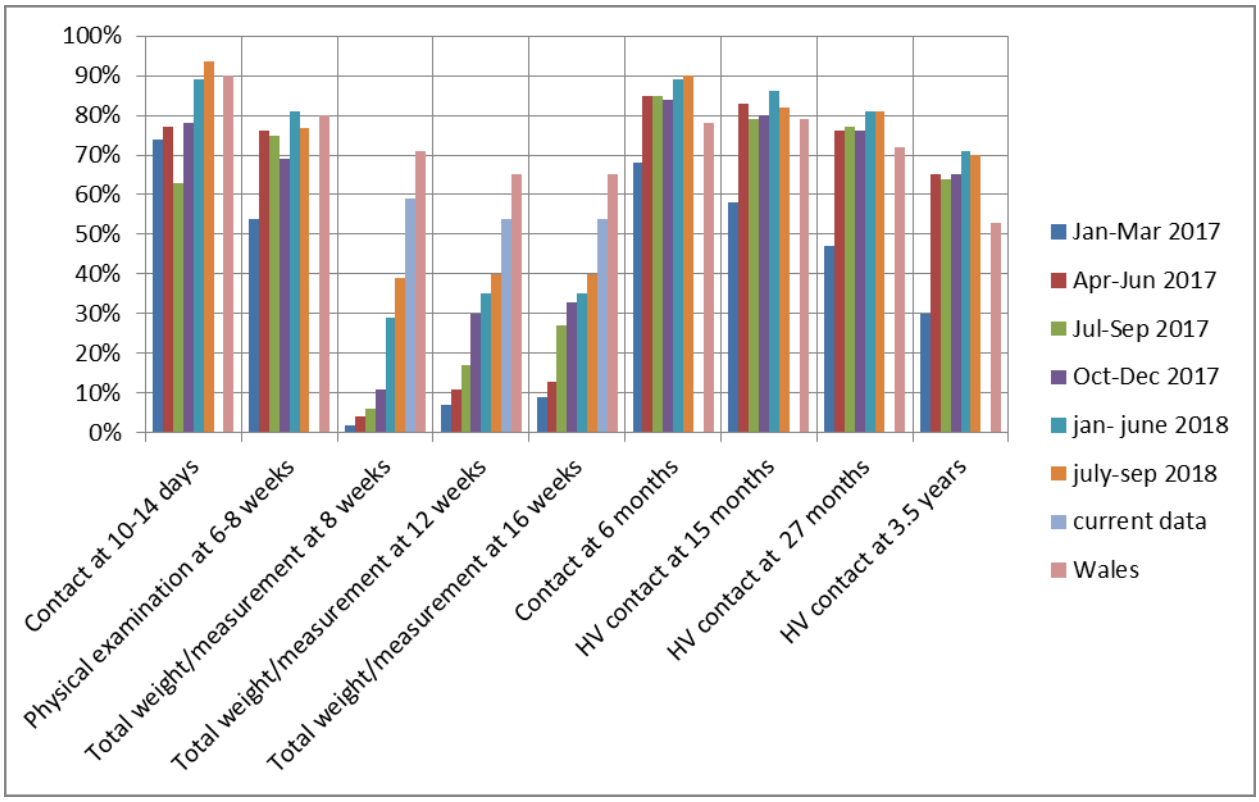
- To implement the 5 key themes from the All Wales Strategic Vision for Maternity Services in Wales
- To implement the key themes from the All Wales Breastfeeding Action Plan (as a clinical board and directorates)
- To develop a paperlite project for electronic maternity information recording
- Open T2 and accept the flow from CTMUHB
- Develop new ways of delivering antenatal education e.g. hypnobirthing, dance, yoga, virtual tours , induction of labour videos
- Implementation of physical activity sessions for pregnant women
- Audit of women with BMI 35-39.9 who start their labour (and birth) outside an OU
- Implementation of recommendations from the Your Birth We Care Survey.

For our children and young people, we held mental health awareness study days and those staff who have attended from the Children's Hospital of Wales have signed a pledge to end the stigma associated with mental health illness.

We are also currently working with Public Health Wales to promote healthy schools using transformational funding to increase prevention work and support emotional wellbeing in school.

We continue to plan implementation of the CHATHealth app.

Our health visiting service continues to promote breast feeding and we were successful in retaining our BFI stage 3 accreditation in 2018, receiving very positive feedback from reviewers
.
An area of concern for the Clinical Board has been our compliance against the 8, 12 and 16 week contacts required by the Healthy Child Wales Programme. During the spring of 2018, we recognised that our compliance was substantially lower that the rest of Wales. In response we implemented a robust pathway to ensure the contacts are completed, recorded and data inputted within the nationally agreed timeframe. Our local data (detailed below), demonstrates that our results are improving quarter on quarter. On the graph below we have included data up to an including May 2019. The national data recently published is using retrospective data from the end of 2018.



Safe Care (Theme 2)

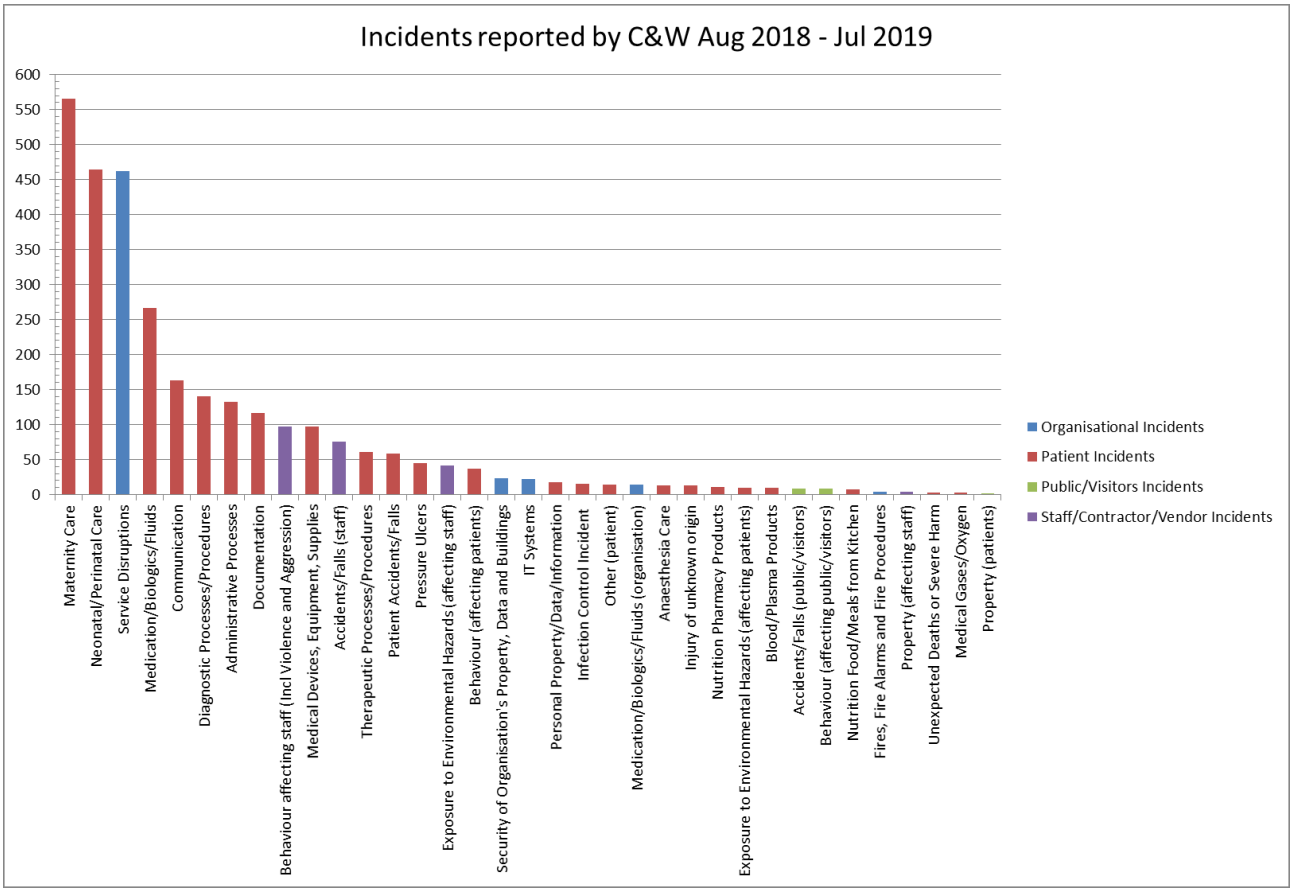
Safety Alerts

With regard to management of safety alerts, the Clinical Board has a robust management system in place for patient safety alerts working in conjunction with the Patient Safety Team. All

patient safety alerts are disseminated widely and further discussed at Directorate and Clinical Board QS&PE Meetings.

There were 3381 incidents reported via e-datix between April 2018 and May 2019. It is important to note that there continues to be a steady increase in the number of incidents reported by the Clinical Board which is indicative of a good reporting culture. Incident reporting is part of the induction process for all newly appointed staff.

The detail of Tier 1 incidents is provided below:-



As you would expect, maternity care and neonatal care are the most common reported Tier 1 codes as this is required in the respective maternity and neonatal trigger list.

The Clinical Board has reported 17 Serious Incidents to Welsh Government from 1st Aug 2018 to date of this report.

To ensure good governance regarding our reported incidents, we have robust mechanisms in place.

Safe Maternity Services

The QS&PE Committee has previously received a report which presented 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. A progress update is proved in a separate report to this September 2019 Committee.

For our Obstetric and Gynaecology Directorate we have a weekly datix meeting where we review all incidents. In addition to this, there is a fortnightly multi professional risk meeting established to review any cases which have met the agreed criteria for review. The Royal College of Obstetricians and Gynaecologists red flag trigger list is used to escalate any concerns. There are clear governance structures and monitoring processes in place via a professional governance group and Quality and Safety meetings in each Directorate.

There is a monthly stillbirth review multi professional forum to review all MBBRACE reportable losses. The maternity safer pregnancy campaign has been embedded into practice in 2018/19. During this time we have seen gains in all areas and a resulting reduction in still birth rates. In 2016, stillbirth rates for C&VUHB were 43, this reduced in 2017 to 35 and for 2018 was 11. To date this year there has been no intrapartum stillbirths. The Gap & Grow programme to identify small for gestational age babies is contributing significantly to this shift.

The Clinical Board works closely with the Maternity and Neonatal network to develop and implement evidence based care and improve the safety culture. We are also working with Welsh Risk Pool regarding PROMPT and National CTG learning opportunities.

To support the above, there are well attended monthly medicines management meetings, chaired by the Clinical Board Pharmacist.

Within the Clinical Board we have seen the number of RIDDORS reduce as detailed in the table below.

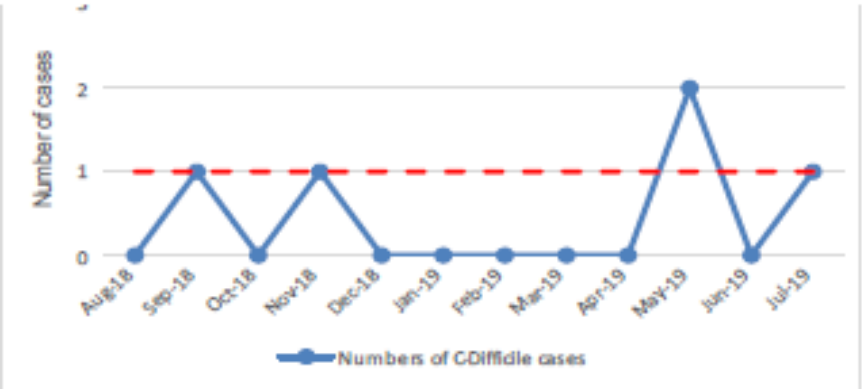
RIDDORs (date of incident)

Staff Riddors	15/16	16/17	17/18	18/19	19/20 to date
Acute Child Health	4	1	2	1	0
Community Child Health	0	3	0	0	0
Obs & Gynae	1	2	2	2	1
Total	5	6	4	3	1

Infection, prevention and control

In 2018 the Clinical Board has made improvements regarding health care acquired infections (HCAI) when compared to the same period last year. We have worked closely with our colleagues in microbiology and in partnership with our Infection, Prevention and Control colleagues to ensure any incidence generates an RCA investigation which is completed in a timely manner and outcomes/lessons learnt are shared at Directorate and Clinical Board QS&PE committee.

2018-2019 saw zero incidence of MRSA. All hand hygiene and BBE scores are consistently above 95%. The table below details our *Clostridium Difficule* incidence from August 2018.



We have however seen a slight increase in HCAI in May. A period of increased incidence meeting was held with all members of the multi-disciplinary team, no clear causation was identified, incidence then decreased. We continue to monitor closely.

Paediatric Surgery

In July 2017, a clinical record review was undertaken by the Royal College of Surgeons (RCS) related to paediatric surgery at Cardiff and Vale UHB. This was published in October 2017. 11 recommendations were made and a comprehensive improvement plan was developed to address those recommendations. The RCS was provided with an update to address those recommendations.

In March 2018, the RCS confirmed in writing that they were satisfied and assured. This matter was reported in full to the September 2018 Health Board meeting.

In addition to the improvements detailed, further actions have been implemented:-

- Agreement to increase number of consultant paediatric surgeons to 7 (5 substantive and 2 locum).
- Streamlining the service into specialities i.e. Urology and Upper GI and Lower GI.
- Fully recruited to the trainee rota
- Regular established M&M meetings led by one of the consultant paediatric surgeons.
- Development of the children's acute theatre.
- Review of job plans to allow sufficient time and flexibility to support enhanced MDT working to improve links with other specialities such as neonates and gastroenterology.

Future wider developments for the safe care standard Include:-

- To embed recently developed delayed walking pathway.
- Embed newly developed pathway for healthcare for home educated children.
- Review effectiveness of pharmacy support in influencing medicine reconciliation and the impact on medication errors.
- To deliver the CAMHs improvement plan underpinning the route to service transformation.

<u>Effective Care</u> theme 3

The Clinical Board has a substantial audit plan in place across all 3 Directorates. The results

from these audits are shared at Directorate and Clinical Board Quality, Safety and Patient Experience Committee.

There are a number of Tier 1 and Tier 2 audits as well as local audits in progress across the Clinical Board.

In 2018, Community Child Health attended LIPS to investigate audit projects including oral health pathway, joint assessment and medication monitoring for children with ADHD.

In addition, the Clinical Board continues to have a healthy portfolio of open research studies.

The 'Spotlight of Maternity Services' safety improvement plan was implemented in 2018 to monitor maternity services and identify improvements through audit. We are currently advertising for a research midwife.

Within Obstetrics and Gynaecology, we have Consultant Midwives who are currently undertaking research as part of their professional portfolio. The Clinical Board can also demonstrate evidence of research into practice such as BUMPEs, Obs Cymru and Pool study.

The NACHfW currently have 33 research studies either open or in set up. We have recently seen an increase in the number of commercial studies including OASIS which is a study for children and young adults suffering from chronic migraines. The Clinical Board are also assisting other Clinical Boards such as Medicine by supporting studies by Paeds ED and Dermatology.

Our Clinical Board Director is Chief Investigator for a global cancer study. Also, one of our Paediatric Neurologists has been asked to be the Chief Investigator for a global commercial study. This is a major achievement for the CHfW. This increases our neurology studies to 6. We are also closely collaborating with Cardiff University's CUBRIC to design and set up a study for children with absence epilepsy.

We are also involved in two major global initiatives which are trying to progress the landscape of Paediatric research. One is in partnership with the EFGCP Children's Medicines Working Party and is looking at the inclusion of adolescent's in adult clinical trials to try and ensure earlier access to new medicines for this population. The second is the newly launched 'Promoting Global Clinical Research In Children' and we are collaborating with partners at the Multi Regional Clinical Trials Centre at the Brigham and Women's Hospital, Harvard University.

Dignified Care – theme 4

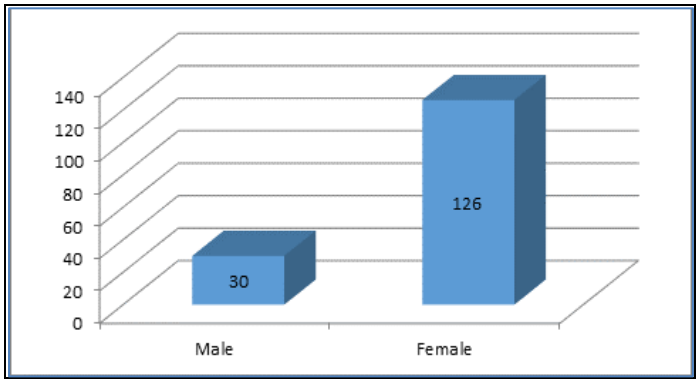
Paediatrics:-

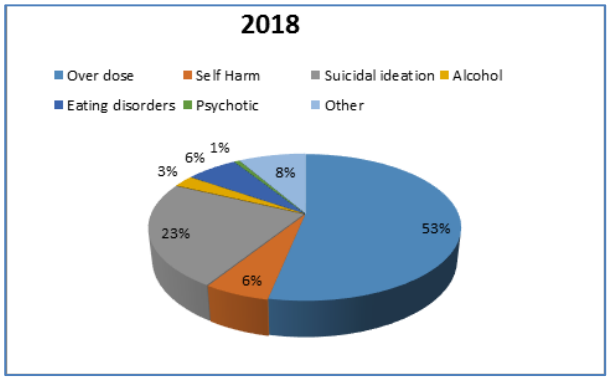
Within the Clinical Board we have developed the Children's and Young person's Charter demonstrating our commitment to the Childs Right's approach based on the principles of the UNCRC.

Copies of the charter are displayed above each bed space at the NACHFW and in each outpatient clinic. We are in the process of delivering awareness raising sessions in conjunction with representatives from UNICEF.

In 2018, the CHFW saw a marked increase in the number of children admitted in crisis with mental health.

The tables below shows the stark difference between the numbers of girls admitted versus boys and the reasons for admission in 2018.





Future developments to support this vulnerable group include:-

- Development of MH competencies for nursing staff
- To embed risk assessment tools into practice
- To liaise with youth worker to support the service user
- To work closely with CAVHYB (Cardiff and Vale Health Youth Board).
- Develop a team of HCSW with skills to support the Children and Young people during their inpatient stay.
- To scope “safe space” with current footprint of CHFW.

Obstetrics

Within obstetrics, a part time bereavement midwife became full time to support the launch of a “Rainbow Baby” clinic for next pregnancy following a loss.

The Clinical Board have also opened a 2nd bereavement room on the obstetric unit for women who are undergoing medical termination of pregnancy or for those women who post birth require further monitoring and are unable to use the bereavement suite. A ‘memory making’ area and dignity room have also been developed.

Dignity/essential care inspections

Within the preceding 12 months the Clinical Board has received a number of internal peer review inspections as well as several inspections from the Community Health Council (CHC). Unannounced CHC inspections are providing feedback that there are no significant concerns to note and that patients are receiving compassionate, individualised and dignified care.

Timely Care:- theme 5

The Clinical Board have had a successful 2019 to date with waiting times consistently being under the 36 week waiting target.

The challenges have come from significant theatre staff shortages and we have managed these with minimal patient cancellations using the flexibility of our service. We are actively profiling our waiting times with a view to reducing our routine waiting times to 32 weeks by the end of the current financial year.

Medical staffing shortages up to August 2019 resulted in an increase of routine outpatient waits, however this is currently being reduced by additional medical staff being in post and utilising those staff for additional activity. The Clinical Board expects to see a significant improvement in the outpatient waiting time in the next 2-3 months. We have not had any 52 week wait patients in the last 24 months.

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Within Obstetrics and Gynaecology, we remain compliant with all cancer targets and these rarely provide cause for concern.

We achieved all diagnostic and therapy targets and continue to meet the demand needed for the service.

A pathway has been developed and piloted within our emergency gynaecology service to provide timely care for women who require urgent treatment for the management of a miscarriage. The new pathway reduces delays for these women, reduces the need to use our elective theatres for his type of treatment and utilises the CEPOD theatre at the beginning of each day. This has been achieved by cross directorate working with the Surgical Clinical Board.

Within CAMHS we have an improvement trajectory which will be presented to Board under separate cover.

Paediatric diagnostics have improved significantly since the previous financial year. Cystoscopy and Bronchoscopy diagnostic tests are currently provided within target. Endoscopic diagnostic testing had breaching patients at the beginning of 2019 and this was reduced to 1 patient by the new financial year by running extra lists each month. A business case has been completed which plans to increase list capacity to reflect the current demand and meet the waiting time target.

Individual Care:-theme 6

Within the Clinical Board, we continue to use the age appropriate questionnaires. For the forthcoming 12 months we intend to work closely with our newly recruited Youth Board to support us with gathering meaningful feedback on the services we provide.

We continue to use the “happy or not “machines as a method of establishing real time feedback of our Children’s Services. 86% of service users were extremely happy with the care provided to them.

We also have children specific information boards in each clinical area encouraging our service users to provide feedback on our services.

Maternity services also undertake ‘2 minutes of your time questionnaires’ for women when leaving the service. A ‘You Said We Did’ feedback mechanism is in place and shared ‘hot boards’ in all areas. Women’s stories are shared via mandatory learning led by the women’s experience midwife who is the main point of contact for concerns and compliments. An active

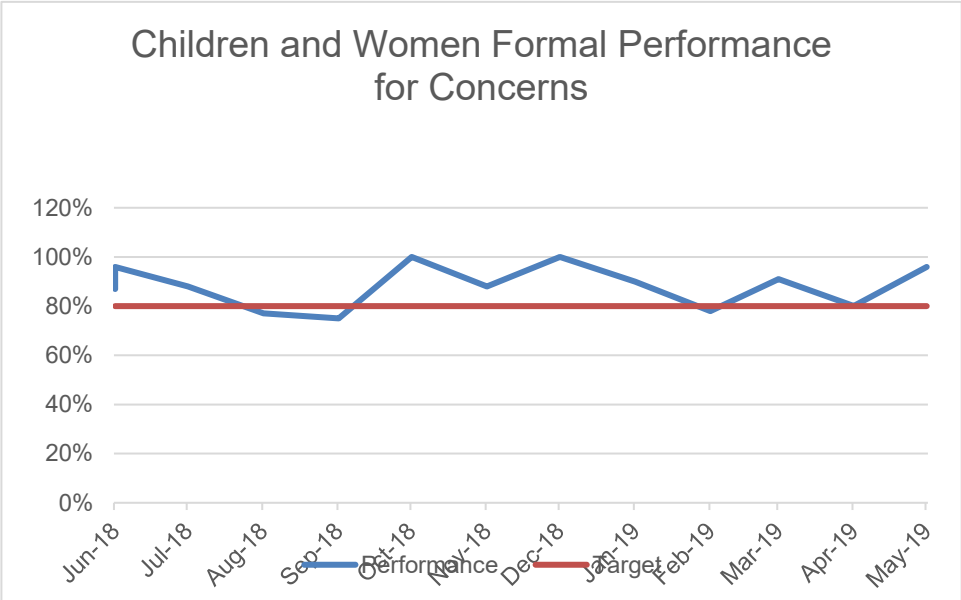
maternity services liaison committee is embedded within maternity services. The committee meets quarterly but also has a 'Parent Voices' Facebook group which is used for sharing parent education class details, guideline development and listening to feedback from women. Virtual tours of the unit are available for all areas. Birth Choice and Birth Afterthoughts clinics are in place for women making choices outside of evidence based recommendations and for women who may need a 'de-brief' following their birth.

The Clinical Board are currently trialing virtual reality to support women's experience. We are working with the maternity services liaison committee and colleagues from Orchard / Rescape to develop bespoke package for maternity such as a virtual tour of the environment, induction of labour educational video, relaxation and distraction for women in early labour using virtual reality. We would also like to develop a virtual reality package for women who have experienced traumatic birth to support them coming back into the intrapartum areas for next birth in a relaxed, facilitated environment.

Concerns/compliments

The Clinical Board continues to receive a significant amount of compliments for the care received.

The management of concerns remains a key priority for the Clinical Board. The Clinical Board holds weekly tracker meeting with the concerns team which allows interrogation of the database and ensures responses are issued within agreed targets. The table below demonstrates our performance against the 30 day target for formal responses.



Staff and Resources:-

Finance:

- The financial position at the end of month 4 (July 2019) is £0.534m deficit.
- The Clinical Board savings target is £1.776 m

- Progress against this target is:

£0.966m green identified 54%

£0.810m amber identified 46%

£0.000m shortfall against target

Children & Women Clinical Board Workforce Summary Report July 2019 Data

Staffing

Key Performance Indicator	Monthly Actual (July 2019)	Comparison with Previous Month (June 2019)	Comparison with Previous Year (July 2019)	2019-20 target
Vacancy Rate (WTE)	3.20%	3.39%	4.49%	5.00%
Turnover Rate (WTE)	9.50%	9.71%	N/A	7.00%
Sickness Absence Rate	4.43% (June 19)	4.62% (May 2019)	4.32% (June 18)	4.18%
PADR Rate	57%	55%	64%	85.00%
Statutory and Mandatory Training Rate	67%	69%	80%	85.00%
Medical Appraisal	74%	72%	N/A	85.00%

Nurse Staffing Act

The Nurse Staffing Levels (Wales) Act 2016 became law in March 2016 and requires health service bodies to have regard for the provision of appropriate nurse staffing levels, and to ensure that they are providing sufficient nurses to allow the nurses' time to care for patients sensitively. The Clinical Board are required to ensure that staffing is aligned and compliant with the requirements of the Safer Staffing Act (2016) for inpatient gynaecology, the same approach is required for Birth-rate Plus compliance for Maternity Services.

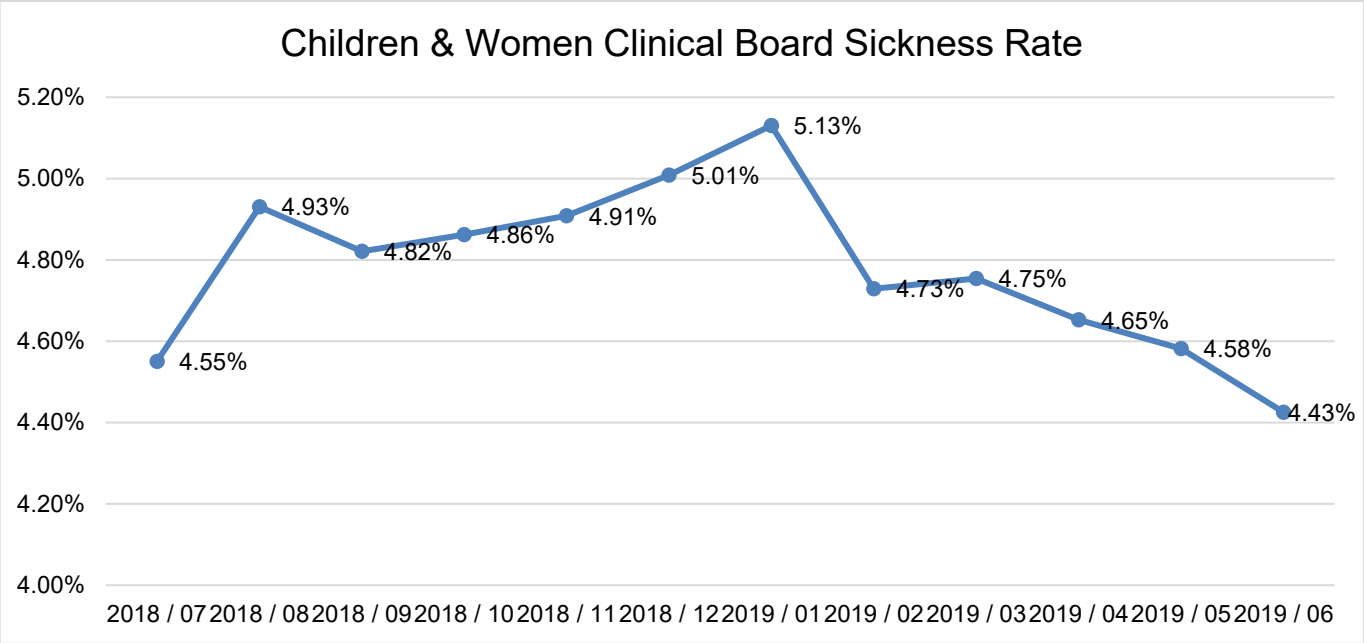
Within Paediatrics ensure we are compliant with British Association of Perinatal Medicine standards for neonates and continue to pilot paediatric inpatient acuity tool to inform further establishment

We review our establishments 6 monthly in line with UHB principles or more frequently if there are service changes.

Sickness absence

Since the beginning of 2019 good process has been made to reduce the Clinical Board's overall sickness rates.

The rate for June 2019 was 4.43%.



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

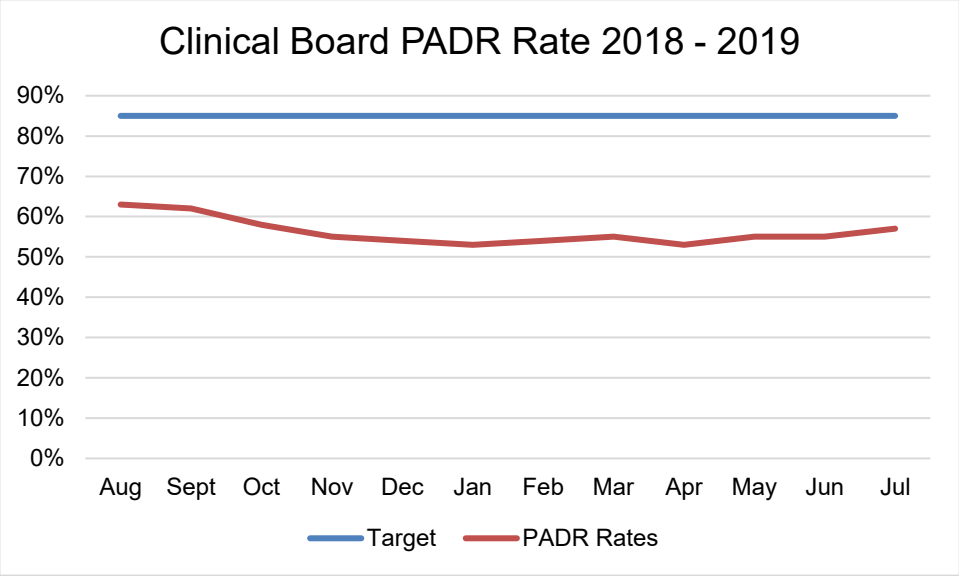
- Support for managers with both short and long term absence.
- Bespoke training by the Workforce & OD Team.
- Sickness absence surgeries with line managers, to discuss individual cases.
- Audit programme, focussing on hot spot areas to check.
- Health & wellbeing promotion via sickness surgeries and 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 64% to 57% 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.

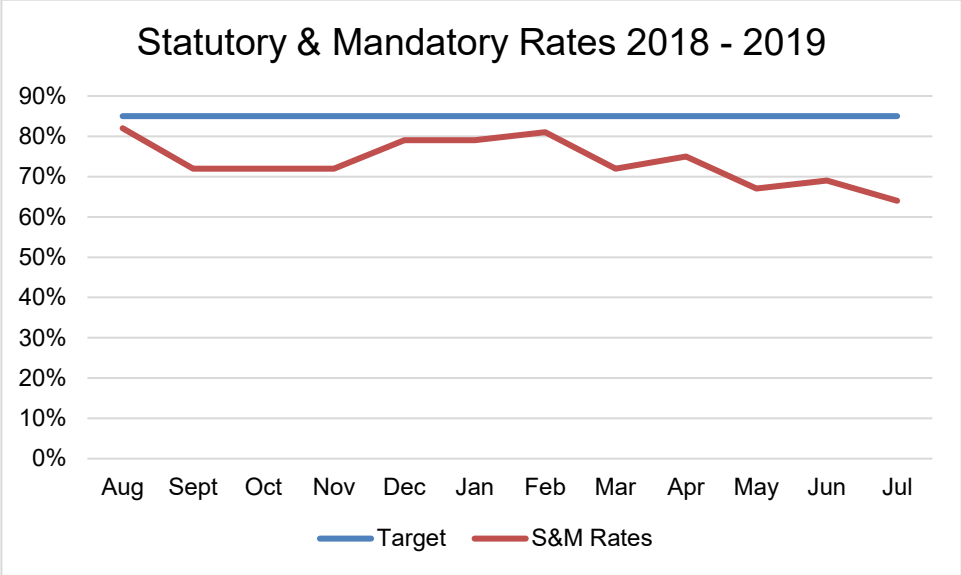


Statutory & Mandatory Training

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 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.



Retention of staff

The preparation for practice Programme in midwifery has been overwhelmingly positive in its approach to supporting newly qualified midwives through their preceptorship year and transition from student to becoming a newly qualified midwife

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

- Winners in the RCN Nurse of the Year Award for Suzanne Goodhall Paediatric Nursing Award (Kath Azzopardi and Sandra Hall Clinical Nurse Specialists)
- Shortlisted in 5 categories at 2018 RCM national awards
- RCN Nurse of the Year Winner 2018 in the education category – Nerys Kirtley for the prep for practice programme
- 2 winners for midwifery wales and west festival – manager of the year and student of the year (who had just joined us as NQM)
- Numerous national and international conference presentations and posters.
- paper accepted at the GAP / GROW symposium in Berlin this October)
- Queen's Award for Nursing 2019 for Community Child Health.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The governance processes embedded in the core business of the Children and Women's Clinical Board and its Directorates
- Evidence of regular performance management reporting
- Temperature gauge activities such as peer reviews, local audits, Clinical Board walkabouts, benchmarking, unannounced inspections, acuity audits, healthcare standards, and patient experience questionnaires
- 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	✓	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.

Number	Recommendation	C&VUHB Current Position	Improvement Plan
1	Health boards and service providers must ensure environments protect the safety and wellbeing of young people. There must be robust systems in place to monitor risks within the environment and ensure maintenance work is conducted in a timely way.	Noah's Ark Children's Hospital, based on the site of the University Hospital of Wales in Cardiff provides health care for children and tertiary services for children across Wales. The service is based within Cardiff and Vale University Health Board. In additon community provision is based at St.Davids Hospital. this is currently being refurbished.With regard to Community outpatient facilities, risk of deliberate harm has been assessed and considered to be low.Cardiff and Vale UHB does not have a suitable environment for those children admitted due to a mental health condition. Whilst considerable work has been undertaken to improve care standards the environment is not ideal.	Cardiff and Vale UHB are currently exploring creation of a "Safe Haven" with CHFW.
2	Health boards and service providers must ensure there is clear communication with young people to help them understand their treatment.	Through engagement work we have identified how information on care and treatment is shared with young people and their parents. There will be work undertaken collaboratively with young people and parents to improve this and ensure that it meets their needs.	This is a priority. There will be a programme of work undertaken collaboratively with young people and the newly recruited CAVYB to ensure that it meets their needs..
3	Welsh Government, health boards and service providers need to improve the communication with, and information available for, young people and their families at the point of referral.	Identified as a priority for the engagement work with young people and parents.	To be actioned and developed collaboratively over the coming months. Particular work needs to focus on what the service can provide and inparticular to feedback when referral was not accepted and signpost to more appropriate services.
4	Welsh Government needs to consider the capacity within CAMHS services across Wales to ensure this meets the needs of young people, including those who are high risk.	Within CAVUHB, an internal review has been commissioned to review current demand and capacity. We await the final report. This will dovetail with the Delivery Units review of Primary Care CAMHS in C&V UHB (report received 17th July).	A formal improvement trajectory is in the process of being developed in response to the recommendations and findings. We will further develop our single point of access and our ability to provide consultation advice. We will review pathway to specialist CAMHS. This be will shared with Executive Board imminently.
5	Welsh Government and health boards need to review the waiting times for CAMHS services, ensure there are timely referrals to other organisations to support young people and how young people can access support at times of crisis.	Capacity and vacancies are currently affecting service waiting times. Vacancies are being recruited to and capacity will be reviewed with the drive of improving waiting times. The Single Point of Access has improved the referral process both internally to the service and for onward referrals. Continued work is underway to improve the functioning of the SPoA including the proposed developed of a clinical duty team function within the SPoA.	The UHB will continue to actively recruit to our vacancies and look at developing robust retention strategies. We are engaging with Universities to look at developing our own staff .
6	Health boards and service providers must ensure there is clear information for young people on advocacy services and flexibility to enable young people to meet with advocacy services at a time of their choice.	This recommendation relates more to inpatient care. However as a prvoder of community services the UHB should also have an awareness of what advocacy services are available for young people and ensure information is available on this. . The are leaflets and information regarding advocacy services on each ward with the CHFW and also at our outpatient clinics. We have developed a young person's charter advocating children's rights and succesfully recruited to our Youth Board who are currently undertaking a UHB approved induction program. we currently use MEIC.	Links to be made and information to be made available accordingly.
7	Health boards and services providers must ensure young people know how to raise a concern	This was escalated as a concern at our least HIW inspection into the CHFW. Each clinical area now has a child friendly information board detailing how to raise a concern. The Children and Women's Clinical Board have developed age appropriate feedback forms and this translated into "you said, we did" information feedback which is widely availalbe.	Further work is planned with our newly established youth board to support engagement with our service users to gather meaningful feedback .
8	Health boards and service providers must ensure that: Patient records, care planning and statutory mental health documentation are comprehensive, accurate and completed in a timely manner. Emergency clinical items, including ligature cutters can be located without delay. Staff have sufficient knowledge on how to support and monitor patients before, during and after mealtimes. Any restraint must be carefully considered, risk assessed and monitored, with the involvement of the young person to ensure their safety, rights and dignity are protected as much as possible	This relates more to inpatient care. Staff are completing the PMVA training for mental health community settings and will continue to do so as part of MAST. SBAR submitted for development of comprehensive electronic patient record as currently utilising paper records. We regularly have inspections of our documentation and patient records. In addition there are routine observations of care audits which are undertaken by senior staff independent of the clinical area. Results are fed back to the Director of Nursing and improvement plans are developed. Within Acute Child Health we are currently exploring where ligature cuffs can be safely stored for access 24/7.	Whilst we recognise this recommendation was aimed predominently at inpatient areas, ligature cutters have been ordered for each of our clinical areas and are stored on the Resuscitation trolley to ensure consistency of approach.
9	Health boards and service providers must ensure CAMHS staff have up-to-date safeguarding training.	Safeguarding supervision has been implemented across the team to support the management of safeguarding within the service and is accessed within the HB Multi Agency Support Team programme. The appointment of a Senior Nurse to the CAMHs service and recruitment to a recently advertised governance lead will support the development we have an up to date safeguarding training record.	To continue to demonstrate compliance.
10	Welsh Government, health boards and service providers must consider how issues around workforce within CAMHS units can be addressed to ensure young people receive care from the right staff with the rights skills to meet their needs.	Following initial choice appointment, young people are matched with practitioners for core work that best meets their needs. Skills mapping of service staff to be completed and clear training needs analysis and plan to be developed. We are currently advertising and working with out comms team to look at innovative ways of filling the high number of infilled vacancies we inherited post repatriation.	To continue to actively recruit to our vacancies and look at developing robust retention strategies. Engage with Universities to look at developing our own staff .
11	Health boards must ensure that children and young people can consistently be treated within designated areas.	Within the Emergency Department we have a designated Paediatric area. In C&V we have the Children's Hospital for Wales.	The UHB needs to review the designated bed arrangements as per item 36/37 below. Within the CHFW we have designated areas for children and young people to be treated. However there is increasing evidence to support the scoping of a dedicated Young persons unit.
12	Health boards must ensure young people consistently receive timely care and treatment within emergency departments and for emergency invasive procedures.	With Emergency Dept - 4hr performance for treatment is consistently above 95%. For invasive procedure we now have a Children's Acute Theatre (in place since August 2018) provided service 5 days per week. Currently have a business case to extend service further.	A Business case is being developed to to extend this further. The Pilot has demonstrated many positive outcomes to include reduction of any delays and Children receiving the right care in the right place.
13	Health boards must ensure that young people know how they can raise concerns about their care within hospitals.	Posters and leaflets are available throughout core services raising awareness and encouraging feedback.	
14	Health boards must ensure that paediatric risk and pain assessment documentation is comprehensive and completed in a timely manner.	Paediatric pain charts are included in our paediatric assessment booklet. We have robust risk assessment documentation which was evidenced during the HIW inspection.	A bid is currently being submitted to appoint a Paediatric CNS for Pain Control.
15	Health boards must ensure that staff working who may work with children and young people have up-to-date safeguarding training.	In the HIW initial inspection of Noah's Ark CHfW, HIW found there were appropriate arrangements for safeguarding children, and as such, did not identify improvements needed for follow up in 2017.	No further action required.
16	Health boards must ensure there are sufficient numbers of staff with the right skills to meet the needs of children and young people	The Clinical Board is piloting the Paediatric acuity tool, the results of which will be presented in October 2019. The Clinical Board is able to succesfully recruit to nursing vacancies and has positive retention rates. Establishments are in line with RCN recommended Paediatric Standards and we are BaPM compliant. As per item 4 and item 10. Currently participating in paediatric acuity audit to support staffing requirement. However we are able to recruit successfully to our agreed establishment for the CHFW. this has continued for 2019 for Paediaitric Nurses. With the increase of children with Mental health conditions to paediatric wards with the increased complexity of those cases, staff on the unit are being given opportunities to expand knowledge and skills within this often challenging area of nursing. we provide in hgouse training days where skills and knowledge are shared to care for these young people along with links with third sector services sharing knowledge and skills to help staff support those admitted in crisis whilst awaitinf CAMHSassesssment.	Since repatriation of CAMHS a significant number of vacancies which has been inherited and the UHB is actively trying to recruit in to these.
17	Service providers must ensure they have comprehensive and up-to-date environmental risk assessments and address any actions highlighted.	Environmental risk assessments have been undertaken in each of the clinical areas in conjunction with the CNS for CAMHS.	
18	Service providers must ensure there are arrangements to support communication needs of children, young people and their families, including facilities to support people who use hearing aids	This relates to hospice care, however arrangements and protocol to be developed for CAMHS. Hearing loop in place throughout CHFW and outpatients service.	N/A
19	Welsh Government needs to assess any unmet demand for palliative care services to ensure children and young people across Wales get the care they need.	Again this recommendation is not relevant to C&V.	

20	Service providers need to be mindful of how they ensure young people and their families are made aware of how to raise a concern about their care	Please see response to recommendation 8	
21	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	Community Child Health have developed Transition protocols. Whilst it is acknowledged we have improved greatly regarding our transition processes particularly in specialised areas such as Renal, Diabetes and Cardiac, there is still work to do regarding our more complex patients.	To work with partners and members of the MDT to deliver improvements as detailed. A member of the Senior Nursing team has been identified to lead this work.
22	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	as above	
23	Welsh Government and health boards must ensure there are sufficient resources and capacity to support effective and timely transition.	as above	
24	Health boards must ensure a named key worker to coordinate transition is identified promptly and consider how to best support transition, including considering designated roles.	as above	
25	Health boards must ensure they have a formal systems for involving young people in the design and delivery of transition processes and learn from their experiences.	C&V UHB, will ask our newly created Youth Board to work with our service users to ensure the voice of our young people is heard . We also have access to a youth worker who works closely with services.	Identify a range of methods to engage with and ensure that the voices of younger people are heard and are used to co-design services for the future.
26	Health boards must ensure young people are involved in the planning and transition process and are provided with adequate support to enable them to adjust.	As advised by the Children's Commisioner, C&V UHB have adopted a children's rights approach.	Identify opportunities to engage further and develop this approach.
27	Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible.	Transition planning starts at the age of 14. Within CAMHS this is not until the service users 17th Birthday	
28	Health boards need review the practices where transition starts later, particularly for services where this starts after the age of 16 and align with national guidelines.		The UHB will work with our CAMHs service leads to review this.
29	Welsh Government and health boards need to ensure there are appropriate transition pathways and support for young people with complex health needs and life-limiting conditions.	This is an area that we recognise needs futher review and focus.	
30	Health boards must ensure there are consistent and robust systems identify young people who will need to transition and support for attending appointments in adult services.	as already mentioned	
31	Health boards must ensure that adult services make every effort to engage with young people and communicate with other involved agencies, to ensure they can successfully transition.	as already mentioned	
32	Welsh Government and health boards need to review the differences between service models and thresholds between child and adult healthcare services and consider how young people can continue to receive holistic care and support into adulthood.	as already mentioned	
33	Health boards must ensure that parents and carers are sufficiently involved in transition planning.	as already mentioned	
34	Health boards must ensure there is clarity across services about how all young people aged 16 and 17 should be appropriately treated, including how they will ensure staff have the right skills to care for them.	C&V UHB provide in-patient care to this group of young people within adult beds. A robust risk assessment is undertaken and where possible the individual is cared for in a single room and Paediaitrc nursing staff are avialble to support with care when required. If the young person is under the care of a Paeditrician then care will continue to be provided in the CHFW.	
35	Welsh Government needs to ensure there is clear guidance about how young people under 18 years of age, should be treated when needing care for physical health needs.	This recommendation is for WG	
36	Welsh Government and health boards must review the practice and frequency of placing young people on non-designated adult mental health wards.	This recommendation is for WG	
37	Welsh Government needs to consider the reporting and monitoring of underage admissions on adult (non-mental health) hospital wards to ensure there is oversight on this issue across Wales.	This recommendation is for WG	

REPORT TITLE:	**Cardiff & Vale UHB Response to the HIW Thematic Review of how Healthcare Services are meeting the needs of Young People in Wales**								
MEETING:	**Quality, Safety and Patient Experience Committee.**						**MEETING DATE:**	**17th September 2019**	
STATUS:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**		
LEAD EXECUTIVE:	**Executive Nurse Director**								
REPORT AUTHOR (TITLE):	**Director of Nursing, Children & Women's Clinical Board**								

PURPOSE OF REPORT:

SITUATION:
The purpose of this report is to provide a Cardiff & Vale UHB response to the Thematic Review undertaken by Health Inspectorate Wales 2018 into how heathcare services in Wales are meeting the needs of young people

REPORT:

BACKGROUND:
In 2018, Healthcare Inspectorate Wales (HIW) committed to undertaking a review of how healthcare services are meeting the needs of young people, including those who need to transition from child to adult services.

In conducting the review, HIW looked back across its inspections over the previous two years relating to children and young people, including in-patient Child and Adolescent Mental Health Services (CAMHS), treatment for physical health conditions in hospitals and care within children's hospices. A range of legislation, strategy, standards, guidance and reviews were also taken into consideration.

The intention of the report is stipulated as producing key themes, issues and highlighting good practice in relation to youth healthcare services.

ASSESSMENT:
The report was published in March 2019, and identified 37 recommendations which Health Boards were initially asked to review and provide comments for accuracy. This was an All Wales review and as such not all of the recommendations made, were relevant to Cardiff and Vale UHB.

Subsequent to this, a specific review into Primary Care CAMHS provision at C&V UHB has been undertaken by the Welsh Government Delivery Unit. In addition the UHB has commissioned an independent external review of its specialist CAMHS service. The report is awaited. Once received the recommendations and associated improvement trajectory actions will be presented

to the Executive Board separately.

Our assessment against the recommendations is detailed in the table attached as Appendix 1.

RECOMMENDATION:

The Committee is asked to note the position outlined within the report in Appendix 1.

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement		

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

Independent Review of Maternity Services at Cwm Taf Health Board – Assurance Framework template

Health Board: Cardiff and Vale University Health Board

Date of Completion: FINAL Version 13 30/08/2019

Terms of Reference from review	Recommendations	Where we are (August 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 MainDashboard - 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 Anonomised 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. Update July – vacancy with corporate scrutiny panel. Awaiting decision to approve There is current fragility and duplication of effort for midwives with data entry due to flow changes from CTMUHB. Flow assumptions of 700 additional women are to be expected from 1st October 2019. C&V are working to identify an urgent IT solution suitable for both UHBs 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 C&V are working with the maternal and neonatal network to ensure that national standards identified within new Vision for Maternity Services in Wales are adhered to	

		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 7.2 Anaes Induction program February 19.docx 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	Continue projects to ensure all guidelines updated and then remain up to date.	

		Work ongoing by Senior Midwife Manager for Inpatient Services to address updates 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. 7.3 ANAESTHETIC QUALITY AND SAFETY Minutes 12 Feb 2019.docx	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 **UPDATE 30.8.19** Since submission to WG of the Assurance Framework in June 2019, meetings have been held with the O&G Audit leads to ensure systems are strengthened. From September 2019, audit sessions will be minuted with formal action logs. Presentations will be made available via the Directorate Admin support team to disseminate learning throughout the Direcotrate and Clinical Board. Learning from Audit sessions will be shared at Directorate and Clinical Board Quality and Safety committees. Discussions are underway with anaesthetic and neonatal colleagues to promote multidisciplinary audit Scoping underway to explore the development of a Clinical Board Governance Day to celebrate success and share learning.	
	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	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. Update July – PADR for O&G now 58%. Plans in place and staff given updated reports to increase compliance July 2019.	

		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		
	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 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	To consider the development of a tool for use at the beginning and end of in house CTG study days to test immediate learning. 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. Awaiting formal feedback from Welsh Risk Pool 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.. (Update August 2019 – installation delayed due	

		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.	to the procurement of a new server. Installation hopefully to be complete October 2019.)	
	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 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.	There is a formal programme of minimum requirements for all locum posts. Long-term locum posts will have an induction programme that spans the first week of employment. Short-term locums will be assessed against minimum requirements and have orientation with the on-call Consultant	
	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 OandG QandS 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 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	Planned relaunch of Freedom to Speak Up summer 2019	

		• 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 amended to include and append the RCOG Guidance "Responsibility of Consultant On Call", ratified at MPF 3/6/19, ratified at Q&S 7/6/19 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 • Conducted in an open and transparent way • Held at a time and place to allow for maximum attendance	Fortnightly Clinical Risk Meetings, open to all already operating. Scheduled to fit in with trainee teaching times. 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	Clinical Risk minutes to be made available as PDF on maternity drive accessible to all maternity staff.	

		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: • Governance meetings • Audit meetings • Perinatal mortality meetings	Maternity Professional Forum 7.2 MPF Agenda and Minutes 2019 Risk Professional Governance 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.	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, 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. (TOR for Perinatal Guideline Meeting and Maternity Professional Forum Ratified 3/6/19 and 7/6/19). **UPDATE 30.8.19** From September 2019 clinical audit meetings will be O&G combined. Consultant meetings have been re-arranged to reflect these changes and enable all key staff to attend.	

	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 **UPDATE 30.8.19** 2 midwives are participating in the RCM clinical leadership programme. Their identified project is to develop formal debrief for staff working with multi professional anaesthetic, neonatal and obstetric colleagues Midwife from Norway coming to C&V for two weeks in Sept / Oct as part of the UHB wide TALK programme to support implementation	
	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 for the trainees are invited on a regular basis 7.14 Obs Gynae Consultant's Agenda 12 Feb 19.doc Quarterly obstetric anaesthetists meetings. 7.3 ANAESTHETIC QUALITY AND SAFETY Minutes 12 Feb 2019.docx	Formal joint meetings with anaesthetics / paediatrics not currently in place. The Clinical Board are currently reviewing structures with potential the Neonatal Directorate will align with O&G. Appointment of 4 additional consultant obstetric posts in progress. Once work completed, joint meetings will be planned. Plans to commence Jan / Feb 2020 **UPDATE 30.8.19** A Programme Board is being developed to explore the neonatal service aligning more closely with the O&G directorate. Terms of reference are to be agreed at the first meeting in September. This work will promote close working with obstetric medical colleagues and the facilitation of joint 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	

			August 2019 - Regional flow assumptions updated July 2019 with confirmation of additional 580 women to flow to C&VUHB. Regional meetings continue and recruitment of necessary staff in place. Plans to start 1.10.19. Plans to develop obstetric clinics at RGH underway	
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. There is a weekly Concerns meeting led by the Executive Nurse Director and	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.	

		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. 7.10 Clinical risk	Strengthen the availability of training for all new staff and for bank and agency staff.	

		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 OandG QandS 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 Director has reminded consultants that it is their responsibility to raise any SI's related to their practice at their appraisal. This practice is led by individual appraisers	
	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 publish 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 OandG QandS 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 Band 7 Research midwife out to advert as at 6th August 2019 **UPDATE 30.8.19** Research midwife interviews are being held on 24th September 2019.	
	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 • Neonatal infection • Baby Friendly accreditation • Bliss Baby Charter accreditation	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 • Lead consultant neonatologist working with midwifery and obstetric colleagues to explore	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.	

		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: • Workload is manageable • That Datix are reviewed, graded and actioned in an appropriate and timely manner	Monthly Clinical Risk and Professional Forum is in place for Gynaecology. These are multi professional and attended by nursing and medical staff 7.27 Gynae Prof Forum 2019	The midwifery management and leadership is very lean when compared to other maternity services across Wales and requires additional support and resilience to ensure that Governance is strengthened across the	

		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	Directorate and to ensure that the role of the Risk Midwife does not become conflicted. The service requires the addition of a Deputy Head of Midwifery and a Senior Midwife for Clinical Governance and Risk Management across the O&G Directorate Deputy Head of Midwifery role out to advert as at 6th August 2019. **UPDATE 30.8.19** Deputy Head of Midwifery interviews being held on 3rd September 2019. The current midwifery leadership structure is under review in light of additional activity with the addition of an additional senior leadership 8b post. The Clinical Board and Directorate have received the RCM's Strengthening Leadership Manifesto (August 2019) and are considering the key recommendations as part of the structure review.	
	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** **7.28 ante natal Dec 18.docx**		
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:	There is effective communication between the Clinical Director for the service and the Medical Director and Clinical Board	We currently do not have a robust system to ensure that all women admitted within obstetrics and	

	• Making sure they are available and responsive to the needs of the service • 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)	Director to ensure that the needs of the service and job planning are effective. 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.	gynaecology are seen by a consultant within 12 hours. Current consultant expansion and review of job plans is taking account of this recognised clinical risk will look to address this. Appointment of additional O&G consultant posts is imminent and trainee staff will be in post by August 2019. Consultant interviews planned beginning September 2019 Improvements are needed to ensure that ward rounds are undertaken by appropriate grades of medical staff and in a timely manner. **UPDATE 30.8.19** Consultant interviews taking place 3rd September. Full complement of trainee rota since beginning of August	
	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. • 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.	Examples of multi professional learning include • 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 consultant 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. **UPDATE 30.8.19** The Clinical Board CD has mandated that job plans for the new consultants must include daily antenatal ward rounds.	
	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.	Multi professional leadership days are being led by Consultant Obstetrician/Consultant Anaesthetist/Clinical Supervisor for	Enhanced communication / attitudes and behaviours training should be considered for all staff	

	• Staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes.	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 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. Birthrate Plus assessment currently underway with report expected October / November 2019 **UPDATE 30.8.19** Recruitment has taken place to ensure birthrate plus 2016 safer staffing is in place. Additional recruitment of 18.20wte midwives to start in October to meet the safer staffing requirements of additional flow from Cwm Taf.	
	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 management • Incident review • Complaints handling	Risk and Governance Midwife Lead midwife and consultant for updating guidelines Lead consultant for Audit. Lead obstetric consultant for medical staff education and training. 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	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 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	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.	

		7.49 Performance Board Report 2017-18.docx Birth Afterthoughts collates themes of patient experience and shares with the clinical board on a quarterly basis		
	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 • 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.	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 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.	Requirement to provide staff training specifically on dealing with on the spot concerns and embed a structured ongoing training programme	

		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 and families affected by events should be part of the improvement, co-design and culture change of the new service.	Women are invited to participate in service change via concerns. For example, input into changing guideline, 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. South Wales recruitment in May / June 2019 has been successful with all UHBs appointing to midwifery vacancies. 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. **UPDATE 30.8.19** Full complement of staff on trainee rota as from August 2019. Recruitment of newly qualified midwives to C&V has been successful in 2019. Wider discussions with Universities taking place via HOMAG. LME has agreed to explore 18 month programme once new NMC standards for midwifery education have been embedded.	

	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 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	Welsh Government should consider working with NSAG to develop an annual workplan in line with HOMAG	
	7.59 Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety, including:	CWM TAF SPECIFIC		

	• Ensuring that length of stay is reduced safely to allow for sufficient capacity in the new merged unit.			
	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. Regional planning meetings underway, flow assumptions now agreed for C&VUHB to be 580 pa. Implementation and recruitment plans in place to safely accept the flow from 1st October 2019.	
	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	**UPDATE 30.8.19** 2 dedicated meetings with the Clinical Board have been held since submission of the assurance framework to explore and update risk registers. Risk registers are a standing agenda iterm and reviewed within monthly quality and safety directorate and clinical board meetings.	

	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		

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:**	**17.09.19**	
STATUS:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**		
LEAD EXECUTIVE:	**EXECUTIVE NURSE DIRECTOR**								
REPORT AUTHOR (TITLE):	**DIRECTOR OF NURSING WOMEN AND CHILDREN'S CLINICAL BOARD**								

PURPOSE OF REPORT:

SITUATION:

The purpose of this report is to provide the Committee with an update in relation to 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

The Committee has previously received a report in June 2019.

REPORT:

BACKGROUND:

The Royal College of Obstetricians and Gynaecologists 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 completed an assurance framework which provided a position statement with regards to the UHB compliance against the recommendations in the report. An overview of the Cardiff and Vale UHB position was presented at the public session of the May 2019 Board. An updated assurance paper can be viewed as Appendix 1.

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 has responded 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 was compliant with 41, partially complaint with 16, and identified 2 areas where immediate action was required and these were:

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.

- **Update September 2019**: the Governance arrangements have been strengthened as recommended. Multi professional meetings have been held and from the September Audit meeting, minutes will be taken and an action log will be completed. Case presentations will be circulated to Obstetric and Midwifery staff (who were not in attendance) and will be stored via a shared drive for staff to access. The Obstetric department has a robust Clinical Audit plan. Audit leads are exploring opportunities to develop Multi professional Audit days with Neonatal staff and Anaesthetics in attendance.

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.

- **Update September 2019:** interviews are scheduled to take place on the 2nd September 2019 and it is anticipated that the UHB will be able to successfully recruit 4 additional Consultant Obstetricians. Antenatal ward rounds will be mandated in their job plans.

Current position against the 70 recommendations:- following review we are now compliant with 45, partially compliant with 13 and have 1 remaining red score which will be addressed shortly with successful recruitment

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 progress has been made 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.

REPORT TITLE:	**Gosport War Memorial Hospital; the Report of the Gosport Independent Panel**						
MEETING:	Quality, Safety and Experience Committee				**MEETING DATE:**	**17 – 09 -19**	
STATUS:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
LEAD EXECUTIVE:	Ruth Walker, Executive Nurse Director						
REPORT AUTHOR (TITLE):	**Assistant Director of Patient Safety and Quality**						
PURPOSE OF REPORT:							

SITUATION:

The pupose of this paper is to provide the Committee with a further assurance report in relation to the main findings of the Report of the Gosport Independent Panel. The Commmittee has received a report previously in February 2019, which provided a level of assurance in relation to the systems and processes that are in place within Cardiff and the Vale UHB to monitor the appriopriate use of opioid analgesics particularly in rehabilitation or repsite settings.

It was agreed that a further report was required to examine the systems and processes in place in relation to:

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

BACKGROUND:

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

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

- Opioid usage without appropriate clinical indication
- Anticipatory prescribing with a wide range of doses
- Continuous opioid usage for patients admitted for rehabilitation or respite care
- Continuous opioids started at inappropriately high doses

- Opioids combined with other drugs in high doses
- Few patients survived long after starting continuous opioids
- The prescription and administration of drugs contravened guidelines

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

ASSESSMENT:

The prevalence of and controls in place in relation to anticipatory prescribing and to prevent the use of opioids without appropriate clinical indication - with specific focus on rehabilitation and respite settings

Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms, and is based on the premise that although each patient is an individual with individual needs, many acute events during the palliative period can be predicted and management measures put in place in advance.

There is All Wales Anticipatory Prescribing guidance in place. This generally applies to prescribing in the last weeks of life. Morphine is now routinely used in place of diamorphine. This is important because previously, this led to issues with the conversion of dose ranges when patients were transferred between settings.

There is also All Wales Guidance on End of Life care decisions which applies to patients with a prognosis of less than 3 months. This aligns with Continuing health Care assessments. Patients are often discharged with anticipatory medication. Anticipatory prescribing practice is audited as part of the National Audit of Care at the End of Life in which the UHB participates. The latest audit can be read here and provides good assuracne in relation to Cardiff and Vale UHB Compliance with the relevant standards.

In Paediatrics there is a Just in Case Box scheme in place. The child ‘s care will be overseen by the children’s community nursing (CCN) team or Paediatric outreach oncology nursing (POONS) team. The paediatrician is responsible for arranging the prescriptions and contacting the paediatric pharmacist to check clinically the drug chart and arrange supply of the PJIC box from the hospital pharmacy.

There is robust education and training in place for district nurses in relation to prescribing and dose conversions. Dose ranges are no longer allowed to be prescribed.

In community settings district nurses and/or the palliative care teams will be involved in the patients care. There is GP cover in community hospitals.

In hospital settings, anticipatory prescribing would be monitored by ward based pharmacists.

All nursing, medical and pharmacy staff have a duty to raise concerns if there is any issue of concern in relation to anticipatory prescribing practice and this applies across the healthcare system.

In community settings, both nurse assessors and district nurses would be able to escalate concerns about patients being cared for in nursing homes. Nurses routinely support syringe driver care in nursing homes.

The UHB commissions a proportion of hospice beds across Cardiff and performance is monitored by the Head of Outcomes Based Commissioning and the Director of Nursing for Primary, Intermediate and Community care. Healthcare Inspectorate Wales is the regulator and has responsibility for inspecting and regulating all healthcare in Wales.

Action required:

- A section on anticipatory prescribing will be added to the UHB Medicines Code
- Strengthen local audit arrangements in relation to anticipatory prescribing practice in line with NICE Quality Standard 144 – Care of dying adults in the last days of life
- Put in place suitable monitoring arrangements in relation to anticipatory prescribing in relevant commissioned services

Mortality relates in community hospitals, rehabilitation settings and respite care

Mortality rates are reported routinely to Board as part of the regular performance report. Generally, condition specific mortality rates are reported. In addition, the Quality, Safety and Experience Committee receives Mortality reports in line with the Committee workplan.

To date, the UHB has not however, routinely presented data which specifically monitors mortality rates by hospital sites and specific hospital settings. This data is however available for review through analysis of available CHKS data.

An updated version of EMAT is being launched week commencing 8th September 2019 and this will also enable us to track crude mortality rates by hospital and hospital setting more robustly.

The Committee will also be aware that the UHB participates in the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP). Currently the UHB is mandated to participate in 38 National Audits some of which have several components. National audit allows the UHB to compare performance with other organisations, against nationally agreed best practice standards in England and Wales. This includes mortality rates across a range of specialties.

Action required:

- Strengthen current UHB arrangements for the routine monitoring, consideration and reporting of mortality data.

Trends and themes in death certification

While the cause of death of patients is recorded on the UHB Electronic Mortality Tool (EMAT), there is currently no systematic process for the regular monitoring of trends in death certification It has been agreed that in the revised versoin of EMAT, a facilty for running a search across free text entries in relation to the cause of death, will be introduced by the application of Snowmed coding software which can be used to code,retrieve and analyse clinical data. This will help support the UHB to identify trends in death certification.

Introduction of the Medical Examiner service in Wales will provide an independent scrutiny of all deaths that are not referred directly to the coroner. This will be done by a Medical Examiner, who is an

experienced and trained doctor, in order to establish an accurate cause of death and to identify any concerns surrounding the death itself which can then be further investigated if required. The Medical Examiner Service is currently being developed in Wales, with the intention that all areas will have access to it from 1 April 2021. This will robustly address the issue of early identification of trends in death certification.

The Once For Wales project has identified an All Wales Risk Management system which will be introduced across Wales from April 2020. This will include a standardised mortality module

Action required:

- Development of the current EMAT system to allow analysis of death certification trends
- Local implementation of the medical examiner system over the next 18 months

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

CONSIDER the contents of the report and **AGREE** that the proposed actions are sufficent to address identifed areas for improvement.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

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

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

REPORT TITLE:	**OMBUDSMAN ANNUAL LETTER 2018/19**						
MEETING:	Quality, Safety and Experience Committee				**MEETING DATE:**	**13/08/19**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information** ✓
LEAD EXECUTIVE:	Executive Nurse Director, Cardiff and Vale University Health Board						
REPORT AUTHOR:	**Assistant Director of Patient Expereince**						

PURPOSE OF REPORT:

SITUATION:

The Public Service Ombudsman for Wales annually writes to each Health Board in Wales and provides an overview of trends, performance and key messages arising from activity in the Ombudsman's office over the previous year. The letters are published on the Ombudsman's website

Link to letter Annual Letter

REPORT:

BACKGROUND:
The Health Board was below the average for complaints received and investigated with Health Board average adjusted for population distribution.

It was pleasing to note that the numbers received in relation to complaints handling were less than the all Wales average. As with all concerns clinical treatment remained the major subject of most concerns received by the Ombudsman.

A. Complaints Received and Investigated with Health Board average adjusted for population distribution

Health Board	Complaints Received	Average	Complaints Investigated	Average
Cardiff and Vale University Health Board 2018/19	102	123	28	30
Cardiff and Vale University Health Board 2017/18	94	118	33	41
Abertawe Bro Morgannwg University Health Board	139	132	35	32
Aneurin Bevan University Health Board	134	146	38	36
Betsi Cadwaladr University Health Board	194	173	44	42
Cwm Taf University Health Board	75	74	22	18
Hywel Dda University Health Board	109	96	20	23
Powys Teaching Health Board	26	33	3	8

The Ombudsman has acknowledged that whilst more cases were upheld in whole or part fewer were considered for investigation.

C. Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution / voluntary settlement	Discontinued	Other Reports - Not Upheld	Other Reports - Upheld in whole or in part	Public Interest Reports	Grand Total
2018/19									
Cardiff and Vale University Health Board	10	16	33	19	-	11	15	3	107
Health Board average (adjusted)	20	15	32	24	2	10	24	2	129
2017/18									
Cardiff and Vale University Health Board	13	12	17	19	-	7	13	-	81
Health Board average (adjusted)	18	12	28	18	1	8	17	1	102

Public Interest reports

Across Wales, 10 Public interest reports were issued in this time frame. 2 were issued to Cardiff and Vale (one of these was jointly with Hywel Dda); one related to a delay in urgent paediatric surgery and the other was a delay in providing aftercare services for a patient with mental health needs who had moved a to a secure facility in England

The Paediatric case has been closed by the Ombudsman who was satisfied that compliance with the recommendations had been achieved. In the second case the evidence of compliance has been provided to the Ombudsman and a closure letter is awaited.

In response to the annual letter the Health Board has been asked to take the following actions

Present the Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance

- Reflect upon the findings in the Public Interest reports issued and positively act upon the recommendations to improve services
- Work to reduce the number of cases which require intervention by the Ombudsman's office
- Inform the Ombudsman of the outcome of the Health Board's considerations and proposed actions on the above matters by **31 October 2019**

Assurance

The previous Internal audit review provided substantial assurance regarding the process within the Health Board for managing Ombudsman cases. All cases are managed via the corporate concerns team who support the Clinical Boards to respond to queries from the Ombudsman; cases are escalated to the Executive team as required. All recommendations are monitored to completion and closure by the Ombudsman's office.

The Health Board has a robust process in place to manage Concerns from the Ombudsman's office.

RECOMMENDATION:

The Committee is asked to **NOTE** the findings of the Ombudsman's Annual Letter 2018/2019

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Putting Things Right

Concerns, Compliments Claims and Redress cases for 2018-19

Contents

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

- Aims to make it easier for people to raise concerns; to be engaged and supported during the process; to be dealt with openly and honestly; and for bodies to demonstrate learning from when things went wrong or standards needed to improve.

- Introduced a single more integrated approach, bringing together the management of complaints, incidents and claims, based on the principle of 'investigate once, investigate well'.

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

The Successes and Challenges across the Health Board 2018/19

Challenges

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. The impact of this is that there has been a marked decrease in the number of informal concerns recorded whilst our recorded formal concerns has increased.

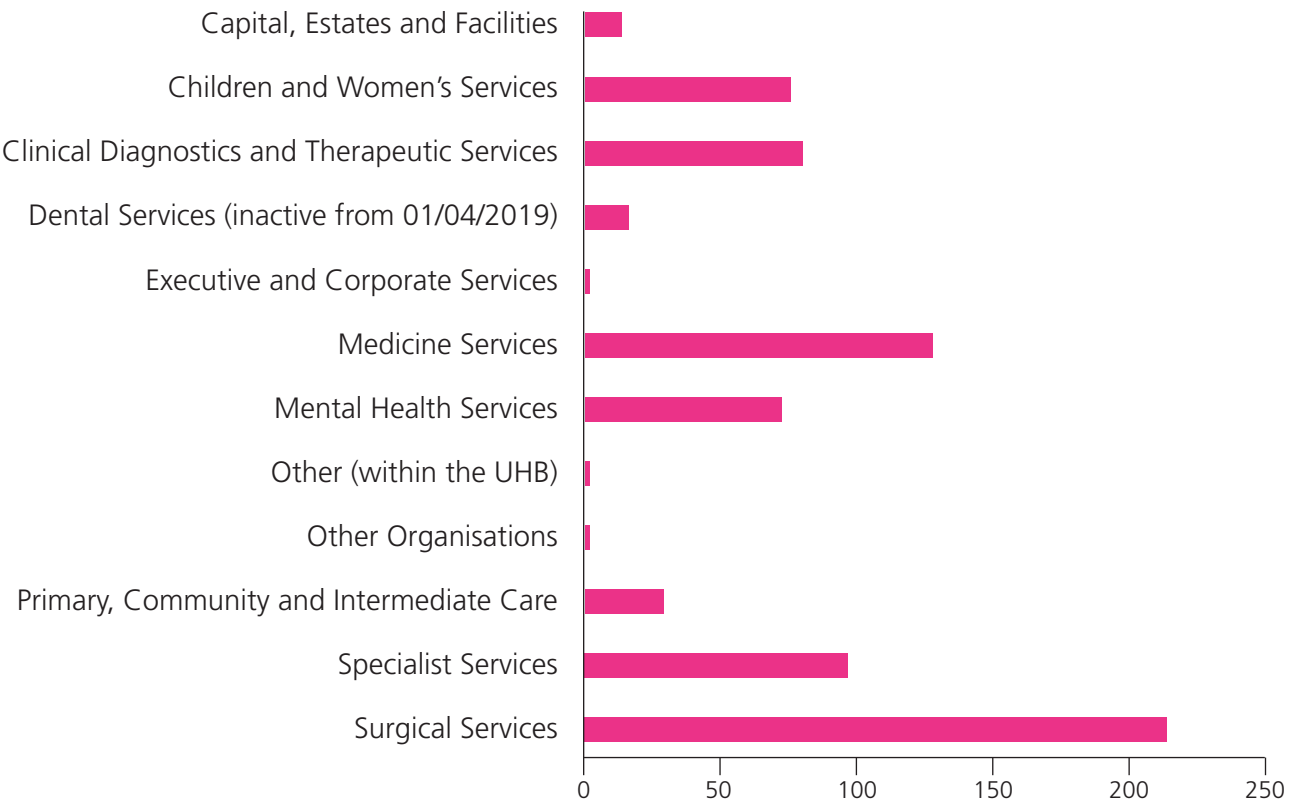
This did of course have a negative impact on our aim of resolving 65% of our concerns informally in 2018/19. This also meant that the data submitted by organisations will be accurate and consistent across Wales. However, the change in definition and data capture means that data presented to previously during the year will be different.

This has presented a huge challenge to the Team as a number of alterations have had to be made to the system and to our process, whilst ensuring that the service we provide to complainants remains the same.

Successes

In 2018/19 we received 2759 concerns.
717 concerns were managed under early resolution, within 2 working days, including date of receipt.

Early Resoltuion



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

The average response time over the year is

87%

an increase of **16%** from 2017/18 and **7%** higher that our target for 2018/19

The table below represents Cardiff and Vale Health Boards performance against the target set by Welsh Government (75%).

Our Aims for 2019/20

We aim to ensure that the changes highlighted above does not have a negative impact on the way we manage our concerns and people raising concerns will still receive a speedy resolution where possible
To maintain a formal response time of 80% across the Health Board

Concerns

Complaints element

During the period 01.04.2018 – 31.3.2019, the Health Board received a total of 2759 complaints; (in the context of over 1.8 million UHB contacts).

Only 25 concerns required an RCA Investigation.

The overall 30 day response time for the year was 87% at the end of March 2018.

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

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

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

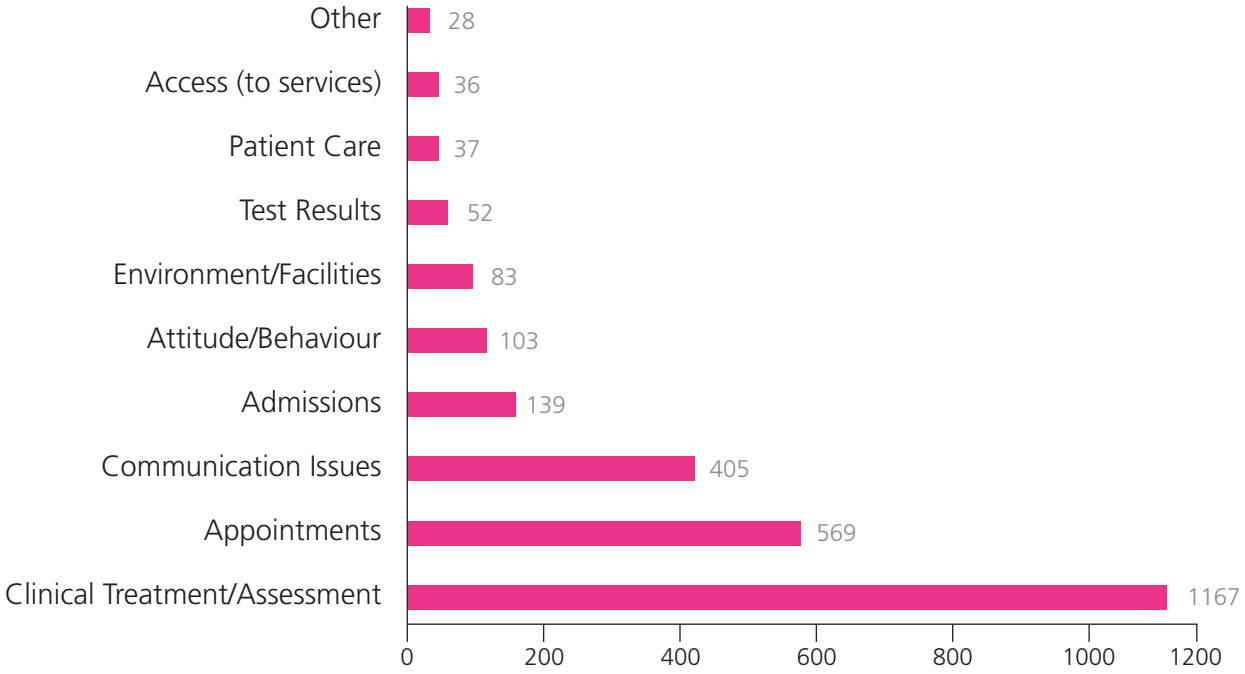
For those investigations that require further time, the Concerns Team contacts the Complainant, prior to the 30 day target, to explain the reason for the delay and advise that further time is needed.

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

Themes

The highest number of concerns relate to clinical diagnosis and treatment followed by waiting time for appointments.

Complaints by Subject (primary) - Top (10)



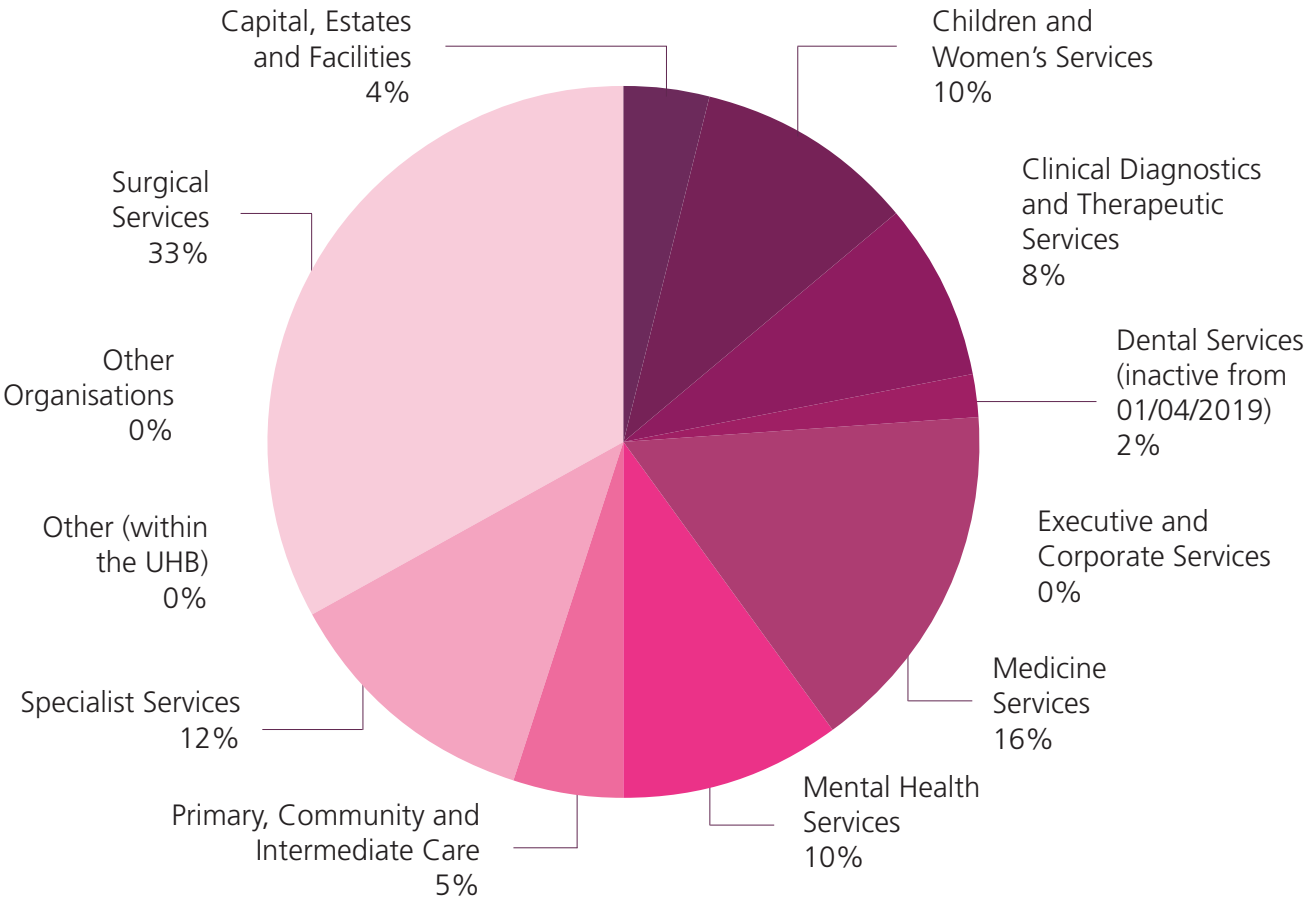
A new parking system was introduced in 2018 and this has resulted in the Concerns Team receiving a high volume of calls and emails relating to car parking and parking tickets being issued, both from members of the public and staff.

A key theme is the difficulties people have with the company to raise concerns or to discuss their cases.

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

Some data re Clinical Boards:

Complaints by Clinical Board



As you will note from the above Surgery Clinical Board received a significantly higher volume of concerns than other Clinical Boards. A high percentage of concerns received during this period related to delay/cancellations in Ophthalmology Outpatient Appointments.

A number of actions have been taken to address the rise in cancellations and delays.

New Measure for Eye Care services across Wales

Following concerns raised by consultant ophthalmologists (eye care doctors) and the Royal National Institute of Blind People (RNIB), the Minister for Health and Social Services in Wales asked a NHS-led group to review the problems facing patients on waiting lists, particularly those who require ongoing treatment.

This resulted in a set of recommendations and a new measure being agreed by the Minister. The new measure ensure that both new and existing patients are see or treated within an agreed timeframe based on their clinical condition.

From April 2019, new guidelines require hospital eye services to have procedures in place ensuring patients receive their assessment or treatment by the most suitable person within a clinically appropriate time. This means that those high risk patients, who need be seen quickly due to their condition, should experience fewer delays.

The measure is based on priority and urgency of care required by each patient. Priority is the risk of harm associated with the patient's eye condition if the target appointment date is missed. Urgency is how soon that patient should be seen given the current state and/or risk of progression of the condition.

The Eye Care Measures:

- Assists with helping us identify clinical target dates for when patients need to be seen by and what clinical priority the patient has been listed as.
- It will also help us to align our services provided to specialties where most support is required.
- To support with providing capacity we have received funding from Welsh Government to expend services provided by optometrists based outside of UHW. This will cover conditions such as age-related macular degeneration, glaucoma, diabetic retinopathy and eye casualty. We are expecting this to be in place Sep/ October 2019.

Actions taken locally to reduce cancellations:

- Approval of an additional substantive oculoplastic consultant
- Further 2 business cases are being put forward further consultants to support sub-specialities (Medical Retina/ Cornea)
- We are continuing to support extra capacity where possible though insource activity or waiting list initiatives.
- Continuing use of text message reminder service
- Expanded our optometrist service within UHW
- Looking into virtual clinics for glaucoma and corneal patients which will increase amount of patients being reviewed

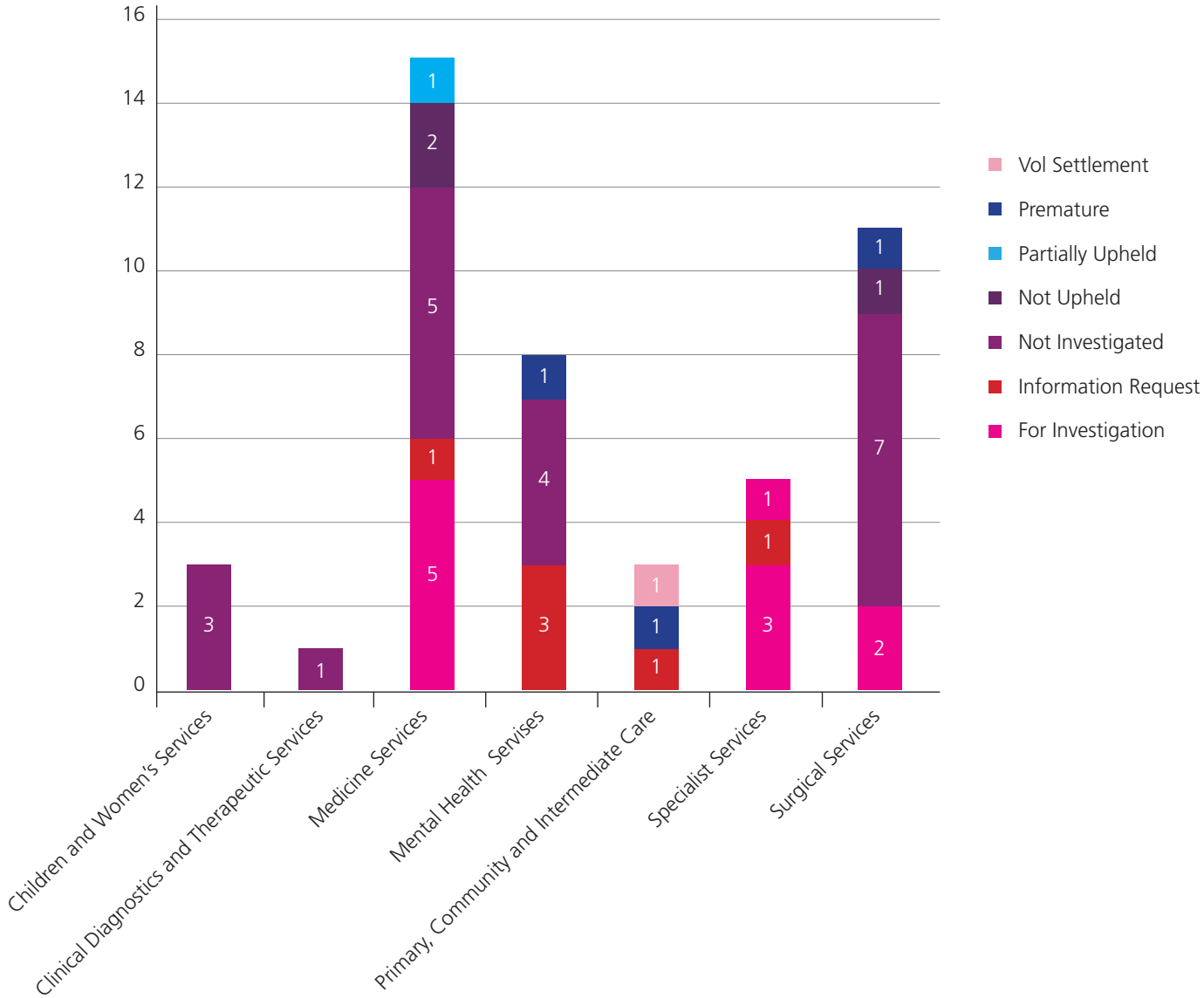
All complaints and patient feedback provide us with an opportunity to make changes to improve the services and Patient Experience. The following are examples of action that the UHB has taken following concerns raised by patients and their families in the previous year: the feedback from our Complainants is that they like the use of "You said-We Did" to convey the actions taken.

Learning from Concerns

You said	We did
OOH Dr incorrectly converted doses of opioid medication due to an unclear table of conversion	Palliative Care have revised the table so that it is clearer and is available in each OOH vehicle
Patient was not aware that she had DNA'd appointment – not advised and no further appt offered for six monthly review. T/O outpatients.	Now routinely inform patients that they have missed their review appointment.
The treatment given whilst attending A&E in Sickle Cell crisis was not adequate.	Educational resources and training sessions set up to improve nursing and medical staff knowledge of Sickle Cell disease and the priorities for management when patients present to EU.
Missed referral to hand clinic.	Service has now been streamlined to help ensure this doesn't happen again.
Patients waiting too long for an appointment in the Botulinum Toxin Service	Additional evening clinics have been arranged.
Patient was unable to be seen In the endometriosis follow-up clinic after surgery due to lack of capacity	Additional clinics have been added so that patients can be seen within the expected timeframe
Concerns raised regarding a clinical room in the EPAU looking like a store room so did not feel that it was appropriate	Apologies that stock was visible. Curtain has been hung up and is pulled around the area in the room where stock is stored and the environment has been improved for the benefit of patients.
Patient was injured by the adjustable footplate on a wheelchair falling on to their leg	All wheelchairs with an adjustable footrest have been fitted with a magnetic locking device to prevent this

Public Service Ombudsman for Wales

During 2018/19 the Health Board had 102 concerns referred to the Public service Ombudsman for Wales and he chose to investigate 28 concerns. In that time period 15 concerns were upheld in whole or in part and 2 public interest reports were issued.

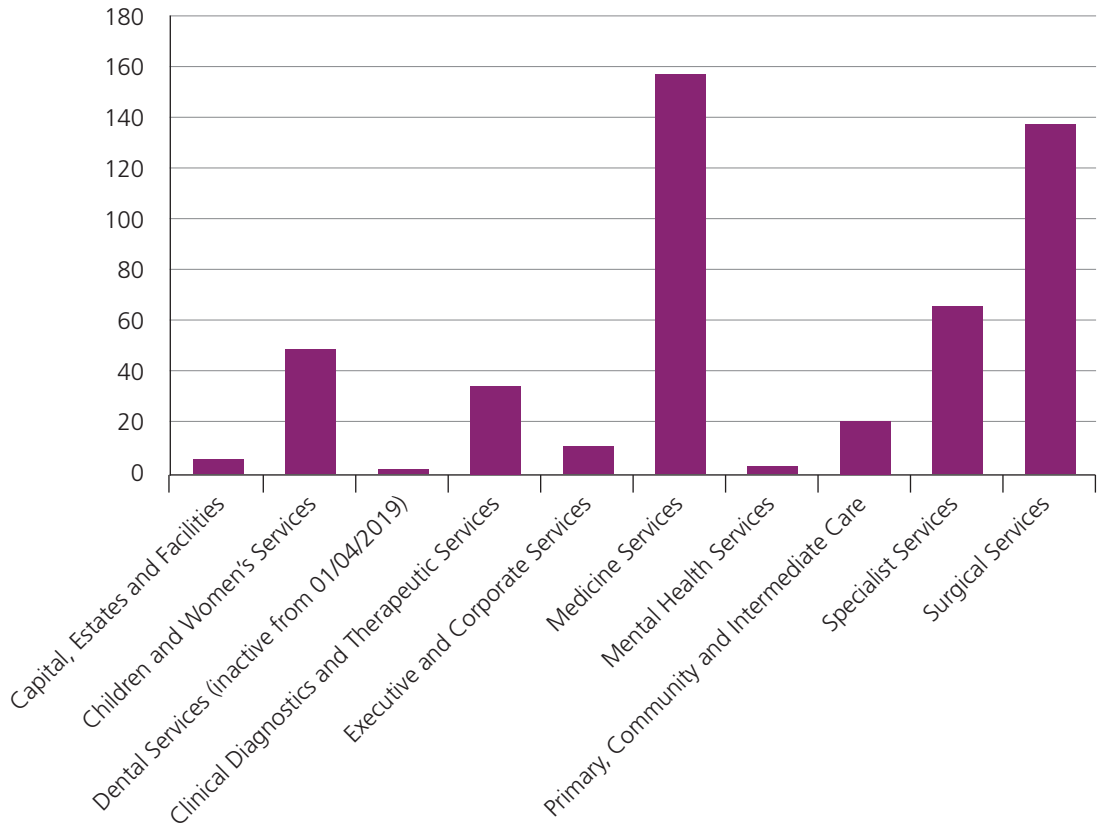


Its is pleasing to note that the number of concerns relating to complaints handling is below the All Wales average.

Compliments

The Concerns Team also log all Compliments received in the Health Board we logged 481 compliments, although it is acknowledged that a lot of compliments are sent directly to areas and are not formally logged. Staff are encouraged to share all feedback with the Concerns Team so that this can be recorded. The Executive Nurse Director sends a letter of thanks to all staff or departments when compliments are received and a letter of acknowledgement to the person sharing their feedback.

Compliments by Clin Board



Compliments

Excellent doctors and nurses on critical care. Wonderful support and empathy from nurses during very difficult time.

Gentleman attended as an interpreter and was very impressed with the behaviour of the staff who acted in a very professional manner treating everyone with dignity and respect

I will never forget how kind you all were and how lucky I was to have such a lovely team caring for us under such heart-breaking circumstances. Thank you, you should all be very proud.

Compliments

Staff were extremely reassuring, friendly, kind and kept me calm and entertained through my whole procedure.

I was given excellent advice from various members of staff while waiting to hear if I was being considered for surgery. The Prehab team were a huge inspiration to encouraging and guiding me every step of the way and I genuinely feel that they have helped in saving my life.

Feedback from Clinical Boards

I have found everyone in your team to be extremely supportive and helpful, nothing is too much trouble.

The tracker meetings are invaluable and act as a source of information, escalation and validation of who 'owns' the concern.

I would like to see some training sessions for IO's who sometimes struggle with formulating responses; do you think this is something that could be looked at for next year?

Our feedback would only be positive. We seem to have a system and an understanding that works very well? Maybe it's because we tend to have specific people to go through, as do you when contacting us. Occasionally the blips are when the concerns may go to someone outside of our normal contacts? Basically, all good, Thank you for all your help

There has been an improvement in the processing of concerns over the last year due to local processes that have been put in place within the concerns team and within the clinical boards.

"I value the input I have from the concerns team, which is reflected by our good compliance performance.

"I don't feel that there are any recommendations that could be done to improve our concerns process and believe that we have a great working relationship which enable us to manage the complaint process.

I am very supportive of the new process for arranging meetings with families as this process has resulted in meetings being more timely and improved engagement with clinical teams.

The regular tracker meetings are very useful, as are the regular updates and the availability of the head of concerns to be able to talk through concerns and to trouble shoot.

We have been able to change the way that we manage to concerns in the dental hospital in line with the standard approach used thorough out the rest of the clinical bard. We were grateful for the accommodating way in which this has occurred and the transition has been smooth.

Key Achievements in 2018/19 in Complaints

Introduced an automated (bilingual) acknowledgement to all concerns received via email so that complainants receive immediate assurance that their concern has been received. This includes a lot of useful information on what they should expect from the PTR process, how they can receive advocacy support, how concerns can be resolved. It also provides a link for members of the deaf community to access a BSL video providing advice on how they can raise concerns.

Listening to people - all complainants are contacted whenever possible by the concerns team.

Marked consistent improvement in 30 day response times, regularly exceeding the Health Boards target of 80% of complainants receiving a response within 30 working.

Introduced a BSL video to assist members of the Deaf Community in raising concerns

Redress

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations were implemented on 1 April 2011. An investigation under Redress is the process of investigating whether there has been a breach in the duty of care and whether this breach has caused harm. If there is both breach and harm, then there is a qualifying liability. Once qualifying liability is established, the UHB can then make a financial offer of Redress. The financial limit for compensation under redress is £25,000 damages. Redress could be an apology, an explanation of what happened or remedial treatment or a combination of these actions. Previousley the financial Redress elements of the Regulations do not apply to primary care providers or independent providers however on 1 April 2019, Welsh Government have brought in a discretionary state-backed Scheme to provide clinical negligence indemnity for providers of GP services in Wales. NWSSP Legal and Risk Services (L&R) were commissioned by Welsh Government to operate the Scheme, which came into force on 1 April 2019.

Redress Process

When a breach in the duty of care has been established, the case is shared with the Redress Leads to investigate causation and qualifying liability. In order to investigate causation it can be necessary to appoint, under joint instruction, an independent expert with specialist knowledge in the relevant field to review the care received.

Once a breach of duty has been identified and there is or may be a qualifying liability, the Complainant is entitled to free legal advice from a firm of solicitors who have a recognised expertise in the field of clinical negligence; if taken up by the Complainant, the legal advice is paid for by the UHB in line with the Fixed Fee Framework of the Regulations.

Once the investigation into causation has concluded, in order to identify the level of qualifying liability, it may be necessary to undertake a further investigation into the patient's condition and prognosis. Once the investigation is complete, the case is discussed at the Redress Panel to agree an appropriate level of quantum in line with the Judicial College Guidelines. The Redress Panel members will include the Assistant Director of Patient Experience, Head of Concerns/Claims, Claims Managers and Redress Leads.

If an offer of settlement is accepted, the recipient must sign a formal waiver confirming that no further claim will be made in respect of the qualifying liability to which the settlement relates.
If the case involves a child or vulnerable adult, approval of any settlement offer needs to be made either by an approved appointee or more increasingly via a formal court approval hearing.

There are currently 47 active cases being managed by the Redress Team.
In 2018-19, the Redress Team closed 36 cases.

Of the 47 active Redress cases, the following themes were identified:	
Administrative/Management (systems failure)	4
Communication	1
Clinical treatment	26
Diagnosis	7
Medication	2
Nursing care	4
Obstetric	2
Surgery	1
Totals:	**47**

Key Achievements for Redress this year:

Imbedded regular Panel meetings to discuss cases, which are, being considered under the Redress Arrangements.

The Redress Team attends quarterly Redress Case Management Networks to share learning with Redress practitioners across all of Wales.

Continue to make financial savings for the Health Board with cases that are handled under Redress, rather than progressed as a civil claim.

The Redress Team have been involved in the Health Board's investigation into the outsourcing of the Ophthalmology cataract cases where RCA investigations have been undertaken.

Redress to Clinical Negligence Claims

The Redress Team also manages clinical negligence cases which have previously been investigated by the Health Board under PTR or as Serious Incidents and/or Inquests.

In 2018 – 19, the Redress Team received 36 new Claims which had previously been investigated by the Health Board.

Of these new claims, 10 were considered to be unsuitable for PTR as the potential value could be over the £25,000 threshold for PTR/Redress.

17 of the claims had been previously investigated under PTR and no Qualifying Liability had been identified.

Of these 36 new clinical negligence claims, 5 were claims brought by the estate on behalf of patients who were deceased.

Of the 36 Redress to Claims, the following themes were identified during 2018/19:	
Administrative/Management (systems failure)	2
Consent	1
Clinical treatment	8
Diagnosis	5
Medication	2
Nursing care	7
Obstetric	1
Surgery	10
Totals:	**36**

Lessons Learnt

An important part of the Redress Regulations for the Health Boards in Wales is ensuring that lessons are learnt and actions taken as a result of any identified failings in care. On completion of each Redress case, i.e. once costs and damages have been paid, Appendix T forms are submitted to the Welsh Government (Welsh Risk Pool with effect from July 2018) for financial reimbursement to the UHB. The main focus of these forms is to identify these lessons learnt and actions taken for each case that has been investigated.

As mentioned above a new system for financial reimbursement for Health Boards in Wales was introduced in July 2018, with the Welsh Risk Pool taking over the overseeing of reimbursement from Welsh Government.

With these new arrangements for reimbursement of redress cases comes a period of learning for the UHB with the introduction of Case File Reports and Case Management Reports, which focus on lessons learnt and actions taken.

The total reimbursement received from Welsh Risk Pool for period 2018/19 was £232, 142, 85. 2017/18 reimbursement was £372,404.41

Claims

Claims Report

Clinical Negligence (CN) and Personal Injury (PI) claims are managed by the UHB, on the basis of legal advice provided by the NHS Wales Shared Services Partnership, Legal and Risk Services (L&R). The Welsh Risk Pool (WRP) will reimburse the UHB for all losses incurred above an excess level of £25, 0000 on a case by case basis. Legal and Risk continue to provide the UHW with monthly quantum reports every quarter.

There have been 72 new Clinical Negligence and 51 new Personal Injury Claims.

Of the 72 Clinical Negligence Claims the following themes have been identified during 2017/18	
Administrative/Management (systems failure)	1
Clinical treatment	37
Medical/nursing equipment	2
Nursing care	19
Obstetric	1
Surgery	10
Unknown (to be changed later)	2
Totals:	**72**

Of the 51 Personal Injury Claims the following themes have been identified during 2018/2019	
Burn/scald	1
Fall from bed/trolley/couch/chair	2
Behaviour/violence - verbal	1
Behaviour/Violence - incidental injury	3
Behaviour/Violence - intentional injury	4
Exposure to chemical substances	1
Fall	4
Patient manual handling/lifting	1
Non-patient manual handling/lifting	1
Needlestick/sharps	13
Struck by object	6
Pushing equipment	1
Repetitive strain injury	1
Slip	5
Occupational stress	1
Trip	5
Vehicle/driving accident	1
Totals:	**51**

Claims Managers

The Claims Managers have provided assurance to Legal and Risk by attending all Case Conferences, Round Table Meetings either in person or by phone to ensure representative on behalf of the Health Board. The Claims Managers provide reports on claims to Clinical Board as and when required.

The Claims Managers attended the following:	
Trials	1
RTMs and Case Conferences	23
Formal Meetings with witnesses	10
Consultant Induction	2

The Claims Managers continue to support the attending witnesses and to protect the interest of the Health Board. This enables the Claims Managers to identify any lessons that can be identified at the earliest stage possible.

Arising from the case conferences, a number of claims were settled. There are three themes identified from the Clinical Negligence and Personal Injury claims from the last year specifically as outlined below.

Surgery Claims – Surgery

Arising from a recent claim the Clinical Board had taken steps to improve their consenting process, particularly with regard to junior staff involved in this process. The Health Board has arranged for consent to be covered at recent training events open to all staff. The Health Board is involved in the all Wales Network Group tasked with improving consenting process. One of the Claims Manager is representing the Health Board on this group.

Obstetrics

The UHB has invested in increased midwifery and support worker staffing to ensure women are reviewed in a timely manner. Call bells are in place and monitored to ensure all women have call bells in good working order and in reach. The Directorate is exploring opportunities to become paper light to enable women's records to be digitalised and reduce the risk of becoming lost. Environmental audits are now undertaken of clinical areas to ensure that sufficient equipment such as monitors and call bells are in place. The audit also identifies whether any repairs are required and these area monitored by the ward manager.

In another case, the teaching of Registrars in respect of the management of impaction would have been provided in accordance with the agreed treatment protocols/procedures in place at the material time. Difficult caesarean sessions are consistently taught as part of their apprentice style model of teaching. Junior obstetricians hold their own logbooks of their personal experience and education received whilst in training.

General Medical Practice Indemnity (GMPI)

L&R has a dedicated team of solicitors to deal with GMPI queries and claims. The aim is to resolve any claim for compensation brought by a patient in relation to their clinical care under the NHS as fairly and as quickly as possible and to identify and feedback risk issues for learning and safety improvement in Primary Care. The GMPI will cover claims for compensation arising from the care, diagnosis and treatment of patients following incidents which happen on or after 1 April 2019 in relation to NHS work. Health Boards in Wales will provide an indemnity arrangement and will be the named Defendant for clinical negligence litigation rather than the General Medical Practices. This is the same indemnity arrangements that are already in place to our Clinicians working within the Health Board.

Impact of Montgomery and actions being taken

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

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

REPORT TITLE:	**Putting Things Right (PTR) Annual Report**							
MEETING:	Quality, Safety and Experience Committee					**MEETING DATE:**	**13/08/19**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	✓
LEAD EXECUTIVE:	Executive Nurse Director, Cardiff and Vale University Health Board							
REPORT AUTHOR:	**Assistant Director of Patient Expereince and Concerns Team Manager**							

PURPOSE OF REPORT:

This report underpins the Health Board's strategy in particular Delivering outcomes that matter to people and reducing waste, harm and variation underpinned by living our organizational values

SITUATION:

This report provides the Quality Safety and Experience Committee with a review of the Complaints/ claims and compliments activity that has taken place 1 April 2018 to 31 March 2019. (see Appendix 1).

REPORT:

BACKGROUND:

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

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

RECOMMENDATION: The Committee is asked to **NOTE** the content of the Annual Putting Things Right report

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

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

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

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

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

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

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

Report Title:	**Parenteral Infusion Pump Policy**								
Meeting:	Quality, Safety Experience						**Meeting Date:**	17/09/2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Medical Director**								
Report Author (Title):	**Tony Powell, Head of Clinical Engineering**								

SITUATION

The UHB has an existing policy that is overdue for review. The policy has been reviewed by various groups including the Medical Equipment Group with minimal amendments made.

The Parenteral Infusion Pumps Procedure for the Cardiff and Vale UHB is designed to reduce the risk to patients and staff from clinical errors in the use of infusion devices.

The policy is managed by Clinical Engineering who employ dedicated nursing staff to deliver training on all types of infusion pumps within the UHB. This includes new starters and also assessment of existing staff to ensure they are maintaining their ability to deliver infusions in the field.

BACKGROUND

This policy was originally created within the UHB to establish a standard for all users to meet the requirements of the guidelines issued by the MHRA.

- Standardisation and use of devices.
- Restrictions in the selection of devices for purchase or use.
- Ensuring that the correct disposable items are available and properly used.
- Requiring those staff who use infusion devices to have adequate training and competence levels.
- Introduction of new devices is carried out in a safe manner
- Ensuring that users always check infusion equipment before use.
- That all infusions must have a minimum standard of monitoring.
- All patients and/or carers are adequately trained when equipment is loaned for home use.

ASSESSMENT

A policy which commits to the UHB carrying out high quality training in a safe and lawful manner has the potential to positively impact on patient care by providing opportunities for staff to receive the correct level of training in the use of a critical medical device for delivery of infusions to a patient.

On reviewing the previous policy and writing the latest policy and procedure and completing the EHIA, there appear to be no negative impacts of the Policy. Therefore no key actions have been identified.

ASSURANCE is provided by: Medical Equipment Group (MEG)

RECOMMENDATION

The Board is asked to:

- Approve the Policy

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	
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		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	x	Involvement	x

Equality and Health Impact Assessment Completed:	Yes

Reference Number: UHB 081 **Version Number:** 2.1	**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*

Parenteral Infusion Pumps Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will *improve patient safety by* reducing the risks of infusion related incidents in accordance with the Medicines and Healthcare Regulatory Agency (MHRA).

Policy Commitment

We will reduce the risk of infusion related incidents through the management of procurement, standardisation, training and procedures used throughout the UHB. The policy will meet the requirements of the legislation and guidance including the Health Care Standards (April 2015) and shall be monitored by Clinical Engineering on behalf of the UHB.

The Policy covers the management and use of all parenteral infusion pumps as defined by MHRA DB 2003 (02) v2.0 (November 2010), namely:

Syringe pumps
Volumetric Pumps
Patient Control Analgesia pumps (PCA)
Epidural pumps (Including PCEA)
Anaesthetic pumps
Ambulatory pumps

Scope

This policy is applicable to all areas of the UHB. It applies to all clinical and technical staff whether directly employed by the UHB or contracted to the UHB who use infusion devices (agency / locum staff or those who hold an honorary contract).

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive impact for Welsh speakers.

Policy Approved by	Board/Committee/Sub Committee
Group with authority to	Quality Safety and Experience Committee

approve procedures written to explain how this policy will be implemented	
Accountable Executive or Clinical Board Director	Medical Director

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	18/10/11	01/11/11	Amendments are to reflect changes in names, designations and structural matters
2			Amendments to reflect changes in Temporary Staffing, publications, names and structural matters. Split into policy and procedure documents.

Equality & Health Impact Assessment for

Parenteral Infusion Pumps Policy and Procedure
Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required[1]
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Not Applicable
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Clinical Diagnostics and Therapeutics Anna Necrews, Practice Development Nurse, Clinical Engineering, 20 Field way, ext 45678
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The policy relates to infusion pumps used within the UHB irrespective of equipment ownership. For example this includes equipment owned by the Cardiff University, School of Medicine that may be used to deliver

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

		infusions to UHB patients. • Establish a set of minimum standards and procedures to meet the requirements of MHRA DB 2003 (02) v2.0 (November 2010) and to manage specific risks in the procurement and use of infusion devices such as: • Standardisation and use of devices. • Restrictions in the selection of devices for purchase or use. • Ensuring that the correct disposable items are available and properly used. • Requiring those staff who use infusion devices to have adequate training and competence levels. • Introduction of new devices is carried out in a safe manner • Ensuring that users always check infusion equipment before use. • That all infusions must have a minimum standard of monitoring. • All patients and/or carers are adequately trained when equipment is loaned for home use.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines	Good practice guidance from the MHRA, RCN, NMC, Department of Health and NICE have been reviewed and considered. Select stakeholders with in-depth clinical knowledge and clinical application of infusion devices were asked for comments on amended policy/procedure.

	• participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	All clinical staff who use infusion devices

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	No impact based upon age for staff or patients	None	Follow policy/procedure
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Any patient considered to have a disability would be treated in line with the UHB *Consent to Examination or Treatment Policy (2016)* All staff, regardless of disability is assessed to	None	Follow policy/procedure

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	ensure safe working practice People with long-term conditions will be able to continue to receive necessary treatment via infusion devices		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her	No Impact	None	Follow policy/procedure

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	No Impact	None	Follow policy/procedure
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No Impact	None	Follow policy/procedure

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Any patient considered to have a language barrier would be treated in line with the UHB *Interpretation and Translation Services Policy (2017)*	None	Follow policy/procedure
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No impact	None	Follow policy/procedure
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	No impact	None	Follow policy/procedure

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	Follow UHB *Policy for the Production of Informtion for Service Users (2008)* and UHB Welsh Langauge Scheme. The Single Equality Scheme – FAIR CARE also allows for translation into other languages and formats if/when required.	None	Follow policy/procedure
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to	No impact	None	Follow policy/procedure

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
work due to ill-health			
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact	None	Follow policy/procedure
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	None	None	Follow policy/procedure

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No impact	None	Follow policy/procedure
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus	No impact	None	Follow policy/procedure

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A	No impact	None	Follow policy/procedure

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No impact	None	Follow policy/procedure

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact	None	Follow policy/procedure
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross	No impact	None	Follow policy/procedure

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales			

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy/procedure allows continuation of use the infusion devices within the UHB to a high standard and ensuring staff and patient safety.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Continuing as per policy/procedure	Anna Necrews	Ongoing	Approve

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Policy/procedure continues unchanged as there are no significant negative impacts	Anna Necrews	Ongoing	Approve

Appendix 1

Equality & Health Impact Assessment

Developing strategies, policies, plans and services that reflect our Mission of 'Caring for People, Keeping People Well'

Guidance

The University Health Board's (the UHB's) Strategy 'Shaping Our Future Wellbeing' (2015-2025) outlines how we will meet the health and care needs of our population, working with key partner organisations to deliver services that reflect the UHB's values. Our population has varied and diverse needs with some of our communities and population groups requiring additional consideration and support. With this in mind, when developing or reviewing any strategies, policies, plans, procedures or services it will be required that the following issues are explicitly included and addressed from the outset:-

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)[4]

This explicit consideration of the above will apply to strategies (e.g. Shaping Our Future Strategy, Estates Strategy), policies (e.g. catering policies, procurement policies), plans (e.g. Clinical Board operational plans, Diabetes Delivery Plan), procedures (for example Varicella Zoster - chickenpox/shingles - Infection Control Procedure) and services /activity (e.g. developing new clinical services, setting up a weight management service).

Considering and completing the Equality & Health Impact Assessment (EHIA) in parallel with development stages will ensure that all UHB strategies, policies, plans, procedures or services comply with relevant statutory obligations and responsibilities and at the same time takes forward the UHB's Vision, 'a person's chance of leading a healthy life is the same wherever they live and whoever they are'. This process should be proportionate but still provide helpful and robust information to support decision making. Where a more detailed consideration of an issue is required, the EHIA will identify if there is a need for a full impact assessment.

Some key statutory/mandatory requirements that strategies, policies, plans, procedures and services must reflect include:

[4] http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)[5]
- Equality Act 2010[6]
- Well-being of Future Generations (Wales) Act 2015[7]
- Social Services and Well-being (Wales) Act 2015[8]
- Health Impact Assessment (non statutory but good practice)[9]
- The Human Rights Act 1998[10]
- United Nations Convention on the Rights of the Child 1989[11]
- United Nations Convention on Rights of Persons with Disabilities 2009[12]
- United Nations Principles for Older Persons 1991[13]
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance[14]
- Welsh Government Health & Care Standards 2015[15]
- Welsh Language (Wales) Measure 2011[16]

This EHIA allows us to meet the requirements of the above as part of an integrated impact assessment method that brings together Equality Impact Assessment (EQIA) and Health Impact Assessment (HIA). A number of statutory /mandatory requirements will need to be included and failure to comply with these requirements, or demonstrate due regard, can expose the UHB to legal challenge or other forms of reproach. This means showing due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups.

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (i.e. their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues. They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

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[5] http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en
[6] https://www.gov.uk/guidance/equality-act-2010-guidance
[7] http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
[8] http://gov.wales/topics/health/socialcare/act/?lang=en
[9] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782
[10] https://www.equalityhumanrights.com/en/human-rights/human-rights-act
[11] http://www.unicef.org.uk/UNICEFs-Work/UN-Convention
[12] http://www.un.org/disabilities/convention/conventionfull.shtml
[13] http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx
[14] http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf
[15] http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en
[16] http://www.legislation.gov.uk/mwa/2011/1/contents/enacted

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently on the basis of where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

The **EHIA** brings together both impact assessments in to a single tool and helps to assess the impact of the strategy, policy, plan, procedure and/or service. Using the EHIA from the outset and during development stages will help identify those most affected by the proposed revisions or changes and inform plans for engagement and co-production. Engaging with those most affected and co-producing any changes or revisions will result in a set of recommendations to mitigate negative, and enhance positive impacts. Throughout the assessment, 'health' is not restricted to medical conditions but includes the wide range of influences on people's well-being including, but not limited to, experience of discrimination, access to transport, education, housing quality and employment.

Throughout the development of the strategy, policy, plan, procedure or service, in addition to the questions in the EHIA, you are required to remember our values of *care, trust, respect, personal responsibility, integrity and kindness* and to take the Human Rights Act 1998 into account. All NHS organisations have a duty to act compatibly with and to respect, protect and fulfil the rights set out in the Human Rights Act. Further detail on the Act is available in Appendix 2.

Completion of the EHIA should be an iterative process and commenced as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

For further information or if you require support to facilitate a session, please contact Susan Toner, Principal Health Promotion Specialist (susan.toner@wales.nh.uk) or Keithley Wilkinson, Equality Manager (Keithley.wilkinson@wales.nhs.uk)

Based on

- Cardiff Council (2013) Statutory Screening Tool Guidance
- NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools and templates[17]
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide[18]

[17] http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf (accessed 4 January 2016)

[18] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782 (accessed on 4 January 2016)

Appendix 2 – The Human Rights Act 1998[19]

The Act sets out our human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights':

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers, issues of patient restraint and control
3. Article 4 Freedom from slavery and forced labour
4. Article 5 Right to liberty and security. NHS examples: issues of patient choice, control, empowerment and independence, issues of patient restraint and control
5. Article 6 Right to a fair trial
6. Article 7 No punishment without law
7. Article 8 Respect for your private and family life, home and correspondence. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers, the right of a patient or employee to enjoy their family and/or private life
8. Article 9 Freedom of thought, belief and religion. NHS examples: the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person

[19] https://www.equalityhumanrights.com/en/human-rights/human-rights-act

13. solely because of their age, patients presented with health options without the use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home
14. Protocol 1, Article 1 Right to peaceful enjoyment of your property
15. Protocol 1, Article 2 Right to education
16. Protocol 1, Article 3 Right to participate in free elections
17. Protocol 13, Article 1 Abolition of the death penalty

Appendix 3

Tips

- Be clear about the policy or decision's rationale, objectives, delivery method and stakeholders.
- Work through the Toolkit early in the design and development stages and make use of it as the work progresses to inform you of those most affected and inform mitigating actions
- Allow adequate time to complete the Equality Health Impact Assessment
- Identify what data you already have and what are the gaps.
- Engage with stakeholders and those most affected early. View them as active partners rather than passive recipients of your services.
- Remember to consider the impact of your decisions on your staff as well as the public.
- Record which organisations and protected characteristic groups you engaged with, when you engaged with them and how you did so (for example, workshop, public meeting, written submission).
- Produce a summary table describing the issues affecting each protected group and what the potential mitigations are.
- Report on positive impacts as well as negative ones.
- Remember what the Equality Act says – how can this policy or decision help foster good relations between different groups?
- Do it with other people! Talk to colleagues, bounce ideas, seeks views and opinions.

Report Title:	**RESEARCH GOVERNANCE POLICY**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**		
Status:	**For Discussion**		**For Assurance**		**For Approval**	✓	**For Information**		
Lead Executive:	**Medical Director**								
Report Author (Title):	**Research and Development Manager**								

SITUATION

The UHB has an existing Research Governance Policy due for review. This Policy has been revisited in light of the UHB requirements specified in the Management of Policies, Procedures and other written control documents Policy. In addition, the UK Research Government Framework for Health and Social Care in Wales has been replaced by the UK policy framework for health and social care research (2017) and the UHB Research Governance Policy needed to reflect this change

BACKGROUND

Research Governance can be defined as the broad range of regulations, principles and standards of good practice that ensure high quality research. Cardiff and Vale University Health Board (UHB) considers the governance of research and development (R&D) activity involving its patients, staff and resources to be of paramount importance. We are committed to high quality, relevant research that is managed appropriately to ensure patient dignity, rights, safety and wellbeing. We will:

- Ensure that R&D is of the highest quality and that researchers operate within the same quality framework as the services which the research is aimed at improving
- Ensure that all R&D is carried out lawfully, properly and sensitively respecting the rights, dignity, wellbeing and safety of participants
- Clearly identify the responsibilities of individuals involved in R&D

ASSESSMENT

A policy which commits to the UHB carrying out high quality research in a safe and lawful manner has the potential to positively impact on the patient community by providing opportunities for patients to receive new and innovative treatments and diagnostic procedures. On reviewing the previous policy and writing the latest policy and procedure and completing the EHIA, there appear to be no negative impacts of the Policy. Therefore no key actions have been identified.

ASSURANCE is provided by: Research Governance Group

RECOMMENDATION

The Board is asked to:

- Approve the Policy

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

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board	**Reference Number: UHB099** **Version Number: 3** **Date of Next Review: TBA** **Previous Trust/LHB Reference Number: 296**

RESEARCH GOVERNANCE POLICY

Policy Statement

Research Governance can be defined as the broad range of regulations, principles and standards of good practice that ensure high quality research. Cardiff and Vale University Health Board (UHB) considers the governance of research and development (R&D) activity involving its patients, staff and resources to be of paramount importance. We are committed to high quality, relevant research that is managed appropriately to ensure patient dignity, rights, safety and wellbeing. We will ensure that all research complies with the law and that financial probity is maintained.

Policy Commitment

The UHB is committed to providing a framework for research which complies with the law and good practice, without unnecessarily restricting the freedom of individual researchers to develop ideas which can improve clinical care.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedures listed below aim to

- Ensure that R&D is of the highest quality and that researchers operate within the same quality framework as the services which the research is aimed at improving
- Ensure that all R&D is carried out lawfully, properly and sensitively respecting the rights, dignity, wellbeing and safety of patients
- Clearly identify the responsibilities of individuals involved in R&D

Other supporting documents are:

Research Governance Procedure (UHB xxx)
Governance & Compliance Audit of Human Tissue For Research Purposes (UHB 134)
Financial Procedure for supporting Non-Commercial Research (RD08)
Archiving of Clinical Trial and Research Study Data SOP (UHB 121)
Research, Consent and Mental Capacity SOP (UHB 147)
Investigating and Handling Allegations of Research Misconduct Procedure (UHB145)
Research Audit SOP (UHB 236)
Managing Breaches of Good Clinical Practice or the Study Protocol SOP (UHB 235)
Oversight and Monitoring in Research SOP (UHB 247)
Data Management for Clinical Trials SOP (UHB xxx)

Safety Reporting in CTIMPs SOP (UHB 253)
Clinical Research Training requirements including Good Clinical Practice (GCP) Training – SOP (UHB xxx)
Applying for Cardiff and Vale UHB NHS Sponsorship SOP (UHB xxx)
Reporting requirements for Cardiff and Vale UHB Sponsored Research SOP (UHB 406)
Managing amendments for Sponsored Research SOP (UHB 302)
UK Policy Framework for Health and Social Care Research

Scope

The scope of this Policy extends to all research activity, both commercial and non-commercial, involving the UHB including:

- Research using patients, carers, volunteers and members of staff at the UHB and in Primary Care settings;
- Research using patient tissue, organs or data;
- Research taking place on UHB premises, satellite sites and authorised external organisations, or involving UHB resources, including non-clinical and laboratory based research;
- Research being undertaken as part of an educational qualification.

Equality and Health Impact Assessment	An Equality Impact Assessment (EqIA) was completed on Version 1 and 2 and this found there to be no impact. This EqIA has been updated with new references to form a EHIA. The changes to the Policy (see below) would not impact on the outcome of the EHIA.

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Research Governance Group
Accountable Executive or Clinical Board Director	Medical Director

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**
2	Review by Research Governance Group 26/04/2016	1/11/2016	The document has been updated to reflect the current Clinical Board and committee structure of the UHB, the changes to Health and Care Research Wales and updated internal UHB documents. The Mental Capacity Act has been highlighted in certain sections. The Audit section has been changed to reflect alignment with the current Research Audit SOP
3	Review by Research Governance Group		In line with UHB requirements, this Policy now follows the Policy template of UHB. UHB Policy has been replaced by a Policy and a Procedure and has been updated to reflect the replacement of the Research Governance Framework for Health and Social Care in Wales with the UK Policy Framework for Health and Social Care Research.

Equality & Health Impact Assessment for

Research Governance Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Research Governance Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Research and Development Office, Medical Director's Office, Executive Clinical Board Research and Development Manager, R&D Office, Room 15A, TB2 Floor 2, UHW
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To: • Ensure that R&D is of the highest quality and that researchers operate within the same quality framework as the services which the research is aimed at improving • Ensure that all R&D is carried out lawfully, properly and sensitively respecting the rights, dignity, wellbeing and safety of participants • Clearly identify the responsibilities of individuals involved in R&D

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	Previous EQIA performed on the previous version of the Research Governance Policy. Comments from those involved in the designing and development stages Good practice guidelines Based on content of the UK Policy Framework for Health and Social Care Research which underwent extensive consultation at the UK wide level at staff and service user level.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Staff and service users involved in Research and Development

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.**
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		

6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Yes Documents are not automatically published in Braille or languages other than English. The primary source of circulation is via the intranet. Software which will read the policy for the reader is now very common therefore documents should generally be accessible to those with a visual impairment. The Disability Discrimination Act requires that information should be made accessible for those with disabilities. In addition, recommendations on accessibility in terms of reading age, form part of the ethical review undertaken of all research taking place within the NHS and are contained in the NRES guidance referenced at the end of this section. Where specific groups with a particular disability are part of a research group under study then as part of the ethical review, arrangements for taking informed consent in an appropriate way and with appropriate skills/tools will be a mandatory part of the review and approval process. The Health Research Authority together with the Medical Research Council 'Consent and Patient Information Sheet preparation Guidance' http://www.hra.nhs.uk/resources/before-you-apply/consent-and-participation/consent-and-participant-information/ highlights the requirement for information to be made available in appropriate ways to allow equality of access to research studies for all. Governance arrangements for Research Ethics Committees available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213753/dh_133993.pdf		

6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		
6.4 People who are married or who have a civil partner.	The policy applies equally to all research participants. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of		

	information governance management. The evidence suggests that it has no impact on this equality group.		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There are potential risks to the unborn child in including women of child bearing age in early phase drug studies. In the past this meant that only men were recruited. However, women are now included in these studies with very careful control of pregnancy testing before during and after the study and follow up and reporting of all pregnancy outcomes to the Medicine and Healthcare products Regulatory Agency. As part of the ethical review that all research studies undergo aspects of equality of access will be closely examined Governance arrangements for Research Ethics Committees available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213753/dh_133993.pdf		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests		

	that it has no impact on this equality group. Issues around cultural and language are dealt with extensively as part of the ethical review that all research projects undergo before getting approval to be undertaken. Evidence has been gathered from the National Research Ethics Service(NRES) website guidance document http://www.hra.nhs.uk/resources/before-you-apply/consent-and-participation/consent-and-participant-information/. In particular it is a requirement as part of ethical approval that if translation is required to enable an individual to consider taking part in a research project then translation must be provided by an independent translator provided by the organisation. There is a specific section in the NRES/IRAS application which highlights the fact that family members must not be used to ensure that there is no coercion. Governance arrangements for Research Ethics Committees available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213753/dh_133993.pdf		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence		

	to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group. Evidence has been gathered from the NMC which highlights the responsibility of all nurses/midwives to treat [people] fairly irrespective of race, disability, age, sexual orientation, religion or belief and gender. Available at http://www.nmc-uk.org/About-us/Equality-and-diversity/Equality-and-diversity-about-us/		
6.9 People who communicate using the Welsh language in terms of correspondence,	In respect of communication the UHB will need to ensure that people who wish to communicate in the Welsh medium have a means to do so as referred to in our Welsh Language Scheme. This can be found on the UHB website http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CA		

information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	RDIFF_AND_VALE_INTRANET/CORPORATE/WELSH_LANGUAGE/WELSH_LANGUAGE_SCHEME/20181130%20DG%20S%20COMPLIANCENOTICE44%20CARDIFF%20AND%20VALE%20UHB.PDF		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the		

access services and facilities	oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	No further additions required		

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered:	The policy applies equally to all research participants and all those involved in the research		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content.		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive	There is potentially a positive impact in this area as some research conducted in accordance with this policy may address how various interventions relating to changing lifestyle to more healthier choices can improve well being		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
services including smoking cessation services, weight management services etc. Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	This policy has little impact in this area		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the	This policy has little impact in this area. However some research conducted under this policy may produce results which show that certain interventions on physical environment may have a		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	positive impact on health and well-being.		
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos	Researchers are encouraged to seek input from the lay community/patient support groups when designing research studies. This can have a positive impact on the sense of belonging and 'community' identity.		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	High quality relevant research as outlined in this policy can have a positive impact on influencing government policy and guidelines		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	A policy which commits to the UHB carrying out high quality research in a safe and lawful manner has the potential to positively impact on the patient community by providing opportunities for patients to receive new and innovate treatments and diagnostic procedures and ensure UHB retains a positive reputation for undertaking high quality research

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	On reviewing the previous policy and writing the latest policy and procedure and completing the EHIA, there appear to be no negative impacts of the Policy. Therefore no key actions have been identified.			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As no negative impact has been identified, it is considered unnecessary to undertake a more detailed assessment.			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	On reviewing this policy and rewriting as a policy and procedure in line with UHB guidelines, the EQIA has been revisited and an EHIA now completed. The policy and procedure have been approved by Research Governance Group. When this policy is next reviewed, this EHIA will form part of that consultation exercise. This EHIA will be reviewed 3 years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required			

Reference Number: UHB 457 **Version Number:**1	**Date of Next Review: 30 APR 2022** **Previous Trust/LHB Reference Number** N/A

RESEARCH GOVERNANCE STANDARD OPERATING PROCEDURE

Introduction and Aim

Research Governance can be defined as the broad range of regulations, principles and standards of good practice that ensure high quality research. The Research Governance Standard Operating Procedure (the Procedure) underpins the Research Governance Policy. The Procedure should ensure that through outlining the responsibilities that fall to individuals involved in R&D that high quality research is carried out in accordance with the law and best practice.

Objectives

- To ensure that R&D is of the highest quality and that researchers operate within the same quality framework as the services which the research is aimed at improving.
- To ensure that all R&D is carried out lawfully, properly and sensitively, respecting the rights, dignity, wellbeing and safety of participants.
- To clearly identify the responsibilities that fall to individuals involved in research

Scope

The Procedure extends to all research activity, both commercial and non-commercial, involving the UHB including:

- Research using patients, carers, volunteers and members of staff at the UHB and in Primary Care settings;
- Research using patient tissue, organs or data;
- Research taking place on UHB premises, satellite sites and authorised external organisations, or involving UHB resources, including non-clinical and laboratory based research;
- Research being undertaken as part of an educational qualification.

Equality and Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has been completed on the Research Governance Policy under which this Research Governance Standard Operating Procedure falls and this found there to be no negative impact.*
Documents to read alongside this Procedure	*See Reference section.* *All R&D related SOPs as listed in the supporting documents section of the Research Governance Policy as they apply to*

	the type of research being undertaken
Approved by	*Research Governance Group*

Accountable Executive or Clinical Board Director	*Medical Director*
Author(s)	*Research and Development Manager*

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
1	30.04.2019	15.07.2019	This is a new Procedure. In compliance with the UHB Policy and Procedure templates, the previous version of the Research Governance Policy (UHB 099) has been rewritten as a separate short Research Governance Policy (UHB 099) underpinned by this Research Governance Procedure

Research Governance Standard Operating Procedure

CONTENTS **Page No.**

GLOSSARY OF TERMS

- **Chief Investigator (CI)** - The investigator with overall responsibility for the research. In a multi-site study, the CI has coordinating responsibility for research at all sites.

- **Investigational Medicinal Product (IMP)** - A pharmaceutical form of an active substance or placebo being tested or used as a reference in a clinical trial including a medicinal product which has a marketing authorisation but is, for the purposes of the trial, being used or assembled (formulated or packaged) in a way different from the approved form, or being used for an unapproved indication or when used to gain further information about an approved use.

- **Medicines and Healthcare products Regulatory Agency (MHRA)** – regulates medicines, medical devices and blood components for transfusion in the UK.

- **Participant** - Patient, service user, carer, relative of the patient or deceased, professional carer, other employee, or member of the public, who takes part in a research study (in law, participants in clinical trials involving IMPs are known as subjects).

- **Principal Investigator (PI)** – an individual responsible for the conduct of the research at a research site. There should be one PI for each research site. In the case of a single site study, the chief investigator and the PI will normally be the same person.

- **Research** - An attempt to derive generalisable or transferable new knowledge by addressing clearly defined questions with systematic and rigorous methods. Research may be aimed at understanding the basis and mechanism of disease, improving the diagnosis and treatment of a disease or designing better ways of delivering healthcare.

- **Research team**- Those conducting the research.

- **Research Ethics Committee (REC)** - Committee established to provide participants, researchers, funders, sponsors, employers, care organisations and professionals with an independent opinion on the extent to which proposals for a study comply with recognised legal and ethical standards. For clinical trials involving medicines, the reviewing REC must be one recognised by the United Kingdom Ethics Committee Authority.

- **Sponsor** - Individual, organisation or group taking responsibility for securing the arrangements to initiate, manage and/or finance a study. A group of individuals and/or organisations may take on sponsorship responsibilities and distribute them by agreement among the members of the group, provided that, collectively, they make arrangements to allocate all the responsibilities identified in the UK policy framework for health and social care research (1) and/or the Medicines for Human Use (Clinical Trials) Regulations 2004 (2) and their Amendments (3,4) that are relevant to the study.

- **Student Research** – Any research performed as part of an educational qualification.

1.0 BACKGROUND

1.1 Research is essential to the successful promotion and protection of health and wellbeing and also to modern, effective health and social care services. At the same time, research can involve an element of risk, both in terms of return on investment and sometimes for the safety and wellbeing of the research participants. Proper governance of research is essential to ensure that the public can have confidence in, and benefit from, quality research in health and social care. The public has a right to expect high scientific, legal and ethical and financial standards, transparent and fully informed decision making processes, clear allocation of responsibilities and robust monitoring arrangements in healthcare research.

1.2 The UK policy framework for health and social care research (1) sets out principles of good practice in the management and conduct of health and social care research that take account of legal requirements and other standards. These principles apply to all research that relates to the responsibilities of the Welsh Government and the other devolved administrations in the UK. It applies to clinical and non-clinical research, research undertaken by NHS or social care staff, research carried out in the Primary Care setting, research undertaken by NHS staff, using NHS resources, and research undertaken by industry, charities, the research councils, universities and local government within the health and social care systems.

2.0 PRINCIPLES

2.1 Explicit written confirmation of capacity and capability from the UHB's Director of Research and Development must be obtained prior to commencing clinical research activity at the UHB for any research which requires capacity and capability to be confirmed.

2.2 To obtain confirmation of capacity and capability the research must be reviewed in accordance with the UHB's R&D processes and in accordance with the Health and Care Research Wales Support Centre policies and procedures

2.3 Where required, written evidence of a favourable opinion from the appropriate NHS Research Ethics Committee must be obtained prior to commencing research. The requirements for ethical review by Research Ethics Committees are set out in the harmonised UK-wide edition of the Governance Arrangements for Research Ethics Committees (GAfREC, 2018), (5) and include:
(i) Requirements for ethical review of research under legislation applying to the UK as a whole or particular countries of the UK
(ii)Requirements for ethical review under the policy of the UK Health Departments, where research relates to the services for which they are responsible

2.4 For clinical trials involving an Investigational Medicinal Product (CTIMP), a Clinical Trial Authorisation from the Medicines and Healthcare Products Regulatory Agency (MHRA) must be obtained prior to the trial commencing. For Device studies a notice of no objection is required prior to the study commencing.

2.5 All research must be conducted in accordance with Good Clinical Practice (GCP) which means the principles and practices for the conduct of a study as provided for by the Medicines for Human Use (Clinical Trials) Regulations 2004 (2) and its Amendments (3,4), and the UK policy framework for health and social care research (1).

2.6 All research involving an Investigational Medicinal Product (IMP) undertaken within the UHB (whether University or NHS based) must adhere to UHB040 Investigational Medicinal Product (IMP) Management Standard Operating Procedure (7).

2.7 All intrusive research (which is not a CTIMP) for which consent is required and which may include participants who lack the mental capacity to agree to taking part must comply with the Mental Capacity Act 2005.

2.8 All investigators must be trained in compliance with the Research Training requirements including Good Clinical Practice (GCP) Training – SOP(UHB 317) (8).

2.9 All agreements and indemnity documents relating to research projects must be submitted through the R&D Office and signed by an authorised signatory. Independent practitioners in the Primary Care setting are responsible for their own agreements and indemnity documents.

3.0 ROLES AND RESPONSIBILITIES

3.1 Responsibilities – Chief Executive

The Chief Executive is responsible for ensuring that there are adequate arrangements in place for the governance of research involving the UHB.

The authorised signatory for agreements involving financial transactions is the Chief Executive or authorised deputy, except service level agreements as per section 3.3. The Association of the British Pharmaceutical Industry (ABPI) indemnity documents relating to clinical trials involving UHB patients must be signed by the UHB Chief Executive or by their authorised deputy.

3.2 Responsibilities - Medical Director

The overall responsibility for this Procedure rests with the Medical Director as Executive Lead for R&D.

3.3 Responsibilities –Director of Research and Development

The UHB Director of Research and Development has delegated responsibility for the conduct, governance and strategic direction of research within the UHB which includes (but is not limited to):

- The approval of Sponsorship or confirmation of capacity and capability of all research involving the UHB;
- Signing, on behalf of the UHB, all contracts for research where there is no financial component, non-disclosure agreements and Service Level Agreements of a small value with other local NHS organisations.
- Ensuring that the R&D Office meets the responsibilities detailed in section 3.5 and that the Office is appropriately resourced to do so.

3.4 Responsibilities – Management

3.4.1 Clinical Board Directors are responsible for:

- Establishing systems at Clinical Board level that facilitate compliance with the UK policy framework for health and social care research;
- Ensuring that all researchers working within their Clinical Board hold either a full or honorary UHB contract of employment in accordance with UHB Procedures, or a letter of access where appropriate.
- Appointment of Clinical Board R&D Leads.

3.4.2 Clinical Board R&D Leads are responsible for:

- Ensuring that research governance issues raised by the UHB Research Governance Group are communicated to their Clinical Board and that any relevant Clinical Board research governance issues are brought to the Research Governance Group.

3.4.3 Directorate R&D Leads are responsible for:

- Undertaking Directorate review of projects submitted for consideration for R&D approval/capacity and capability confirmation and informing the R&D Office whether the Directorate is able to support the proposed research activity. This should include scientific review where appropriate.
- Establishing systems at Directorate level to comply with the R&D Approval/capacity and capability confirmation processes of the UHB and for ensuring research governance issues are communicated throughout the Directorate.
- Reporting to Clinical Board R&D Leads and Clinical Board Directors.

3.4.4 Clinical Directorate Directors are responsible for:

- Appointment of Directorate R&D Leads and Deputy R&D Leads.

- Ensuring that, subject to section 3.8.1, in the event of the PI leaving the UHB and the study being terminated, the R&D Office is notified and, where applicable, appropriate arrangements are made to archive the study documents and data for closed studies ensuring it is still accessible. Study documents and source data must be retained in accordance with NHS Policy and in accordance with the R&D Standard Operating Procedures UHB 121 Archiving of Clinical trial and Research Study Data (9) and UHB 139 Data Management in Clinical Trials SOP (10)

3.5 Responsibilities - Research and Development Office

The UHB R&D Office is responsible for:

- Developing and establishing systems for the management of research involving the UHB including systems to ensure that the UHB can meet the responsibilities of a Sponsor under the Clinical Trials Regulations and the UK policy framework for health and social care research ;
- Ensuring the UHB R&D approval/confirmation of capacity and capability process meets the requirements of the Welsh Government;
- Maintaining a record of all clinical research being conducted within the UHB
- Ensuring, where necessary, that an appropriate NHS REC has approved the research;
- Assessing applications for the UHB to act as research Sponsor to individual studies;
- Arranging for written agreements to be put in place, where necessary, for research involving an external partner, funder and/or Sponsor;
- In relation to commercial research, costing commercial research studies, negotiating contracts, developing and establishing systems to ensure financial probity in collaboration with the UHB Finance Department;
- Providing advice relating to in basic research methodology and governance;
- Monitoring and audit of research practices across the UHB to include ensuring receipt of monitoring reports where appropriate;
- Permitting and assisting with any monitoring, auditing or inspection required by relevant authorities;
- Assisting with the development of the UHB R&D Strategy;
- Assisting with the identification of intellectual property arising from research and development;
- Compiling and submitting the UHB R&D Annual Report to the Welsh Government;
- Compiling and submitting research governance reports to the Research Governance Group and Quality, Safety and Experience Committee;
- Taking action in accordance with relevant UHB policies upon receipt of any report of suspected research fraud or misconduct;
- Taking relevant action in accordance with the Safety Reporting in CTIMPs SOP (UHB 253) (11) upon receipt of any serious adverse event report.

3.6 Responsibilities – Researchers

3.6.1 All research staff, including those holding an Honorary Contract with the UHB, have the responsibility of being familiar with clinical research training requirements in accordance with the UHB Research Training requirements including Good Clinical Practice (GCP) Training – SOP (UHB 317) (8) and as described in the UK policy framework for health and social care research and, where applicable, the Clinical Trial Regulations and the Mental Capacity Act 2005, and must conduct their role accordingly.

3.6.2 Researchers who do not hold a substantive employment contract with the UHB must obtain an Honorary Research Contract or Letter of Access (as deemed appropriate by the UHB) if they wish to undertake research activity in the UHB which involves:

- direct or indirect contact with patients/service users;
- access to identifiable or anonymised patient data derived from health records;
- access to identifiable or anonymised patient samples, tissues or organs;
- working on UHB premises;
- direct contact with UHB staff; access to identifiable or anonymised staff data.

3.6.3 Researchers are responsible for ensuring that:

- The research is conducted in accordance with the following:
  - The current version of the study Protocol (REC and UHB approved)
  - The UK policy framework for health and social care research (1)
  - The Clinical Trials Regulations (where relevant) (2-4)
  - The Data Protection Act (2018) and General Data Protection regulations (GDPR) (12)
  - Confidentiality Code of Practice for Health and Social Care in Wales (13)
  - Health and Safety at Work Act (1974)(14)
  - The Human Tissue Act (2004) (15)
  - The Mental Capacity Act (2005) (16)
  - The Mental Capacity Act 2005 (Loss of Capacity during Research Project) (Wales) Regulations 2007 (17)
  - The Mental Capacity Act Code of Practice (18)
  - Freedom of Information Act 2000 (19)
  - Medical Devices Legislation (20-22)

  - All relevant UHB Policies and Procedures

- The appropriate care professionals are informed of a subject's participation in research (with patient permission, where applicable).
- The integrity and confidentiality of clinical and other records and data generated by the research is protected in accordance with Data Protection Legislation (12) and the Caldicott Principles (23).
- Any failures in conducting the study in accordance with the above are reported as appropriate.
- All relevant adverse events are recorded and reported in accordance with the Safety Reporting in CTIMPs SOP (UHB 253) (11).
- Suspected fraud or misconduct is reported in accordance with UHB policies and procedures.
- Complying with Managing breaches of GCP or the Protocol SOP in accordance with SOP (UHB 235) (24)
- Informed consent is taken in accordance with UHB policies and procedures and the Mental Capacity Act 2005 is followed where appropriate.

3.7 Responsibilities - Chief Investigator (CI)

3.7.1 The CI must be a senior individual, with appropriate experience, expertise and training to either:

- undertake the design, conduct, analysis and reporting of the study to the standards set out in the UK policy framework for health and social care research or;
- lead and manage others who have been delegated responsibility for some of these aspects.

3.7.2 The CI has overall responsibility for the conduct of the research and is accountable to their employer, and, through them, to the Sponsor(s) of the research. If the research is taking place at more than one site, the CI takes on personal responsibility for the design, management and reporting of the study, and co-ordinating the Principal Investigators at other sites.

3.7.3 The CI is responsible for ensuring that:

- The research team gives priority at all times to the dignity, rights, safety and well-being of participants;
- The study complies with all legal and ethical requirements;
- The research is carried out to the standards required within the UK policy framework for health and social care research;

- All members of the research team/trial site team are trained in accordance with the UHB's Research Training requirements including Good Clinical Practice (GCP) Training – SOP (UHB 317) (8);
- For CTIMP studies each member of the research team, including those at collaborating sites, is qualified by education, training and experience to discharge their role in the study, and their qualifications are documented and retained in the Investigator Site Files at site;
- Students and new researchers have adequate supervision, support and training;
- A suitable Sponsor is secured and agreements are in place detailing the responsibilities of all parties involved in the research;
- Ensuring robust scientific review is obtained where applicable
- The study is registered as per IRAS requirements
- R&D confirmation of capacity and capability is obtained from each care organisation involved prior to commencing the study at that care organisation;
- The Protocol is, where required, submitted for review by a NHS REC, the study does not start without a favourable opinion, and the research team acts on any conditions attached to the ethics opinion;
- Unless urgent safety measures are necessary, the research follows the protocol or proposal agreed by the relevant REC, the UHB R&D Office and the Sponsor(s)[1];
- Substantial amendments to the project are re-submitted for HRA/HCRW approval (where required), and Sponsor(s) agreement (and MHRA approval where appropriate) in accordance with UHB procedures (25, 26). With the exception of urgent safety measures, these amendments are implemented only when approved[2];
- When a study involves participants under the care of a doctor, nurse or social worker for the condition to which the study relates, those care professionals are informed that their patients or users are being invited to participate (unless exemption has been given by a REC), and they confirm their agreement to retain overall responsibility for their care;
- When the research involves a service user or carer or a child looked after or receiving services under the auspices of the local authority, the agency director or their deputy agrees to the person (and/or their carer) being invited to participate, and is fully aware of

[1] For clinical trials involving medicines, it is a legal requirement to follow the protocol approved by the licensing authority (the Medicines and Healthcare products Regulatory Agency).
[2] Also, for clinical trials involving medicines, to the licensing authority (MHRA)

the arrangements for dealing with any disclosures or other relevant information;

- Potential participants and other service users and carers are involved in the design and management of the study whenever appropriate;
- Unless participants or the NHS REC opinion says otherwise, participants' care professionals are given any information directly relevant to their care that arises in the research;
- For clinical studies involving medicines and/or devices, the research follows any conditions imposed by the UK Regulatory Authority (the MHRA);
- Procedures are in place to ensure collection of high quality, accurate data and to maintain the integrity and confidentiality of data during processing and storage[3];
- Recruitment data uploads entered by participating sites on national databases are checked. In circumstances where central upload of recruitment data is mandated, to accept responsibility for the upload of all participant recruitment data onto the national database.
- Arrangements are in place for the management of financial and other resources provided for the study;
- Arrangements are in place for the management of any intellectual property arising from the research;
- Reports on the progress and outcomes of the work required by the UHB R&D Office, the Sponsor(s), funders, MHRA or others with a legitimate interest are produced on time and to an acceptable standard;
- The findings from the work are open to critical review through the accepted scientific and professional channels;
- They accept a key role in detecting and preventing scientific misconduct by adopting the role of guarantor on published outputs. Once established, findings from the work are disseminated promptly and fed back as appropriate to participants;
- There are appropriate arrangements to archive the data when the research has finished, and to ensure it is still accessible. Study documents and source data must be retained in accordance with NHS Policy and the R&D Standard Operating Procedures UHB 121 Archiving of Clinical trial and Research Study Data (9) and Data Management in Clinical Trials SOP (UHB 139) (10). All data and documentation associated with the study are made available at the request of the inspection and auditing authorities.

[3] Also, for clinical trials involving medicines, procedures to comply with legal requirements concerning Good Clinical Practice during the trial, and Good Manufacturing Practice in manufacturing investigational medicinal products.

3.7.4 Where the CI delegates responsibilities to members of the research team, this must be clearly documented in a study delegation log or similar, and kept in the Trial Master File or similar for each study. The CI remains accountable for the actions of his/her research team.

3.8 Responsibilities - Principal Investigator (PI)

3.8.1 The PI is the individual responsible for the research site where the study involves specified procedures requiring capacity and capability assessment. For multi-site studies, there should be one PI for each research site. In the case of a single site study, the CI and the PI will normally be the same person. In this case the CI must assume the PI responsibilities detailed in this procedure in addition to the CI responsibilities.

3.8.2 The PI is responsible for the conduct of the study at the study site and must ensure that:

- The research team give priority at all times to the dignity, rights, safety and well-being of participants;
- The study complies with all legal and ethical requirements;
- The research is carried out to the standards in the UK policy framework for health and social care research;
- All members of the research team/trial site team are trained in accordance with the Research Training requirements including Good Clinical Practice (GCP) Training – SOP (UHB 317)(8);
- Each member of the local research team is qualified by education, training and experience to discharge his/her role in the study, and their qualifications are documented and retained in the Investigator Site File;
- All local researchers involved in a clinical trial of IMPs are aware of their legal duties and expressly agree to accept their tasks and roles on an individual study basis
- Students and new researchers have adequate supervision, support and training;
- UHB R&D approval/confirmation of capacity and capability is obtained prior to commencing the study;
- Unless urgent safety measures are necessary, the research follows the protocol or proposal agreed by the relevant ethics committee, by the UHB R&D Office and by the Sponsor[4];

[4] For clinical trials involving medicines, it is a legal requirement to follow the protocol approved by the licensing authority (MHRA).

- When a study involves participants under the care of a doctor, nurse or social worker for the condition to which the study relates, those care professionals are informed that their patients or users are being invited to participate, and they confirm their agreement to retain overall responsibility for their care;
- When the research involves a service user or carer or a child looked after or receiving services under the auspices of the local authority, the agency director or their deputy agrees to the person (and/or their carer) being invited to participate, and is fully aware of the arrangements for dealing with any disclosures or other relevant information;
- Unless participants or the ethics opinion says otherwise, participants' care professionals are given any information directly relevant to their care that arises in the research;
- For clinical trials involving IMPs and or devices , the research follows any conditions imposed by the Regulatory Authority (the MHRA);
- Procedures are in place to ensure collection of high quality, accurate data and for the integrity and confidentiality of data during processing and storage[5];
- Arrangements are in place for the management of financial and other resources provided for the study;
- Arrangements are in place for the management of any intellectual property.
- Reports on the progress and outcomes of the work required by the CI, the UHB R&D Office, the Sponsor(s), funders, MHRA or others with a legitimate interest are produced on time and to an acceptable standard;
- The findings from the work are open to critical review through the accepted scientific and professional channels;
- Once established, findings from the work are disseminated promptly and in accordance with Sponsor arrangements and fed back as appropriate to participants;
- There are appropriate arrangements to archive the data when the research has finished, and to ensure it is still accessible. Study documents and source data must be retained in accordance with NHS Policy and the R&D Standard Operating Procedures UHB 121 Archiving of Clinical Trial and Research Study Data (9) and UHB 139 Data management in Clinical Trials SOP (10)

[5] Also, for clinical trials involving medicines, procedures to comply with legal requirements concerning Good Clinical Practice during the trial, and Good Manufacturing Practice in manufacturing investigational medicinal products.

- All data and documentation associated with the study are made available at the request of the inspection and auditing authorities;
- In the event that the PI's position at the UHB is terminated that either (a) an appropriate individual assumes the role of PI and the Sponsor(s), REC, MHRA, CI and the R&D Office are informed and approve of the change in PI or (b) the study is terminated. The PI must ensure that information is provided to the Clinical Director so that the responsibilities in section 3.4.4 can be discharged

3.8.3 The PI must ensure that the R&D Office is involved in arranging agreements relating to the UHB's responsibilities in conducting research involving an external partner, funder and/or Sponsor and that these are authorised through the R&D Office in accordance with section 3.5

3.8.4 In relation to commercial research, the PI must:

- Refer all commercial research to the R&D Office at the earliest opportunity prior to the research commencing;
- Ensure that commercial research is performed under a written agreement between the UHB and the commercial company. This agreement must be signed by the Chief Executive of the UHB or delegated deputy and must have been checked for authorisation by the R&D office.

3.8.5 The PI is responsible for ensuring that recruitment data for the site is uploaded onto the Local portfolio management System (ReDA3 in a timely manner, as instructed by the UHB R&D Office

3.8.6 The PI is responsible for ensuring they provide the R&D office with sufficient information on each study for completion of the mandatory minimum data set required by Welsh Government

3.9 Responsibilities – All UHB staff

Before agreeing to their patients or service users being approached, all staff must satisfy themselves that the research has been approved by the UHB R&D Office and, where necessary, the appropriate REC and regulatory authorities. All staff have a responsibility to act within the limitations of their role, their training and competence. Staff must be supported to meet the required standards of the UHB in relation to skills training and competence assessment both prior to, and for the duration of their time working on the research study.

4.0 RESOURCES

4.1 The UHB R&D Office has responsibility for ensuring arrangements are in place for monitoring and auditing of research. This helps to ensure that the UHB's legal responsibilities in relation to the conduct of R&D can be met.

4.2 It is a legal requirement for all staff involved in studies covered by the Clinical Trials Regulations to work to the principles of GCP. There will be ongoing resource implications for ensuring all relevant staff have training as per the Clinical Research Training requirements including Good Clinical Practice (GCP) Training – SOP (UHB 317) (8) This should be funded from the Health and Care Research Wales allocation to the UHB.

4.3 Research will not be undertaken unless there is appropriate resource identified.

5.0 TRAINING

5.1 Clinical Board R&D Leads will ensure that the relevant staff within their Clinical Board are aware of the Research Governance Policy and this Research Governance Procedure and the implications for their practice.

5.2 The existence of the Research Governance Policy and Procedure and its implications for researchers will be covered during UHB R&D training events.

5.3 Ongoing support of research staff will be provided via the UHB R&D Office.

6.0 IMPLEMENTATION

All staff undertaking R&D within the UHB together with those who have a specific responsibility within this Procedure are responsible for its implementation.

7.0 EQUALITY

The UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate

against individuals or groups. We have undertaken an Equality and Health Impact Assessment on the Research Governance Policy under which this Procedure falls and received feedback on the Policy and the way it operates. We wanted to know of any possible or actual impact that the Policy or Procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact to the equality groups mentioned.

8.0 AUDIT

8.1 The UHB Research Governance Group is responsible for overseeing the operational management of research governance and for providing assurance of robust research governance arrangements in the UHB. It will be necessary to ensure that research projects hosted by the UHB are being carried out in accordance with the Research Governance Policy and Procedure..

8.2 Risk-based audit of a small selection of research projects will be carried out in compliance with the Research Audit SOP (UHB 236) to ensure that processes comply with this procedure. Similarly, for selected UHB Sponsored studies, audit visits will assess awareness of and compliance with this procedure. Audit findings will be reported to the Research Governance Group and to the UHB Quality, Safety and Experience Committee where appropriate. Principal Investigators may also be expected to carry out self-audit under the guidance of the R&D Office.

9.0 DISTRIBUTION

The document will be available via the UHB Intranet and on the R&D Internet pages once reconfigured in partnership with Health and Care Research Wales Support Centre.

10.0 REVIEW

The Procedure will be reviewed every 3 years, or more regularly if new legislation so requires.

REFERENCES

(1) UK policy framework for health and social care research v3.3 7/11/17. https://www.healthandcareresearch.gov.wales/uploads/Policy%20%26%20Strategy/Research%20Governance/uk-policy-framework-health-social-care-research.pdf

(2) The Medicines for Human Use (Clinical Trials) Regulations 2004 (Statutory Instrument 2004/1031) and amendments. The Medicines and Healthcare products Regulatory Agency http://www.legislation.gov.uk/uksi/2004/1031/contents/made

(3) The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006 (Statutory Instrument 2006/1928). The Medicines and Healthcare products Regulatory Agency (2006). (http://www.hmso.gov.uk/si/si2006/20061928.htm)

(4) The Medicines for Human Use (Clinical Trials) Amendment (No. 2) Regulations 2006 (Statutory Instrument 2006/2984). The Medicines and Healthcare products Regulatory Agency (2006). (http://www.hmso.gov.uk/si/si2006/20062984.htm)

(5) GAfREC is available at https://www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/research-ethics-committee-standard-operating-procedures/

(6) HRA guidance on requirements for ethical review https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/research-ethics-committee-review/applying-research-ethics-committee/

(7) Investigational Medicinal Product (IMP) management Standard Operating Procedure. (UHB 040)

(8) Research Training requirements including Good Clinical Practice (GCP) Training – SOP (UHB 317)

(9) Archiving of Clinical Trial and Research Study Data SOP (UHB 121)

(10) Data Management in Clinical Trials SOP (UHB 139)

(11) Safety Reporting in CTIMPs SOP (UHB 253)

(12) The Data Protection Act (2018) and General Data Protection Regulation (GDPR) *https://ico.org.uk/for-organisations/guide-to-data-protection/introduction-to-data-protection/about-the-dpa-2018/*

(13) Confidentiality Code of Practice for Health and Social Care in Wales http://www.wales.nhs.uk/sites3/Documents/950/CodeofPractice.pdf

(14) Health and Safety at Work Act (1974) http://www.hse.gov.uk/legislation/hswa.htm

(15) The Human Tissue Act (2004). http://www.legislation.gov.uk/ukpga/2004/30

(16) The Mental Capacity Act (2005). http://www.legislation.gov.uk/ukpga/2005/9

(17) Welsh Statutory Instrument 2007 No.837 (W.72) The Mental Capacity Act 2005 (Loss of Capacity during Research Project) (Wales) Regulations 2007

(18) The Mental Capacity Act 2005 Code of Practice http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpgacop_20050009_en.pdf

(19) Freedom of Information Act (2000) http://www.legislation.gov.uk/ukpga/2000/36/contents

(20) Medical Devices Regulations 2002 http://www.legislation.gov.uk/uksi/2002/618/introduction/made

(21) The EU Regulation on Medical Devices 2017/745 https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32017R0745&from=EN

(22) The EU regulation on In Vitro Diagnostic Medical Devices 2017/746 https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32017R0746&from=EN

(23) NHS Executive. Caldicott Guardians. HSC 1999/012 (1999).

(24) Managing Breaches of GCP or the study protocol SOP (UHB 235)

(25) Managing Amendments for UHB Sponsored Research (UHB 302)

(26) Amendments to research studies which are being hosted by Cardiff and Vale UHB – information on submission and review (ISR-RP-

Report Title:	**FRAMEWORK FOR THE MANAGEMENT OF PERFORMANCE CONCERNS IN GENERAL MEDICAL PRACTITIONERS (GPs) ON THE MEDICAL PERFORMERS LIST WALES**								
Meeting:	**QUALITY, SAFETY AND EXPERIENCE**						**Meeting Date:**	17.09.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**	✓	**For Information**		
Lead Executive:	**MEDICAL DIRECTOR**								
Report Author (Title):	**PCIC QUALITY AND SAFETY MANAGER**								

SITUATION

Health Boards (HBs) are responsible for assessing and arranging appropriate and proportionate action in response to concerns expressed to them about any General Medical Practitioners (GMPs, also termed GPs) or GP Specialty Trainee included on their Medical Performers List or providing NHS General Medical Services in their catchment area. The performance management of General Practitioners is underpinned by the National Health Service (Performers Lists) (Wales) Regulations 2004 (as amended), the NHS Wales Act 2006 and the Medical Profession (Responsible Officer) Regulations 2010. At all times, decisions must be made in accordance with existing legislation.

REPORT

BACKGROUND

The *Framework for the Management Of Performance Concerns In General Medical Practitioners (GPs) on the Medical Performers List Wales* (the Framework) (Appendix 1) has been developed by NHS Wales Shared Services Partnership in conjunction with key Health Board stakeholders to guide the management of the operational aspects of HB Performance Procedures for GPs who are on a Medical Performers List in Wales. The Framework outlines the process by which teams identify, manage and support GP Performers when performance concerns arise. The Framework is complementary to Welsh Government guidance WHC (2005) 059, guidance issued by Health Departments for dealing with disciplinary matters and guidance on the management of Medical Performers lists.

ASSESSMENT

Whilst the Framework has been designed to ensure consistency of approach across Wales, it is also recognised that local context varies; the Framework has been modified to account for the particularities of Cardiff and Vale University Health Board (UHB). This format of the Framework has been submitted to, and accepted by, the Primary, Community and Intermediate Care (PCIC) Clinical Governance Group and PCIC Quality, Safety and Experience Group.

ASSURANCE is provided by: strong governance arrangements within the PCIC Clinical Board, comprising weekly discussions of ongoing cases and regular meetings with the Senior Advisor from Practitioner, Performance and Advice (formerly the National Clinical Advisory Service), the PCIC Director of Operations, PCIC Director of Nursing, and the Head of Primary Care, as well

as regular updates from the PCIC Clinical Director for Clinical Governance to the UHB Medical Director.

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

- Approve the Framework for use in the UHB.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

FRAMEWORK FOR THE MANAGEMENT OF PERFORMANCE CONCERNS IN GENERAL MEDICAL PRACTITIONERS (GPs) ON THE MEDICAL PERFORMERS LIST WALES	
Author: Primary, Community and Intermediate Care (PCIC) Clinical Governance Team, based on the document developed by the Primary Medical Care Advisory Team (PMCAT)	
Date: 23rd April, 2019	**Version:** 4
Status: Final	
Intended Audience: UHB Board, Medical Director, PCIC Senior Management Team, Director of Primary, Community and Mental Health, Assistant Medical Directors, Head of Primary Care, GPC Wales, LMC, Wales Deanery	

FRAMEWORK FOR THE MANAGEMENT OF PERFORMANCE CONCERNS IN GENERAL MEDICAL PRACTITIONERS ON THE MEDICAL PERFORMERS LIST WALES

1. Introduction

1.1. This Framework for The Management of Performance Concerns in General Medical Practitioners on the Medical Performers List Wales ("The Framework") has been developed to guide the management of the operational aspects of Health Board (HB) Performance Procedures for General Medical Practitioners (GMPs, also termed GPs) who are on a Medical Performers List in Wales. The Framework outlines the process by which teams identify, manage and support GP Performers when performance concerns arise.

1.2. The Framework applies to all doctors on a Medical Performers Lists (MPL) in Wales and provides guidance on a uniform and consistent approach and interpretation in dealing with GP performance concerns.

1.3. The Framework is underpinned by the National Health Service (Performers Lists) (Wales) Regulations 2004 (as amended), the NHS Wales Act 2006 and the Medical Profession (Responsible Officer) Regulations 2010. At all times, decisions must be made in accordance with existing legislation.

1.4. The Framework is complementary to Welsh Government guidance WHC (2005) 059**,** guidance issued by Health Departments for dealing with disciplinary matters and guidance on the management of Medical Performers lists.

1.5. For those GPs who are directly employed by Health Boards, the Upholding Professional Standards in Wales (UPSW) disciplinary procedure guidance should also be considered.

1.6. Performance concerns regarding GPs in training should be managed in consultation with the Wales Deanery, Health Education and Improvement Wales (HEIW).

1.7. The professional regulator, the General Medical Council, is required to investigate and/or take action when serious concerns are raised regarding Fitness to Practice. Action taken by the professional regulator may have implications for the status of the Performer on the Medical Performers List.

2. Roles and Responsibilities

2.1. Health Boards (HBs) are responsible for assessing and arranging appropriate and proportionate action in response to concerns expressed to them about any GMP or GP Specialty Trainee (GPST) included on their Medical Performers List (MPL) or providing NHS General Medical Services in their catchment area.

2.2. The responsibility for action in respect of a Performer rests with the Health Board (HB) on whose MPL in Wales the Performer is included. The Responsible Officer (RO) of the Health Board on whose Performers List the Performer is included has responsibility for deciding the most

appropriate course of action. For GP Specialty Trainees the Responsible Officer is the Postgraduate Dean.

2.3. Regulation 16 of the NHS (Performers Lists) (Wales) Regulations 2004, as amended, details the notification requirements where probity action is taken against a Performer, regardless of whether or not that individual is also on the Performers List of another Primary Care Organisation in England, Scotland or Northern Ireland.

2.4. Any contractual issues that may arise should be dealt with separately under the NHS (General Medical Services Contracts) (Wales) Regulations 2004, as amended.

2.5. GP Performers have a statutory and professional duty to comply with any assessment, review or investigation.

3. The Medical Performers List

3.1. All GPs working in Wales must be either provisionally, conditionally or fully included on an MPL in Wales. Where a GP has been granted provisional inclusion in a List, the GP Performer may work in Wales for up to 3 months from the date of receipt of their application or until a final determination has been made on the application by the relevant HB.

3.2. GP Registrars who have submitted an application to work in Wales will be granted a grace period of 3 months from the date of their GP placement during which they can work in Wales without being on the MPL.

4. Governing Principles

4.1. At every stage in the performance process, the following governing principles should be followed:

- Patient safety must be paramount
- The process should be fair, transparent and proportionate
- The welfare of the practitioner should be taken into consideration throughout the process

4.2. Local procedures aim to provide a structured framework to:

- Protect the safety and wellbeing of patients and the public when a performance concern has been raised
- Respond appropriately to expressions of concern about practitioner performance (at an early stage whenever possible)
- Outline circumstances when further action (such as an external investigation and/or performers list action process) is required
- Provide a structured framework for the assessment and/or investigation of a performance concern
- Ensure the process for any assessment, investigation or review is open, transparent and fair to all parties
- Provide an accurate report upon which to base decisions and actions
- Take a formative approach if appropriate

- Support those involved
- Encourage learning and reflection regarding performance risk factors, case process and outcomes

4.3. It is important that potential problems are identified as early as possible, both to protect patients and to support practices and practitioners in managing clinical risks appropriately. A formative approach should be encouraged throughout the process.

4.4. Whilst the information itself is confidential, the process must be fair and well-defined for practitioners involved in the process. The process should be carried out in a robust but timely manner with regular communication with the practitioner as appropriate. A well-documented audit trail of activity should be recorded, including the rationale behind any decisions made.

4.5. The concept of performance is based not only on an individual's competence but also on the systems and processes supporting the clinician within the working environment. Therefore the environment within which a GP Performer works should be taken into consideration for any performance concern raised. Organisational responsibility for assuring a safe working environment should be considered as part of any performance review.

4.6. Consistent terminology should be applied across organisations to ensure those involved are clear about stage, roles and responsibilities.

4.7. It is important that all parties have confidence in the process. Individuals and teams involved in the delivery of the Framework should have appropriate training, support and performance review relevant to their respective roles.

4.8. Advice and support for the practitioner should be encouraged at every stage of the process. Advice and support can be provided by the Local Medical Committee (LMC), the British Medical Association (BMA) and/or the GP Performers Medical Defence Organisation (MDO).

4.9. It should be acknowledged that the performance process may be stressful for a Performer. Health and wellbeing support for the Performer can be accessed through support services, which can include:

- The GP occupational health service linked to each Health Board
- The Health for Health Professionals Wales Service (or equivalent)
- BMA counselling service
- The practitioners GP

5. Identifying and addressing concerns

5.1. A performance concern relates to any aspect of a performer's conduct or performance, which may, or may appear to:

- Present a risk to patient safety
- Undermine the efficiency of primary care services
- Undermine patient and public confidence in the NHS
- Represent a financial risk to the organisation or service

- Represent a significant departure from accepted guidelines and/or professional standards

5.2. Concerns about a practitioner's performance can come from a wide range of sources including (but not exclusively):

- Patient complaints
- Colleague concerns
- Prescribing data
- Practice inspections
- Incident reporting systems
- Information from the police or coroner
- Information from regulatory bodies
- Public Service Ombudsman for Wales (PSOW)
- Court actions
- Media reports
- Counter fraud services
- Safeguarding services

5.3 NHS organisations should aim to develop and maintain a culture that provides an environment where people feel able to raise concerns. However, if an individual wants to raise a concern confidentially this should be respected. "Protected disclosure" is the legal term for whistleblowing and is referenced in the context of describing the protection afforded to the person raising the concern in the interest of the public. There are statutory provisions for individuals who make what are termed "protected disclosures".

6. Health Board Stages

6.1. Health Boards have an obligation to take account of all information provided to them. Where this information gives rise to concerns about a practitioner's conduct, performance or health, the Health Board is required to take appropriate action to safeguard patients and the Performer involved.

6.2. When an expression of concern regarding performance is received by the Health Board, the process for managing the performance concern can be considered using a four-stage process:

1. Stage 0 – Receipt of Concern and Consideration
2. Stage 1 – Initial Assessment
3. Stage 2 – Investigation
4. Stage 3 – Reference Panel

6.3. The performance process does not require that each stage in the process be applied sequentially. Under certain circumstances, it may be necessary for a HB to act rapidly, especially if there are serious concerns over patient safety. In these circumstances, Practitioner Performance Advice, NHS Resolution (PPA) has agreed to provide a rapid response advisory service for Health Boards. Similarly, a screening process can take place at any stage. Any decision made should be appropriately justified and the Performer informed of the reasons for the decision.

6.4. Further assessment and/or investigation may **not** be required following consideration of the following:

- There is no dispute of relevant facts
- Sufficient evidence exists to take action
- Where the reported performance concerns:
  - Do not have a substantial basis
  - Are refuted by other available evidence
  - Are frivolous, malicious or vexatious.
  - The case needs to be referred to the Police or NHS Counter Fraud Service Wales (CFS)
  - The doctor agrees with the relevant facts
  - Confirmed or suspected ill health would make an investigation inappropriate at that time.
  - Concerns are being investigated by another agency

6.5. At any stage, the Medical Director (or nominated deputy) may request the advice of a Health Board decision-making group, the Primary Medical Care Advisory Team (PMCAT), Health Education and Improvement Wales, the National Clinical Assessment Service (Practitioner Performance Advice) and/ or the General Medical Council (GMC).

6.6. If "protected disclosure" status is declared then the HB should ensure due process is followed to protect the complainant as appropriate

6.7. The process should be transparent to all parties and follow standard guidelines to minimise legal and organisational risk.

6.8. Anonymous complaints and concerns based on 'soft' information should be considered within the same decision-making process and a record kept of the concern and the justification for whether further action was required.

6.9. The welfare of the Performer should be taken into consideration at each stage in any performance process.

6.10. It is recommended that a GP Performer involved in a performance concern, inform his or her practice partners and/or working colleagues as early in the process as possible.

6.11. An occupational health assessment should be considered and/or offered to any Performer involved in a performance concern.

6.12. If at any time an attitudinal and/or behavioural component to the concern is raised, advice from PPA should be considered.

7. Receipt of potential concern and consideration (Stage 0)

7.1. Every expression of concern received by a Health Board should be recorded and initially considered within a consistent decision-making process in relation to context, source, severity, risk and overall degree of concern. All concerns and decisions (with justification) should be recorded.

7.2. Depending on the degree of concern and potential risk to patient safety, a decision should be made as to the most appropriate further management of the concern.

7.3. If "protected disclosure" status is declared then the HB should ensure that due process is followed to protect the complainant as appropriate. It is recommended that whistle –blowing status is considered and clarified for any performance concern so raised. (See All Wales Procedure for NHS Staff to Raise Concerns)

7.4. The HB should ensure that any allegation of a malicious or potentially malicious nature is adequately corroborated by evidence from another source or verified by an initial assessment before action is considered.

7.5. Where concerns are considered to be minor (so called "soft concerns") and do not pose any significant or immediate risk, a decision can be made to deal with the matter by addressing concerns as areas of development via discussion with the Performer, or through the GP appraisal process. These "soft" concerns may not require to be escalated but would require to be logged and monitored by the Health Board. It is recommended that "soft" concerns are shared with the Performer.

7.6. The key component of the consideration stage is that there is a written record describing the concern, who it was from, how it was handled and the rationale behind any decision made.

7.7. In general, the system and process for early-stage consideration and/or Initial Assessment where there are soft concerns must be responsive, flexible, proportionate and sensitive to individual circumstances but be robust enough to produce effective and timely action.

8. Initial Assessment (Stage 1)

8.1. A Health Board may receive a performance concern about a GP Performer that requires further information regarding what the concern means, the context within which it was raised and whether there is a reasonable and valid explanation from the Performer.
8.2. The purpose of a **Stage 1 Initial Assessment** is to look at the validity, nature and severity of the performance concern based on available information, and to determine whether the received concern can be resolved by local approaches with the practitioner (such as mentoring, action plans, and mediation) or whether the concern requires further investigation or review (Stage 2) and/or a more formal process (such as a Reference Panel and/or referral to an external or regulatory body).

8.3. The **Stage 1 Initial Assessment** would also determine whether action is indicated for the whole practice in terms of team or organisational processes.

8.4. Information gathered for the **Initial Assessment** may include the following:

Performance Information:

- Prescribing data
- Referral data
- QOF Performance

Quality Information:

- Complaints and Concerns including "soft concerns"
- Significant events/incidents
- Regulatory Issues
- Clinical Governance Practice Self-Assessment Toolkit (CGPSAT)
- Healthcare Inspectorate Wales (HIW) Reports
- Practice Development Plans
- Cluster Development Plans
- Sustainability Framework Returns
- Health Board Information
- Appraisal/revalidation information

Contract Information:

- Contract Visit Information
- Contract Performance Data
- Details of any breach notices

Practice/practitioner response Information:

- Correspondence/communication from the practice/practitioner

8.5. Guidance is available on how to undertake an initial assessment within the resources section.

8.6. A **Stage 1 Initial Assessment** is managed by the Health Board **Primary, Community and Intermediate Care (PCIC) Clinical Governance Team**. People undertaking this role should be appropriately trained.

9. Investigation (Stage 2)

9.1. Where concerns are of a more serious nature and/or there is a need for more information following a Stage 1 Initial Assessment, the PCIC Clinical Governance Team may require a more detailed investigation (Stage 2).

9.2. The PCIC Clinical Governance Team should check the Medical Performers List (MPL) as to which HB the GP Performer is included. Where this differs from the HB with whom the concern was initially raised, the responsibility for the Investigation and/or screening process reverts to the HB on whose MPL the GP Performer is included. This is particularly important where GP Performers are freelance/locum and work across several HBs.

9.3 The aim of a Stage 2 Investigation is to gather facts, information and evidence relating to the circumstances of a performance concern

9.4. It may be necessary to undertake a Stage 2 Investigation prior to the screening process to establish more facts to support decision-making. Evidence presented at this stage should be adequately corroborated and verified.

9.5. A **Stage 2 Investigation** will usually be appropriate where case information suggests that the performer may:

- Pose a threat or potential threat to patient safety
- Work outside acceptable practice guidelines and standards
- Undermine the reputation or efficiency of services in some significant way
- Expose services to financial or other substantial risk.

9.6. The (A)MD may appoint a **PCIC Clinical Governance Team member** to lead or coordinate the investigation but shall retain responsibility and oversight for the conduct of the investigation.

9.7. The **PCIC Clinical Governance Team** should appoint a **Case Investigator** to undertake the investigation.

9.8. The **Case Investigator** may be an appropriately trained member of the HB, an independent medical practitioner specially contracted to the HB for this purpose or a Primary Medical Care Advisor from PMCAT.

9.9. A Primary Medical Care Advisor from PMCAT may undertake an investigation or external review (as a **Case Investigator**) on behalf of the Health Board particularly if the case involves complex clinical issues or if independent medical advice is required.

9.10. PPA can offer guidance as to the most appropriate process for the Health Board to pursue, including whether a PMCAT investigation or review is appropriate.

9.11. Guidance is available on how to conduct an investigation or external review. It is recommended that Case Investigators are appropriately trained and kept up to date for this role.

9.12. Case Investigators should consider whether any conflict of interest exists before agreeing to undertake the investigation.

9.13. The role of the **Case Investigator** is to ascertain facts around what has happened, the context and reasons behind a concern and to compile a factual report for the **PCIC Clinical Governance Team**.

9.14. Any Investigation will be subject to clear and specific Terms of Reference provided by the **PCIC Clinical Governance Team** and agreed by the **Case Investigator**. Terms of Reference may require amendment during an investigation.

9.15. The GP Performer must be informed in writing by the HB as soon as it has been decided that an investigation is to be undertaken. The Health Board should ensure that the GP Performer receives the agreed Terms of Reference for the investigation, including the specific performance concerns raised. The GP Performer should also be informed of the names and functions of any individuals involved in the investigation. Any subsequent agreed changes to the Terms of Reference should be shared with the Performer.

9.16. GP Performers who are on a HB Medical Performers List and Practices contracted with the HB are required to cooperate with any such investigation under Paragraphs 76 and 77 of the NHS (GMS Contracts) (Wales) Regulations, 2004 (as amended).

9.17. The **Case Investigator** should be given a signed Letter of Authority from the HB before visiting the practice. Case records should not be viewed without this authorisation.

9.18. The HB should not notify the Local Medical Committee (LMC) at this stage without the consent of the Performer. However, the Performer should be encouraged to discuss any performance concerns raised with the LMC and the practice.

9.19. Once the **Case Investigator** has completed the investigation, the **PCIC Clinical Governance Team** will decide whether further action should be undertaken through local means or whether a performer's list regulations process (such as a Reference Panel) should be requested.

9.20. The Health Board may request suggestions for improvement or support from the **Case Investigator** but it should be recognised that conclusions and suggestions made will be based solely on the findings from the specific Terms of Reference for the investigation and not on information gathered by the **Primary, Community and Intermediate Care Clinical Governance Team** from other sources.

10. Screening Process

10.1. The function of the HB screening process is to consider corroborated allegations and other available evidence regarding concerns about the professional performance of a GP Performer. The process should take into account (as appropriate) the circumstances of the GP and the environment in which he or she works. The **PCIC Clinical Governance Team** should make recommendations on actions to address any issues. The screening process is not a statutory requirement. It advises the HB and the GP Performer on appropriate actions to be taken to resolve concerns but does not have the authority to make demands or request sanctions. The screening process can take place at any stage in a performance concern.

10.2. The screening process should provide a repository of expert advice from individuals with appropriate training, experience and knowledge of performance procedures and professional standards and be able to provide objective advice.

10.3. Membership of the screening process group should comprise the following individuals:

- An independent member of the HB Board who will chair the group
- An appropriately trained and experienced senior NHS manager
- A doctor nominated by the LMC

10.4. Individuals on the screening process group should not also be members of the Reference Panel for the same case.

10.5. The appropriate **PCIC Clinical Governance Team member** (with appropriate support) should attend to present the Primary, Community and Intermediate Care Clinical Governance Team report, which will include results of any assessment, reviews and/or investigations. The

PCIC Clinical Governance Team member can be questioned by the screening process group or by the practitioner. If PMCAT or any other external organisation has been involved in the investigation, the **Case Investigator** from that organisation may also be asked to attend and answer questions and/or submit a statement for the panel.

10.6. A Community Health Council representative may be invited to attend as an observer.

10.7. The GP must be involved in the screening process and may be accompanied by a companion. Without prejudice to the procedure set out in Schedule 2 to the Employment Act 2002, the companion may be an official or lay representative of the British Medical Association or Medical Defence Organisation; a representative of the LMC, a friend, partner or spouse. The companion may be legally qualified but should not be acting in a legal capacity. (WHC (2005)059)

10.8. The Terms of Reference for the screening process group should outline the following:

- The screening process group must act in a fair and transparent manner
- The screening process should consider the performance concerns and any related submissions presented to it by the HB and the GP
- The process should consider whether claims have been substantiated and not take action with regard to unsubstantiated claims other than to request more information
- The process may also consider any submissions made by the practice in which the GP works
- The information being considered by the screening process group should normally be made available to the GP at least one week or five working days prior to the screening process group meeting
- If the GP declines to attend it will not be possible to produce an agreed Action Plan and the HB will need to consider whether to use other informal arrangements or to convene a Reference Panel. If there are extenuating circumstances such that the GP is unable to attend, the Chair may agree to delay the screening process meeting.
- The group will make recommendations to the HB and/or practitioner. If referral to a statutory body is not indicated, the screening process group should make recommendations that are supportive and formative for the practitioner.
- The screening process should agree an Action Plan including timescales for the resolution of the performance concerns which have been raised
- The screening process may determine that there are no grounds for continuing concern and that no further action is needed
- The screening process may recommend further more formal action which may include referral for a PPA assessment or referral to a Reference Panel if they feel that patient safety has been, or is likely to be, significantly compromised
- The screening process should ensure that minutes of the meeting are shared with the practitioner

11. Action Plan

11.1. Where appropriate, the Stage 1 Initial Assessment and/or Stage 2 Investigation report will support the **PCIC Clinical Governance Team** and/or screening process in making recommendations to the practitioner and/or HB. This may lead to an Action Plan agreed between the HB and the GP Performer.

11.2. The GP Performer should be fully engaged in this process and a level of understanding established between the HB and GP.

11.3. The Action Plan should state:

- Clear objectives
- Who is responsible in providing support and assistance to the performer in making changes
- Whether and what further training needs are required
- A reasonable agreed timescale
- A clear monitoring and evaluation system
- Who is providing financial support and for which activity within the action plan

11.4. Where applicable, the practice team may also require to be involved, especially if performance concerns relate to the practice as a whole.

11.5. The Health Board **PCIC Clinical Governance Team** is responsible for monitoring the Action Plan.

11.6. There will be a timescale with a stated period of review agreed in the Action Plan. A Primary, Community and Intermediate Care Clinical Governance Team should have the authority to amend an Action Plan in conjunction with the GP Performer if circumstances change and it is appropriate to do so.

11.7. The GP Performer should be made aware the timescales around a process of review by the Health Board within the Action Plan. If the agreed objectives are not met within the time set, then the HB should make it clear to the Performer that the Action Plan is in danger of failing. The reasons behind any delay should be explored urgently with the GP Performer or Practice and a decision made as to whether additional support or actions are required.

12. Reference Panel (Stage 3)

12.1. The function of the HB Reference Panel is to consider evidence regarding the professional performance of a GP. Evidence presented at a Reference Panel may come from a number of sources (for example a report from the GMC, an independent investigation commissioned by the HB etc).

12.2. The Reference Panel makes recommendations to the HB Chief Executive Officer regarding the practitioner's status on the Medical Performers' list and/or restriction of practice.

12.3. A Reference Panel is a formal process, which must conform to the statutory requirements of the National Health Service (Performers Lists) (Wales) Regulations 2004 (as amended).

12.4. The membership of the Reference Panel will include:

- HB Officer with the power of suspension (bestowed by the Chief Executive Officer). This member will normally chair the panel
- Independent Member of the Health Board
- Medical Director, Assistant Medical Director or their deputy (usually from another HB)
- Local Medical Committee Nominee (which can be from another LMC area)

12.5. The Local Medical Committee member of the Reference Panel is in addition to any LMC representative present at the panel meeting who is acting in the capacity of a "friend" of the GP.

12.6. Reference Panel members should be independent of the process up to this stage. HB or LMC nominees should not be involved in both the Screening Process and the Reference Panel. However, membership of a previous Reference Panel relating to the GP Performer should not preclude further involvement in the process.

12.7. All Reference Panel members should have had appropriate and recent training and experience in performance procedures to fulfil these roles effectively

12.8. In addition, those "in attendance" at the Reference Panel may include:

- A member of the PCIC Clinical Governance Team who investigated the case, who will prepare and deliver a statement of case and can be supported by other professionals as appropriate
- A "friend" of the GP
- A senior member of NHS Wales Shared Services Partnership Primary Care Services (NWSSP-PCS) or any successor organisation to advise on process.
- A recorder to ensure that accurate records of the proceedings are kept
- Any individual who has undertaken an independent investigation at the request of the Health Board may be invited to present findings of their investigation

12.9. Further detail on Reference Panel Terms of Reference is provided within the Regulations and in the model procedures guidance published by NWSSP – Contractor Services as outlined in Appendix 1.

12.10. The Reference Panel will have the power to make a range of decisions that can include recommending the following restriction of practice sanctions on the Performer:

- Suspension
- Removal
- Contingent Removal

12.11. The HB must consult with PPA if it is considering suspension, contingent removal or removal of the Performer from its Performers List unless it is necessary to effect immediate action to protect patients before such advice is available.

12.12. The standard of proof required for decisions to be made at Reference Panel is on the balance of probability.

12.13. The final decision/outcome of a Reference Panel is taken by the HB through the Chief Executive Officer or their authorised nominee.

12.14. The Chair of the Reference Panel should ensure that the GP Performer is notified both verbally and in writing within seven days of the outcome of the hearing. The practitioner must be advised fully of any right of review and appeal, as appropriate.

12.15. The HB must issue a letter to other statutory organisations notifying such organisations of any decision to remove, contingently remove or suspend. The Performer must also receive a copy of this letter.

12.16. The Reference Panel should ensure that minutes of the open session of the meeting and the outcome of any decision is shared with the GP Performer

12.17. Under Regulation 16 of the National Health Service (Performers Lists) (Wales) Regulations 2004 (as amended), Health Boards are required to notify probity decisions to the following bodies:

- Welsh Government
- any other Health Board or equivalent body that to the knowledge of the notifying Health Board
    - has the performer on any list or equivalent list, or
    - is considering an application for inclusion in any list or equivalent list by the performer,
    - in whose area the performer provides services;
- the Scottish Executive
- the Secretary of State;
- the Northern Ireland Executive;
- the relevant regulatory body (GMC) or any other appropriate regulatory body;
- where it is a fraud case, the NHS Counter Fraud Service Wales

April 2019

Abbreviations

(A)MD (Assistant) Medical Director

BMA	British Medical Association
CFS	Counter Fraud Services
CGPSAT	Clinical Governance Practice Self-Assessment Toolkit
CHC	Community Health Council
GMC	General Medical Council
GMP	General Medical Practitioner
GP	General Practitioner
GPST	General Practice Specialty Trainee
HB	Health Board
HB	Health Board
HIW	Healthcare Inspectorate Wales
LMC	Local Medical Committee
LoA	Letter of Authority
MDO	Medical Defence Organisation
MPL	Medical Performers List
NHS	National Health Service
NWSSP	NHS Wales Shared Services Partnership
PCS	Primary Care Services
PMCAT	Primary Medical Care Advisory Team
PPA	Practitioner Performance Advice, NHS Resolution
PSOW	Public Service Ombudsman for Wales
RO	Responsible Officer
ToR	Terms of Reference
UPSW	Upholding Professional Standards in Wales
WG	Welsh Government
WHC	Welsh Health Circular

Further Resources

1. PMCAT Investigation Templates http://www.primarycareservices.wales.nhs.uk/pmcat

2. Upholding Professional Standards in Wales (NHS Wales 2015)
http://www.wales.nhs.uk/documents/Upholding%20Professional%20Standards%20in%20Wales%20October%202015%20FINAL.pdf

3. WHC 059 (Welsh Assembly Government 2005)
http://www.wales.nhs.uk/documents/WHC_2005_059.pdf

4. A Framework of Operating Principles for Managing Invited Reviews within Healthcare (Academy of Medical Royal Colleges 2016)
http://www.aomrc.org.uk/wp-content/uploads/2016/05/Invited_reviews_210116.pdf

5. A Risk Matrix for Risk Managers (National Patient Safety Agency 2008)
http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/

6. Toolkit for Managing Performance Concerns in Primary Care (NHS England 2016)
https://www.england.nhs.uk/wp-content/uploads/2016/02/toolkit-managing-performance-concerns-pc-feb16.pdf

7. PPA Resources
http://www.ncas.nhs.uk/resources/must-knows-wales/

8. The National Health Service (Performers Lists) (Wales) Regulations 2004 (as amended)
http://www.legislation.gov.uk/wsi/2004/1020/contents/made

9. National Health Service (Wales) Act 2006
http://www.legislation.gov.uk/ukpga/2006/42/contents

10. The Medical Profession (Responsible Officers) Regulations 2010
http://www.legislation.gov.uk/uksi/2010/2841/contents/made

11. The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 (as amended)
http://www.legislation.gov.uk/wsi/2004/478/contents/made

12. GMS Contract
http://www.wales.nhs.uk/sites3/home.cfm?orgid=480

13. Just Culture guidance (NHS Improvement March 2018)
https://improvement.nhs.uk/resources/just-culture-guide/

REPORT TITLE:	**DIABETIC RETINOPATHY**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**13/08/19**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	✓	
LEAD EXECUTIVE:	Executive Nurse Director, Cardiff and Vale University Health Board								
REPORT AUTHOR:	**Assistant Director of Patient Expereince**								

PURPOSE OF REPORT:

This report underpins the Health Board's strategy in particular Delivering outcomes that matter to people and reducing waste, harm and variation underpinned by living our organizational values.

SITUATION:

This report provides the Quality Safety and Experience Committee with an overview of a patient notification exercise that was carried out when it became apparent that a number of patients with Diabetic retinopathy, appeared to have been lost to follow up by Diabetic Eye Screening Wales.

REPORT:

BACKGROUND:

Diabetic Eye Screening Wales moved to Public Health Wales on the 1st April 2016 from Cardiff and Vale UHB.

Diabetic Eye Screening Wales is an all-Wales service designed to detect sight threatening diabetic retinopathy at an early stage before visual loss occurs. All patients registered with their GP with diabetes are offered annual retinopathy screening.

The service was commissioned by the Welsh Assembly Government in July 2002 and initially hosted by Cardiff and Vale University Health Board.

In October 2015 Dr Andrew Goodall, Chief Executive NHS Wales wrote to the Chief Executive of Public Health Wales stating that DESW was to move to Public Health Wales from 1 April 2016.

ASSESSMENT

In March 2016, as part of the transition of the service to Public health wales a risk review was undertaken. One of the risks identified was that there was not a robust failsafe across the whole pathway for patients and that it appeared possible that patients may be on an incorrect pathway. Work around failsafe and the pathway was established starting with a pathway review day to identify current practice and develop a gap analysis. An action plan was drawn up and a task and finish group established to progress this work.

As part of the failsafe and pathways, a review of the lists generated by the information system was undertaken.

This identified that there were 34,071 patients categorised as 'awaiting their screening appointment' and concerns were raised as the first person on this list had been last offered an appointment in 2011. This raised concerns and work was undertaken to explore the list further. On further exploration it was

identified that 2,848 patients had been waiting for longer than one year to be offered a screening appointment. The other patients on the list were in their normal position for their annual recall and they were not overdue their invitation.

It was clear that there was not a simple explanation of why these patients had been waiting longer than a year for their screening invitation and so further work was required.

Further work to investigate the 2,848 patients was undertaken and a meeting of the failsafe and pathway task and finish team was held and clinical director was invited to ensure there was clinical input. The decision was taken to progress the incident as a serious event as there was potentially harm to this cohort of patients who had been delayed in their offer of invitation.

There were 2,848 patients identified in the cohort who had not been offered appointments as appropriate Reviewing the dates of this cohort:

- 959 should have been appointed in 2015
- 1392 should have been appointed in 2014
- 463 should have been appointed in 2013
- 31 should have been appointed in 2012.

(3 were not able to be categorised).

Information detailed that 336 of the cohort did not require an appointment as they were no longer eligible (e.g. deceased, moved out of area, confirmed opted out or confirmed medically unfit).

Therefore the number of patient within the cohort that required an appointment were **2,512.**

The incident had the potential to have serious untoward harm. This was identified as

- Sight loss or blindness due to programme deficiency.

Cardiff and Vale held governance for the service previous to 1 April 2016 and Public Health Wales holds governance from 1 April 2016.

The decision was taken that information would be included in the invitation pack to those patients that have been delayed by 18 months or longer to inform them that their appointment had been delayed.

The priority groups identified from discussion with the clinical director were ‘never been screened’, ‘those with previous diabetic retinopathy of R1 or greater’ and then those waiting the longest for their screening appointment.

This group would be prioritised with the wider group of patients so that there were three groups that were appointed to as a priority:

- Never been screened
- Patients on digital surveillance
- The cohort who had had a delay in invitation

Communication to staff
Administration and screening staff needed to be aware of this issue as there could be queries from the

public. There was a decision to prepare a Frequently Asked Question information sheet and communicate well to staff so that they felt informed and able to give consistent messages to the public.

Root Cause
A review of the cohort was undertaken to try and identify the root cause of the issue. Three issues are assumed to have contributed to the situation:

- A subset of the cohort (n=99) was reviewed and 98 of these had not attended (DNA) their last appointment. It is now believed that by the patient not attending their appointment the IT system had generated the lists for appointing in a way that the DNA patients remained at the bottom of the lists and therefore were not appointed.

- There had been variation in how the clinics had been appointed within administration and this variation may have contributed to the situation.

  Recent work which had been undertaken in relation to the Standard Operating Procedures with consistent prioritization may have resulted in some of this cohort already having been identified and offered screening.

- The DESW patient IT management system is complex and the generated categories of lists were not very transparent.

Action to resolve the issue and offering the cohort a screening appointment
Work was undertaken to process this cohort to offer them a screening appointment.
Although patients phoned to rearrange appointments there were no concerns raised initially from patients about the delay.

All cases following screening if necessary were referred back to their local Health Board/ Trust for review or treatment. In total 124 cases required further review after their diabetic retinopathy screening had been completed

Each of these 124 cases were monitored by Cardiff and Vale and the local provider shared their view as to whether the delay in screening had caused any harm. Six cases were sent to an Independent Reviewer this was following discussion with the patients involved. Two patients did not suffer any harm as a result of a delay in screening. Four patients suffered mild to moderate harm these cases have been managed in accordance with the redress guidelines although one of these cases may be slightly outside of the redress scheme and causation is currently being reviewed. All reports have been shared with the patients involved and discussed with them directly It should be noted that in the delayed cohort the percentage referred to secondary services was within the usual expected approximately 4% of those patients screened

This is a summary of the lessons learnt from the incident investigations and what changes /improvements have been implemented / taken forward to improve the service

- It was good practice to have kept in contact with the cohort of patients identified as having a breach in their care, and for those patients identified as possible harm. All appreciated the personal contact and spirit of openness was recognised.
- The route cause analysis taken forward by IT provided wider learning around the effectiveness of planning and the management of IT changes.
- The importance of robust planning, IT changes and failsafe mechanisms so patients do not get lost within the system was a priority for all screening services.
- Information has been added to screening requests to emphasise to patients the risks of not attending regular screening and the DNA rate will be monitored

Assurance

All of the patients lost to follow up have been screened, triaged and where harm has been identified contact has been made and the 4 cases of harm are being processed. Two Cases have been settled, one patient declined financial compensation and accepted an apology and the final case is currently being further assessed in relation to the level of deterioration that was avoidable due to the screening delay. It can be somewhat difficult to assess due to the degenerative impact of the underlying condition and further expert review is being undertaken.

The system has been made more robust to minimize any potential of a recurrence. The work has also prompted a review of other screening services.

RECOMMENDATION: None Required.

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

Report Title:	**POSITION PAPER – STROKE REHABILITATION MODEL AND WORKFORCE**								
Meeting:	Quality Safety and Experience Committee					**Meeting Date:**	2nd September 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 and Chair of the Stroke Rehabilitation Workforce Group** **Kim Atkinson, Therapy Lead to Stroke Rehabilitation Workforce Group** **David Pitchforth, Senior Nurse for Stroke** **Niki Turner, Project Manager to Stroke Rehabilitation Workforce Group**								

SITUATION

The Stroke Rehabilitation Centre (SRC) at Llandough Hospital is demonstrating improvements across all elements of quality, safety and experience in patient care delivery.

Key Quality and Safety Measures (1st May 2019 to 29th August 2019)

Falls

There have been 44 falls in this time period.
There has only been 1 Serious Incident in this time period reported to WG.

Medication Errors

There have been 5 Medication Errors in this time period. Of these, 2 were administration to patient, including administered but not prescribed, and administered but drug chart not signed. One preparation/formulation process, where there was an incorrect preparation/formulation. One dispensing error to the incorrect patient and one 'other' medication/biologics/fluid incident.

Pressure Damage

There has been no healthcare acquired pressure damage reported via Datix or Health and Care Standards Dashboard.

Healthcare Acquired Infections

There have been no Healthcare Acquired Infections reported during this period.

Flow

SRC has seen a reduction in its average Length of Stay as reported on the 27th August 2019. Target Throughput is 57.69, currently achieving 47.24 days.

BACKGROUND

Since the previous report (June 2019), this working group has been joined by a nominated Therapy Lead to work alongside the Senior Nurse and Lead Nurse in reviewing multidisciplinary practice, promoting key QSE principles and making recommendations for ongoing work in reviewing the workforce model. A report from this review work is due in October 2019.

From observations and time spent with the clinical team, there are many examples of strong multidisciplinary working practice in SRC. The unit has an active multidisciplinary improvements programme which has served to empower the MDT and instil a culture of integrated teamworking towards improving patient care. Evidence of improvements achieved have been seen through the key QSE measures (as demonstrated above) and through feedback received from Exec walkabouts, staff feedback and service user feedback.

> *"We the family…would like to express heartfelt gratitude to all the staff who took such excellent care of our mother who showed such care and understanding to the family"* (Relative Feedback, June 2019)

> *"All the staff on the stroke unit were outstanding, there are too many of them to individually mention, but from consultants, physios, OTs, staff nurses, auxiliary nurses, housekeepers and catering staff, there were/are very special people all of whom deserve to be recognized for the work each of them carry out…"* (Patient Feedback, July 2019)

It is also recognised that SRC has not received a formal concern since 9th November 2018 and has received only two informal concerns which have been resolved within five days.

Clear improvements are noted at SRC through the MDT's efforts. There is acknowledgement that SRC needs to now work towards its future role as the rehabilitation centre within a revised service model which delivers hyperacute stroke care at UHW. The acuity of patients at SRC is likely to change and the pace of rehabilitation delivery will need to support flow across the whole pathway. Part of this work involves changes to the Stroke Consultant model which will transfer some SRC consultant sessions to UHW; the SRC multidisciplinary team is ready to 'step up' and support this change through identified support mechanisms described in this paper. It is noted that some professional groups are under-established (specifically Occupational Therapy and Nursing) and this affects their ability to engage fully in all interdisciplinary elements of the rehabilitation provision needed to support the stroke pathway.

ASSESSMENT

Measures needed to support the SRC MDT to continue to drive improvements, maintain their high standards of integrated rehabilitation and support the new consultant model for the stroke service include:

- Provision and support for senior leadership across nursing and therapies with a clear integrated leadership pathway to support clinical decision making and the new consultant model.
- Strengthening of the Key Worker role and processes
- Enhanced links with service users and third sector organisations to inform and drive a patient centred model of improvement within SRC and the stroke services.
- Promotion of culture that SRC is MDT-led, encouraging staff across disciplines to work at the top of their license and represent the MDT at all opportunities.

Enablers to the success of these measures include:

- Support from nursing and therapy leadership to maintain confidence in the interdisciplinary team working and to provide professional leadership in provision of an MDT-led rehab service.
- Ensuring that workforce establishment for each professional group is appropriate to deliver safe, effective care whilst complying with National Clinical Guidelines. This includes dedicated clerical support to support the clinical practice of the MDT.

- Future workforce developments at SRC will consider the development of a 7-day rehabilitation workforce. The potential of registered and unregistered roles will be reviewed in the context of their ability to support flow across the pathway.
- Accessing all Health Board wide support (e.g. Integrated Discharge Service and Community Services) to enable SRC to provide the pace of rehabilitation to support flow across the stroke pathway, particularly in the context of hyperacute stroke developments.
- Reintroduction of the rehabilitation assistant role to work alongside both the nursing and therapy teams to deliver goal orientated practise and functional rehabilitation.

ASSURANCE is provided by:

- Monthly Stroke Services Transformation Programme meetings
- Monthly Quality, Safety and Experience meetings
- Monitoring of Key QSE measures via a new Stroke Quality Dashboard

RECOMMENDATIONS

Immediate actions for SRC to implement include:

- Revision of Multi-disciplinary Documentation to enhance current processes and improve cross-professional and patient communication.
- Discussions with the Integrated Discharge Service and Primary Care about further support to the SRC rehabilitation model.
- Agreement of the Nursing and Therapy Leadership model to support the change in consultant model and to sustain the Quality Improvement Agenda.

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:	**NATIONAL CLINICAL AUDIT**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**17.09.19**	
STATUS:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Medical Director								
REPORT AUTHOR:	Head of Patient Safety and Quality Assurance								

PURPOSE OF REPORT:

SITUATION: This paper provides the Quality Safety and Experience Committee with an update on recent national audit publications and UHB benchmarked performance.

REPORT:

BACKGROUND:

The NHS Wales 2019/20 National Clinical Audit and Outcome Review Plan (NCAORP) confirms the list of national audits that health boards are expected to participate in. Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh Health and Care Standards. Participation is a central component of the suite of Delivery Plans developed for NHS Wales eg Stroke Delivery Plan, Diabetes Delivery Plan and Heart Disease Delivery Plan etc.

National audit allows the UHB to compare performance with other organisations against nationally agreed best practice standards in England and Wales. These audits also deliver improved processes and outcomes for the population that the health board serves by informing and measuring the effectiveness of quality improvement initiatives. The extent of this data driven improvement programme is wide reaching, incorporating services across all Clinical Boards.

For the past two years a process has been in place to ensure that all national audit publications are reviewed and the health board results are considered and where necessary the requisite improvements are put in place. The Health Board reports these results, and improvements, to Welsh Government.

ASSESSMENT:

Since May 2019, there have been a number of national publications and adjunct reports. Below is a summary of the headline national and local results as well as a synopsis of key quality improvement initiatives that have been implemented to address the results of each audit.

National Diabetes Foot Care Audit (NDFA)
The audit summarises the findings derived from all foot ulcers registered up to March 2018 and followed for up to 6 months. The audit reinforces the fact that ulcers undergoing expert

assessment within two weeks are more likely to heal within 12 weeks and are less likely to lead to hospital admission.

While it was identified that over half of organisations in the UK did not have a foot protection pathway in place the UHB are meeting this standard. One in three patients across the UK with a severe ulcer had a foot related admission within six months of their first assessment while the proportion of patients in Cardiff and Vale UHB is 21.7%.

The Development of a walk in clinic for diabetic foot emergencies in Cardiff and Vale UHB by January 2020 is being taken through the NDFA Quality Improvement Collaborative. The expected outcomes include faster access to first expert assessment leading to improved healing rates and outcomes

National Paediatric Diabetes Audit (NPDA)

The audit aims to compare the care and outcomes of all children and young people with diabetes receiving care from Paediatric Diabetic Units (PDU) in England and Wales. The audit collects data submitted by PDUs detailing patient demographics, completion of health checks recommended for children and young people with diabetes, and their outcomes. The health checks audited were those recommended by NICE guidance for the diagnosis and management of children and young people with Type 1 and Type 2 diabetes.

In general C&V UHB paediatric diabetes service have delivered outcomes which have met or exceeded the national NPDA findings for 2017/18. For example, the national percentage of young people with T1 diabetes aged 12 years and over receiving all 7 key care processes was 49.8% while the proportion in the UHB was 69.8%. There has been no reduction in the average HbA1c nationally as has been the case in previous years and the mean HbA1c (adjusted) in the CAV population was 69.5mmol/litre - similar to the national figure.

The Paediatric Diabetes Team meet weekly for 30 minutes to discuss QI projects associated with the audit and discuss run charts for HbA1c, downloading of technologies by patients at home and completion of healthcare checks – preliminary data for 2018/19 that has already been submitted indicates further improvements in HbA1c and healthcare check completion are being achieved.

National Core Diabetes Audit

This audit provides a comprehensive view of diabetes care in England and Wales benchmarked against NICE clinical guidelines and Quality Standards in 2017/18. This includes the measurement of patients that receive care processes and achieve the NICE defined treatment targets.

58% of patients with diabetes receive all eight care processes annually but in Wales this is only 24.7%. In Cardiff and Vale UHB the proportion of patients having all eight care processes recorded 23.7% and 16.5% are meeting all three treatment targets (HbA1c, BP and Cholesterol).

Work is underway to encourage the completion of the diabetes gateway enhanced service module across primary care with the intention of improving the completion of the core processes. The development of an integrated model of care is underway and will involve community diabetic specialist nurses working across localities to improve care in particular for complex patients, to avoid unnecessary attendance at secondary care and to upskill primary

care professionals.

National Chronic Obstructive Pulmonary Disease Audit

Key process measures audited include provision of timely review by a member of the respiratory team, oxygen prescription, provision of non-invasive ventilation (NIV), spirometry, recording of smoking status and prescription of smoking cessation pharmacotherapy, DECAF scores (an indicator of the risk of mortality in hospital) and discharge processes.

Nationally 3 key QI priorities have been identified for hospital care in terms of timely NIV, spirometry results availability and smoking cessation management. The UHB are achieving fairly similar outcomes against national results, although in some areas nationally they are very poor. For example the proportion of patients receiving NIV within 2 hours of arrival in hospital is nationally only 19% and the UHB perform similarly, achieving 21% compliance. The availability of spirometry results remains at only 27.5% in the UHB while nationally this stands at 37%.

Quality improvement has focused on the development of COPD admission and discharge bundles which it is anticipated will impact of the recording of spirometry results and smoking cessation management. In addition there is work underway with Lightfoot to ensure respiratory review and admission of patients to ward B7 in UHW.

Sentinel Stroke National Audit Programme

The Sentinel Stroke National Audit Programme SSNAP is a major national healthcare quality improvement programme that measures the quality and organisation of stroke care in the NHS in England and Wales. The NHS Delivery Unit uses the SSNAP data to report of performance and delivery and to drive the programme of quality improvement.

	UK 2017/18	Cardiff and Vale UHB					
		Apr-Jul 2017	Aug – Nov 2017	Dec 17-Mar 18	Apr-June 2018	Jul-Sep 2018	Oct-Dec 2018
Number of patient who go directly to stroke units within 4 hours	57%	56.2%	48.8%	37.8%	45.4%	63.9%	57.8%
Number of patients who receive thrombolysis	11.4%	12.8%	13.5%	13.8%			
Number of patients who spend 90% or more of their stay on a stroke unit	82.5%	90.7%	83.5%	82.5%			
Number of patient treated by a stroke early supported discharge team	37.1%	48.4%	33.5%	47%			

The number of patients who are admitted to a stroke ward within 4 hours within the UHB is subject to seasonal effects. In order to mitigate against this, beds on ward A6 are ring fenced for use in the stroke pathway and focused work is underway around flow through the stroke pathway.

National Audit of Breast Cancer in Older People (NABCOP)

NABCOP reports the results of a prospective audit to evaluate the care provided to and subsequent outcomes for women diagnosed with breast cancer aged 70 and over, comparing this with a younger cohort aged 59-69. One of the key themes emerging nationally is that women over 70 are not receiving the same treatment to those in the younger cohort. Cardiff and Vale UHB are meeting or exceeding the majority of the standards. Nationally 67% of women age

50-69 and 60% of women over 70 with high risk invasive cancer received radiotherapy following mastectomy while Cardiff and Vale achieved 53% and 49% respectively.

Since the launch of the NABCOP audit the breast cancer team have worked with colleagues to develop an onco- geriatrician service for older women with breast cancer. Since the end of 2018 surgeons are now assessing women over the age of 70 years using the Edmonton Frailty Scale as well as using co-morbidity scores. This is becoming a fully embedded part of the surgical assessment that ensures appropriate treatment and intervention is determined by the patient's fitness rather than their age.

The team have used a shared decision making approach for a number of years with younger patients and intend to introduce this for those over 70 years of age in 2019/20. In addition work is underway with the national programme manager for PROMS and PREMS to start collecting patient reported outcomes data.

National Lung Cancer Audit (NLCA)
The audit summarises the current quality of care and outcomes for patients with lung cancer. This includes audit standards for diagnostic measures, surgery and treatment rates, curative and survival rates and specialist nursing input. The audit highlights that there is significant variation across both Wales and England not just in the number of treatments given but also in the way organisations deliver care.

Clinical trials have demonstrated that patients with advanced and incurable non-small cell lung cancer (NSCLC) can benefit from systemic anti-cancer treatment (SACT), delivered to improve quality of life and to extend survival. Nationally the audit standard has greatly improved and has been met for the first time (65%), whereas the UHB are achieving 51.5% although this is in line with the rest of Wales. Consistent improvement has been seen in relation to chemotherapy rates in small cell cancer nationally with the audit standard reached at 70%. The UHB have far exceeded this at 92.8% and places the organisation into the good practice group.

The main focus of the quality improvement work aligned to the audit has been to reduce the delays in patients receiving oncology treatment and in improving pathways with Velindre Cancer Centre.

National Oesophageal Gastric Cancer Audit NOGCA (Short Report)
The recent publication is a short report that encompasses headline information only. A full report will be published later this year and it is these results that will be considered in full and requisite improvements will be developed and reported in response.

The main curative treatment option for patients with localised oesophago-gastric (OG) cancer is surgery to remove the tumour, usually in combination with chemotherapy or chemo-radiotherapy. However, surgery is only suitable for patients who are appropriately fit.
Due to many patients being diagnosed with OG cancer at advanced stages, just 30% of patients are considered candidates for curative surgery. The National Oesophago-Gastric Cancer Audit (NOGCA) has reported that only two-thirds of patients with a plan for curative surgery go on to have a surgical resection recorded in the audit. This difference is not wholly explained by non-submission of surgical information by hospitals (estimated case ascertainment 89%).

Nationally of 6,249 patients reported as having curative surgery as their planned treatment but 69.3% were a recorded as having surgery, the report examines the potential reasons for the gap

between planned and actual treatments. Of 126 patients reported locally between April 2014 and March 2017 the UHB, 82.5% were recorded as having curative surgery. 30 day post-operative mortality for April 2017 to March 2017 is 1.8% nationally and for the UHB 2.5%which is within two standard deviations and is therefore normal variation.

National Prostate Cancer Audit (NPCA)
The aim of the NPCA is to assess the process of care and its outcomes in men diagnosed with prostate cancer in England and Wales. The NPCA determines whether the care received by men diagnosed with prostate cancer in England and Wales is consistent with current recommended practice, such as those outlined in the National Institute for Care Excellence (NICE) Guidelines and Quality Standards. In total 14 performance indicators are reported against.

Differing results have been observed nationally for over and under treatment of low and high risk disease respectively. The UHB reported only 3% of men with low risk localised disease having radical treatment and potentially being 'over treated' as compared to 4% nationally. While 33% of men nationally with locally advanced disease who did not undergo radical treatments were potentially 'under treated' as compared to 18% in the UHB. Work is underway to review and understand the PROMS data relating to the UHB in particular the number of men reporting at least one genito-urinary complications post operatively.

National Audit of Dementia

The Audit looks at the quality of care provided to people with dementia in general hospitals, specifically aspects of care delivery known to impact upon people with dementia as inpatients. Recent studies have shown that up to 42% of people over 70 who have an unplanned hospital admission have dementia.

Nationally 36% of patients had information collected about factors that cause distress and 32% had information collected about actions that could relieve distress. Performance in UHL was in line with national performance while in UHW.

The UHB results demonstrated underperformance around initial delirium assessment on admission with only 16% of case notes reviewed having documented evidence of assessment in comparison to 58% nationally.

Since publication of the audit the 4AT delirium assessment has been included in the generic clerking proforma and the UHB is participating in an All Wales Delirium Audit. A working group chaired by Public Health has been convened to review the results of the National Dementia Audit and to take forward the requisite improvements.

National Audit of Care at the End of Life (NACEL)
The first round of NACEL was published in July 2019 and is a comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in hospital. The audit reviewed a number of themes including:

- Communication with the dying person
- Communication with families and others
- Involvement in decision making
- Governance
- Workforce / specialist palliative care

In all themes the UHB performance was in line with or exceeded national performance. A poor return rate from the quality survey meant that the UHB was unable to identify themes or trends from the information provided by families and others. Since the NACEL publication six "z beds" have been procured and are available in UHW and UHL to improve the comfort of families who wish to stay with relatives who are receiving end of life care.

RECOMMENDATION:
The committee is asked to

NOTE: the assurance provided by participation in the National Audits and the headline results and associated quality improvement actions in place.

CONSIDER whether a further more detailed assurance report is required in relation to any of the audits presented.

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

REPORT TITLE:	**HEALTHCARE INSPECTORATE WALES ACTIVITY**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**17-09-19**	
STATUS:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	Assistant Director Patient Safety and Quality								

PURPOSE OF REPORT:

SITUATION:

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the reviews/inspections carried out by Healthcare Inspectorate Wales (HIW) since the last over-arching report to the Committee in April 2019. The paper seeks to assure the Committee that action is already being implemented in response to the findings of inspections and that appropriate monitoring of progress against the actions is being undertaken.

A separate report outlining HIW activity in Primary care is presented as an additional agenda item.

REPORT:

BACKGROUND:

HIW is the independent inspectorate and regulator for health care in Wales. The core role of HIW is to review and inspect the NHS and Independent Healthcare organisations in Wales so that assurance can be given to patients, public, Welsh Government (WG) and healthcare providers that services are safe and of good quality.

Hospital Inspections are a means of providing assurance that a patient's dignity is being maintained whilst in receipt of care. It is a structured inspection and supports the view of Francis (2013) who emphasised the importance of undertaking direct observations of care. The unannounced inspections undertaken by HIW focus on the following themes:

- Quality of the patient experience
- Delivery of safe and effective care
- Quality of management and leadership
- Delivery of a safe and effective service

ASSESSMENT:

Thematic reviews

Since the last report to the committee the UHB, HIW have announced their intention to carry out two thematic reviews:

National Maternity Review

This will involve a series of unannounced visits to maternity units across Wales. The UHB has already submitted a self-assessment and the necessary required evidence and anticipates an inspection in the near future.

Self- assessment of surgical services – trauma and orthopedic care

Last year, Healthcare Inspectorate Wales (HIW) started undertaking inspections of surgical departments throughout Wales. This inspection programme is continuing this year. The inspection approach takes account of the National Safety Standards for Invasive Procedures (NatSSIPs). The programme of work was devised through consultation with stakeholders including Royal College of Anaesthetists, Royal College of Surgeons, The Association for Perioperative Practice, Welsh Risk Pool Services, NHS Wales health board representatives, 1000 Lives Improvement, NHS Wales Delivery Unit and Welsh Government.

The UHB has completed a self-assessment and submitted the necessary requested evidence. Again, an inspection is expected in the near future.

Announced visits

There have been no announced inspections in secondary care services since the last report to Committee in April 2019.

Unannounced inspections

- **Emergency Unit/Assessment Unit and Lounge at University Hospital of Wales**

In the April 2019 HIW update report, the Committee was advised of an unannounced inspection of the Emergency Unit/ Assessment Unit at University Hospital of Wales that had taken place on 25th – 27th March 2019. This visit, resulted in 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. There was also an unlocked medication cupboard containing eye medication.

Immediate action was taken to increase staffing levels as an interim measure and to put in place more senior oversight and review of patients in the Lounge on a 2 hourly basis. All staff have been reminded of the need for regular checks of resuscitation equipment and fridge temperatures and new thermometers have been ordered for domestic fridges which are used to store food. The unlocked medicine cupboard has been de-commissioned and the eye medication that was contained in it has been re-located to another suitable, secure cupboard in the department.

The full report can be viewed here

A robust improvement plan has been put in place – see Appendix 1 – and a range of measures to address the flow of patients through the Assessment Unit and specifically the Lounge area are being implemented. These include:

- The opening of a Trauma Ambulatory Care Unit (TACU) from 9th September 2019 which will provide a 7 day a week cover from 7am -7pm
- Extension of the Surgical Assessment Unit provision to weekend cover from 8.30 to 7pm from end November/early December 2019.
- Further work to improve access to surgical in-patient beds to accommodate surgical patients in the Lounge/Assessment Unit.

- **Mental Health Services at Hafan Y Coed (Willow, Beech and Oak wards)**

An unannounced visit was carried out w/c March 18th 2019. The report was very positive and highlighted the facts that:

- Staff on the three wards provided care to patients in a caring and professional manner
- Patient feedback was sought on up-to-date issues with a view to continuously improving the care provided
- The three wards had good leadership structures in place, supported by the organisational structure of Hafan y Coed
- Patients notes and care plans were of a very high standard

Areas for improvement included:

- Aspects of Mental Health Act documentation
- Garden areas on all wards were in need of maintenance and the responsibility for this, needed to be confirmed
- Inconsistency of information displayed for patients and relatives across the wards

The full report and improvement plan can be viewed here

Primary Care Contractors

The outcomes of visits to Primary care contractors is described in a separate report to Committee.
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HIW Annual report

HIW presented the Cardiff and Vale UHB report to the May 2019 Board meeting. Mr Alun Jones, Deputy Chief executive commented that:

- inspection findings for the UHB were generally positive
- where improvement was required, all services had responded constructively
- engagement from the UHB's leadership team had been positive
- re-inspections had shown improvement in many areas and it was clear that the UHB sees external and internal scrutiny as a positive means of learning and improving
- further work is required in general practices and some hospital settings to ensure that patients are aware of how that can raise a concern about the care they received.
- HIW's inspection of the emergency and assessment unit at University Hospital revealed several issues which were impacting on the safety and dignity of patients. (as described earlier in the report).

A summary of the Cardiff and vale UHB annual report can be seen here

RECOMMENDATION:

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the level of HIW activity across a broad range of services.
- **AGREE** that the appropriate processes are in place to address and monitor the recommendations

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			
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2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
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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.									

Improvement needed	Standard
Patient comfort is maintained within the lounge area in AU, whilst they are waiting for assessment or allocation to a bed.	4.1 Dignified care
Privacy and dignity is maintained due to the location of the lounge area. Consideration must be made when patients request assistance to use the toilet facilities.	
Patients are not left sitting in the chair within the lounge for prolonged periods of time, particular by night, resulting in sleep deprivation.	2.5, 4.1 & 5.1
Hot meals are offered to patients along with consideration of their nutritional requirements, for those identified as requiring admission to a bed, and for those waiting for assessment over prolonged periods of time. Basic patient hydration is maintained and water is readily available for those sitting in the lounge, particularly for those who have mobility difficulties	
A review of the model of care for managing patients sat in the chairs with the AU lounge is immediately undertaken. This must include a solution to ensure that those who are acutely unwell are able to lie on a bed/ trolley, in an appropriate and timely manner.	2.1, 2.2, 2.3, 2.5, 3.1, 5.1 and 7.1
Review of the current provision of care to ensure that patients within the lounge are having their needs met in relation to prevention of pressure ulcers, falls prevention and the adequate assessment and provision of basic and appropriate nutrition and hydration.	
A review of the registered nursing establishment is immediately undertaken, which takes in to account the layout of the unit and visibility of the patients, and to consider the immediate increase in staffing numbers particularly within the lounge area where visibility of all patients is poor. A clear understanding is gained of the reasons why senior medical staff, nurses and other staff within the AU feel that there is a risk to patient safety.	
Ensure that patients are not transferred to the AU inappropriately from the EU, to prevent a 12 hour breach	

Resuscitation equipment/medication is always available and safe to use in the event of a patient emergency on both the AU and EU and within all other wards and departments across the health board.	Standard 2.6 and 2.9
Refrigerated medication is stored safely and at the correct temperatures on both the AU and EU, and within all other wards and departments across the health board. Thermometers are installed within the refrigerators used to store patient food on the AU, and that the temperatures are recorded on a daily basis. In addition, that this is replicated across all other wards and departments across the health board.	2.1, 2.6 and 2.9

Service Action	Person Responsible	Timescale	Action update
To support the provision of effective assessment and the provision of the fundamentals of care as well as ensuring that risk assessments are maintained and acted upon, the Emergency and Acute Medicine directorate (EAMD) have increased the Assessment Unit Lounge area nursing establishment from one registered nurse to two registered nurses and a Health Care Support Worker (HCSW) 24/7.	Lead Nurse	In place and subject to daily monitoring	
An Emergency / Assessment unit huddle is now undertaken at periodic intervals during the day to escalate patients who are prioritised according to clinical need and those who are particularly vulnerable. This will ensure that pressures within the Emergency Unit are considered in conjunction with those in the Assessment Unit and the Lounge area and all patients are prioritised appropriately according to their clinical presentation and vulnerability and not according to where they are being cared for.		Complete	
A Curtain and rail will be erected by 07.06.19 to screen off the AU lounge seating area and will be used in conjunction with mobile screens as required to assist with maintaining patient privacy and dignity.	Senior Nurse	Complete	Completed in June
The Clinical Board is currently implementing a number of initiatives to increase the number of band 5 nurses in post. These include: • work with the Universities as part of student streamlining and recruitment as they qualify • recruitment of overseas nurses • supporting Adaptation and return to practice programmes • Focus on retention of nurses A recruitment trajectory will see 26 vacancies filled and will address the vacancy position by in total March 2020.		Mar-20	15 nurses have been recruited from student streamlining. The Senior Nursing team will be present at the next recruitment day in September to support futher student streamlining. Return to practice nurse currently being supported in
The increased nursing establishment in the lounge area will mean the area will be supervised at all times. Registered nurses and HCSW will be available to support patients to mobilise to the toilet and with other aspects of their care.		Complete	
4 Recliner Chairs are now available for patients to use (due to lack of space the use of the chairs will be available following an individual patient risk assessment by the nurse in charge). Patients will be risk assessed and the most vulnerable and those expected to spend longer in the department will be prioritised for a trolley or a recliner.		Complete	4 x Recliner chairs put in AU lounge on 05/06/2019
MCB have agreed that they will be providing Surgery Clinical Board with regular updates on escalation levels and risk within the AU department so that there is an improved approach to managing this.	Director of Nursing MCB	In place and embedded as part of routine practice	
A revised nutrition and hydration plan was put in place in September 2018. This allows for patients in AU Lounge area to have access to breakfast, lunch (hot soup and sandwiches) and dinner. All staff have been reminded of this plan which had not previously been fully enacted.	Lead Nurse/Senior Nurse	Complete	
The Red Cross are a valuable support to patients and their families: spend time with patients, families and carers whilst waiting for treatment. • speak to medical staff on behalf of patients to explain their needs and find out information. • provide practical assistance such as contacting a relative on the patient's behalf, providing drinks, food, blankets, collecting pharmacy prescription and accompanying patients whilst having tests. • Prompt and encourage any patients at mealtimes as • guided by the Nursing staff.			16/08/19 -Welsh Goverment has confirmed the Redcross will continue until March 2020.
An Assessment unit Lounge Standard Operating Procedure is now in place. This formalises the escalation process and decision making to ensure all staff are clear of their roles and responsibilities to ensure patient comfort and experience.	Lead Nurse EU/AU/Clinical Director EU/AU	In place and embedded as part of routine practice	Final version on
Since the inspection, and following discussions at the Health Board's Management Executive the Health Board is actively pursuing options for decongesting the Assessment Unit seating area by 'streaming' more surgical patients to a separate surgical assessment unit. This would involve a significant extension of the current Surgical Assessment Unit service. Our Surgical Clinical Board have drafted initial options for delivering this. These are being brought together for consideration and approval at our Management Executive. It is anticipated that the UHB will be able to identify the best option and work through funding within June. The commissioning of this additional service would then require a period of recruitment before implementation. Therefore, the short term measures outlined in the actions within this document would then be followed by an interim term change in the model (diverting a larger group of surgical patients away from the AU) leading to ongoing improvement based on LOS and flow work – as described in other actions.	Dir Ops and Dir Nursing Surgery Clinical Board Director of Ops and Director of Nursing Surgery Clinical Board Medicine Clinical Board Director of Operations	Initially identify preferred option by end June 2019	• The opening of a Trauma Ambulatory Care Unit (TACU) from 9th September 2019 which will provide a 7 day a week cover from 7am -7pm • Extension of the Surgical Assessment Unit provision to weekend cover from 8.30 to 7pm from end November/early December 2019. • Further work to improve access to surgical in-patient beds to accommodate surgical patients in the Lounge/Assessment Unit.
Working with our external partner, Lightfoot, a series of multi-disciplinary workshops have commenced to identify solutions to the wider issues of 'Flow' that affect the EU/AU and Lounge area Red2Green and Everyday counts		Review Sept 2019	Continued workshops held with Lightfoot to support the respiratory flow of patients.
Four recliner chairs have are now available for vulnerable patients. Individual risk assessments will be undertaken by the nurse in charge to ensure vulnerable patients are accommodated including those who are expected to spend longer periods in the department. All registered and non-registered staff have been reminded of the importance of accurate and complete documentation. Compliance will be audited by the nurse in charge and spot checks by the senior nurses to ensure due process and procedures are being followed. The increased nursing establishment will support the improved delivery of the fundamentals of care within the lounge area.	Lead Nurse EU/AU	Complete	
The Emergency and Acute Medicine directorate (EAMD) has reviewed registered nursing establishment and put in place a permanent additional Registered Nurse and Health Care Support Worker in AU lounge 24/7 to support the nurse in delivering the fundamentals of care and ensure that risk assessments are maintained and acted upon.	Lead Nurse EU/AU	Mar-20	On going until further progress from the Surgical directorate. If unable to fill the additional staffing the Assessment Unit Lounge will not go above a 1 to 10 nurse patient ratio.
The Emergency and Acute Medical Directorate (EAMD) is actively encouraging staff to complete a Datix form to record the instances when the staff feel that patient safety is at risk and why. The Senior team have spoken with staff on an individual basis and as part of team days to offer support, advice and listen to staff The AU Standard Operating Procedure will assist in identifying the risk to patient safety and incorporates the required escalations to patient access and the clinical boards. The introduction of an ambulatory scoring system will strengthen current processes for identifying those patients who are a clinical risk. As part of the SOP an escalation card has been produced to allow staff to follow the correct escalation process. The risk will then be escalated 13.00 and 17.00 Huddle. Those patients identified as being at risk are then prioritised for a trolley/bed regardless of where in the department they are being cared for. The UHB will consider undertaking a Safety Culture Survey or implement the Manchester Patient Safety Framework A schedule of unannounced visits by the Corporate professional nursing standards team will be put in place over the next 6 months ensure that standards in relation to nutrition and hydration are being maintained throughout EU and AU. These inspections will be documented and reported to the Medicine Clinical Board to action. The Lead Nurse is meeting with the Head of Patient Safety to discuss the governance arrangements. A review of all Patient safety incidents reported over the previous quarter will be undertaken to establish if there are any actions or investigations outstanding All staff have been reminded of all the available channels to feedback safety concerns and these include the UHB Freedom to Speak Up and Safety Valve processes	Lead Nurse EU/AU/Clinical Director EU/AU	Embedded as part of routine practice	
AU length of Stay is currently monitored at Management Executive and reported to the Board. A Board Development day has been arranged with focus on the patient flow experience within the Assessment Unit as part of the unscheduled pathway The UHB uses a systematic approach to managing our hospital urgent and emergency admission areas. This risk-based patient access and bed allocation approach was adopted following extensive work with the Welsh Government Delivery Unit. It ensures individual patient concerns form the basis of our bed allocation system and ensures that clinical staff both inform and prioritise the allocation of beds based on system clinical risk. A snapshot audit of patients in the lounge area will be undertaken over three weeks to understand the acuity of the patient cohort in this area – to be considered by Clinical Board / Directorate senior management team. A 90 day improvement plan has been initiated to support the EU and AU in reducing length of stay, improving patient experience and outcome whilst focusing on quality and safety. There are a number of work streams including a dedicated work stream around the AU trolley and chair areas. The EAMD will involve the Acute Care Physicians and nurse in charge of AU to combine with periodic huddles during the day to understand the risks to all areas and ensure appropriate actions are put in place to improve the patient outcome. The formal escalation process will trigger additional support when required. The prioritisation of patients within the EU footprint, is carried out in line with Welsh Government (WG) guidance governing emergency unit transit times. The Health Board will ensure that it's flow management processes identify and record prolonged waits within the AU to ensure that patients are prioritised according to clinical prioritisation	Chief Operating Officer Lead Nurse EU/AU; and Clinical Director EU/AU Director of Operations Medicine	Jun-19	16/08/19 - Daily gathering of 12 hr patient breaches in AU lounge is undertaken. Every weekday morning these are sent to each clinical board who has a patient waiting over 12 hours in the AU lounge.

All defibrillation trolleys were immediately updated with the latest UHB resuscitation checklist and are checked daily as per guidelines. These are now standardised throughout the EU and AU. The checks will be monitored by the nurse in charge of the units. Weekly checks will be carried out by the senior nurses to ensure compliance with the process.	Senior Nurse	Complete	
Communication with staff via Facebook, email accounts and daily handovers has been put in place to reiterate the importance of daily checks for the quality and safety of our patients.			
The schedule of unannounced visits by the Corporate professional nursing standards team will also ensure that standards in in relation to appropriate checks of resuscitation equipment are being maintained	Deputy Executive Director Of Nursing	Ongoing	
All fridges that store medications have a checklist and are checked daily. These checks are in line with the manufactures guideline for both the fridge and the drugs within. All staff have been reminded of the requirement for daily checks. The checks will be monitored on a daily basis by the nurse in charge. Spots checks will be carried out by a senior nurse to ensure the process is being followed. The checklist is standardised across EU and AU.	Lead Nurse	Complete	
Both of the food fridges in AU north and south have been condemned and food is now stored in a fridge with an internal and external thermometer. This fridge will be checked three times a day in accordance with food hygiene recommendations.	Lead Nurse	Complete	
The schedule of unannounced visits by the Corporate professional nursing standards over the next 6 months will also ensure that standards in relation the recording of fridge temperatures is being maintained throughout EU and AU. Results will be documented and reported to the Medicine Clinical Board to action.	Professional Standards team	In progress until December 2019	Recent audit on the 19/07/19

Improvement Needed	Standard	Service Action	Person Responsible	Timescale	Action Update	
Consideration is given to how patient privacy and dignity can be maintained when patients are assessed within the adult and paediatric triage rooms in EU. Medical and nursing staff maintain patient privacy and dignity at all times when assessing patients in the EU by closing curtains when appropriate.	4.1 Dignified care	All staff have been reminded of their responsibility to maintain patient's privacy at all time and this includes: · Ensuring that the doors to the triage rooms are closed as appropriate (while maintaining staff safety) when it is necessary to ensure patient privacy and dignity · ensuring that curtains are drawn around the assessment areas when consultations or care is underway	Lead Nurse	Complete		
		A schedule of short unannounced visits to the department over the next 12 months will include this as a necessary observation	Corporate Nursing Standards and Professional practice team	With immediate effect	Visits have begun from the professional standards team 24/07/19	Carol- 3 internal inspections completed
Signage at the hospital is reviewed to ensure it is easy to read and able to direct patients and visitors to the AU and MEACU. Consideration should also be made to ensure all signage is bilingual to include Welsh	4.2 Patient information	Signage for both AU and MEAU has been reviewed and revised signage has been ordered and is a priority to be erected.	General Manager	Review August 2019	Signage for EU is up and AU is currently being made 03/07/19 AU signs put up on 02/08/2019	
Health, care and injury management leaflets are available in Welsh, and to consider the option to provide each leaflet to be translated and printed in to other languages		Health, care and injury management leaflets will be translated into Welsh and made available to patients. Provision of health care and injury management information in languages other than English and Welsh will be considered on a case by case basis, utilising WITS and Language Line and if required providing translated written material on demand.	Lead Nurse EU/AU	End June 2019	Awaiting BOE to support the translation 08/07/19 13/08/19 - Meeting held with BOE. BOE are able to provide EU with multiple languages for advice cards and a desktop version. Awaiting leaflets to then get translated into Welsh.	
The health board is required to ensure that all staff make every attempt to maintain patient privacy and confidentiality when communicating care and plans amongst team members.	3.2 Communicating effectively	The importance of ensuring patient's privacy and confidentiality has been raised at the Band 6 and 7 nursing away day. Minutes of the meeting have been sent to all nursing and medical staff.	Lead Nurse EU/AU	Complete		
		The issue is on the agenda to be discussed at the July Nursing and Medical Away Day.	Lead Nurse EU/AU	Jul-19	Completed on 10/07/19	
		Staff have been reminded of the importance in the safety briefing.	Lead Nurse EU/AU	Complete		
The plan for addressing ongoing recruitment and retention of staffing issues in AU is shared with HIW	5.1 Timely Access	There is a detailed plan for recruitment and retention of staffing in EAMD.	EAMD	Complete	Students form student streamlining will be reday to start in September. With another 4 Band 5 nurses going through Trac	
The process for accepting patients from GPs into the MEACU for assessment is reviewed, to ensure appropriate attendance		A joint project between Primary Community and Intermediate Care (PCIC) and Medicine is underway to review the streaming of patients into MEACU. A pilot proposal is currently being developed and will be presented to the Local Medical Committee prior to launch. The project will include the development of a crib sheet to ensure adequate assessment of patients.	General Manager EU/AU	A pilot will commence end of August	Ongoing 24/07/19. discuss with Nolan For Discussion at SMT on 21/08/19	Carol- Not clear if the pilot has begun?
The arrangements for the handover of patients between WAST ambulance crews and EU staff is reviewed, to ensure that there is clarity between the EU staff and WAST crews, when patients are required to wait on an ambulance.		A Standard Operating Procedure in already in existence which details the agreed arrangements around handover between WAST and EU.	General manager	Complete		
A SOP should is readily available for staff relating to patient arrivals and delayed handover of care from WAST to the EU. This should also include the arrangements for when patients require the use of UHB facilities for situations such as the toilet		All staff have been reminded of the jointly agreed SOP		Complete		
		A monthly EAMD and WAST meeting is undertaken to discuss all operational issues including the handover between WAST and EU and arrangements around toileting etc. A flow chart has been agreed with WAST around processes for toileting patients included in.	Lead Nurse EU/AU	Complete	On going meetings in place with the general manager and lead nurse.	
		All staff have been reminded of the jointly agreed arrangements for managing the situations where patients on ambulances require the toilet.	Lead Nurse EU/AU	Complete		
		There is an expectation that all EAMD staff will support WAST colleagues in providing the fundamentals of care	Lead Nurse EU/AU	Complete		
		WAST will be given an opportunity to raise any concerns about support and care delivery of patients at the monthly meetings	Lead Nurse EU/AU	Complete		
The health board is required to ensure that staff fully complete patient assessments and care plans to ensure that patient needs are communicated effectively to maintain consistency and patient safety	6.1 Planning care to promote independence	There is a Joint Assessment Documentation in use across the department where all care, results and treatment is documented. This is used by Doctors and Allied Health Professionals and ensures treatment is communicated effectively and that there is continuity of care. Nursing staff use a separate nursing booklet which contains the nursing risk assessment. There are specific time frames associated with each risk assessment and compliance is monitored and reported	Clinical Leads EU /AU	Complete and will be embedded as and reported as part of routine practice on a monthly basis	All appropriate staff are using the joint booklet	
		An audit schedule has now been developed reviewing compliance with each of the documentation and care audits. These audits will be reported through the department Q&S meeting.			Monthly meeting held to conduct and review audits.	
The health board is required to ensure that patients and their families/ carers understand their rights in terms of raising concerns/complaints about NHS care, and that NHS PTR posters are displayed and leaflets are readily available, to read and take away	6.3 Listening and learning from feeback	All staff will be reminded of their responsibility to maintain patient records in line with their professional codes of conduct	Lead Nurse EU/AU	Complete	To gather themes of concerns to identify any areas of concern	
		Putting Things Right poster are now displayed throughout the department and leaflets are displayed on both reception desks.				
		The nurse in charge of each unit undertakes a daily spot check and Senior Nurses undertake the same checks on a weekly basis. The availability of Putting Things Right leaflets has been added to the Spot Check list.	Senior Nurse	Weekly		
		Staff will be reminded of the importance of supporting patients and their carers and relative to raise concerns.				
		In April 2019, 100% of concerns raised were managed informally and within 48 hours				
Cleaning schedules are in place and all areas are regularly audited for cleanliness	2.1 Managing risk and promoting health and safety	Cleaning schedules are in place for the department. C4C undertake environmental audits on a weekly basis the nurse in charge will ensure that a member of the nursing team is delegated to support this audit process and highlight issues. The results of the environmental audits will be forwarded to the Lead Nurse to review.		Completed	Meeting to be arranged to ensure that the is co-working when the c4c audits are undertaken. Meeting arranged for the 20/09/2019	
		The Cleaning of equipment is the responsibility of the nursing staff and is included on the daily checklist for nursing staff.				
All equipment is checked for cleanliness, and that worn items are repaired or replaced		All staff have been reminded of this role and responsibility	Lead Nurse EU/AU	Monthly		
		A review of Furniture and Equipment will be undertaken to ensure that all equipment that is found to be damaged is condemned and disposed of.	Lead Nurse EU/AU	Jul-19		
The torn sofa in the room used for patients presenting with mental health issues is repaired or replaced		The sofa in the Mental Health Assessment Room has now been replaced	Lead Nurse	Completed	Sofa moved and replaced	
The seating bench in the paediatric EU is repaired appropriately or replaced		The seating Bench in the Paediatric EU has been removed	Lead Nurse	Completed		

Consideration is given to the vulnerability and safety of lone workers within the adult triage room in the main waiting area, due to the single point of entry and exit		A second swing door will now be constructed within the triage rooms to allow a second point of access/ exit.	Lead Nurse	Completed		The swing door was completed on the week the 25/06/19
The overall storage facilities on AU and EU are reviewed, to consider appropriate storage areas to minimise the risk of injury and cross infection		Since the inspection a declutter and deep Clean of the Assessment Unit has been undertaken and similar is planned for EU by the end of June.	Lead Nurse	Completed		AU declutter was completed in May. EU declutter to be arranged. EU declutter arranged for the 03/09/2019
The storage of equipment within the corridors is monitored and addressed appropriately		All broken trolleys and equipment have been removed from the department. Consideration will be given as to how larger items in the department can be stored in a safer way (bearing in mind the lack of available space) A stock manager reviews the department stock levels and orders on a daily basis to prevent stockpiling and additional pressure on storage capacity. The daily spot check undertaken by the nurse in charge includes identification and removal of trip hazards, Issues are identified that cannot be immediately resolved will be escalated to the Senior Nurse.	Lead Nurse	End of July 2019		On going requests are put in to ensure all broken equipment is either removed or taken for fixing. On going work to identify areas in which larger items can be staored.
All bins that are not in acceptable working order are replaced in the units inspected, and elsewhere in the health board.		All bins within the department have been replaced since the inspection	Lead Nurse	Completed		
On admission to AU, pressure ulcer risk assessments and skin assessments are completed for all appropriate patients	2.2 Preventing pressure and tissue damage	There is a specified schedule of risk assessments to ensure timely completion. Waterlow Assessments should be completed within 6 hours of a patient arrival in the department. Vulnerable patients are prioritised and risk assessments will be completed much sooner. All staff have been reminded of the need to assess all patient for their risk of developing pressure damage	Lead Nurse		Jul-19	
		A new nursing booklet has been produced this booklet contains guidance on how to identify and grade pressure ulcers. This includes pictures of differing grades of damage. It also contains guidance about what dressings and equipment should be used and how to access this them. It also provides ongoing care planning. This will be implemented within the department.	Lead Nurse	Complete		The pressure damage booklet is being used and staff regularly remind of its importance.
Nursing staff regularly reposition patients and check the patients' skin for signs of pressure and tissue damage on AU and EU		The education team will disseminate and promote the new nursing booklet in support of pressure ulcer risk assessment, prevention and management	Lead Nurse	Complete		
Assessments and documentation within the relevant pressure ulcer care documents are undertaken and completed robustly on AU.		Intentional rounding is in place for all appropriate patients and this includes repositioning of patients and checking of pressure areas two hourly. The UHB will benchmark practices against neighbouring health boards to identify processes to support the reduction in pressure damage.	Pressure Damage Group		Oct-19	
		All grades of pressure damage are reported and monitored. All grade 3, 4 and unstageable health care related pressure damage is reported as a Serious Incident. All are reviewed using the All Wales Pressure Damage Tool. There is a low threshold for identifying pressure damage as health care acquired, and failure to document a risk assessment or intentional rounding within UHB best practice is deemed evidence that the pressure damage is health care related in keeping with WG guidance	Lead Nurse	Imbedded as part of practice		
		Monthly audits of compliance against this schedule are undertaken.	Lead Nurse	Monthly		
		Results of these audits will now be reported through the department Q&S meeting	Lead Nurse	Monthly		
		The Pressure Damage Group will ensure that lessons learnt from the inspection are disseminated across the health board.	UHB Pressure Damage group		Sep-19	
		The Pressure Damage Group is piloting an approach to greater scrutiny of pressure damage RCAs to ensure that the lessons are understood and learned.	UHB Pressure Damage group		Sep-19	
		Benchmarking with practice in other organisations will be undertaken to ensure that best practice is being applied	UHB Pressure Damage group		Sep-19	
On admission to AU, nursing staff must assess patients for their risk of falls, and that patients are re-assessed where applicable, and with the appropriate falls care plan in place	2.3 Falls prevention	All patients should have a risk assessment undertaken within 4 hours of arrival into the department. All staff have been reminded of this responsibility Audit of compliance against this standard is undertaken monthly and results of the audit will now be reported through the department Q&S meeting.	Lead Nurse	August 2019 and reported monthly thereafter		
Staff knowledge and skills must be updated and competence assessed with further provision of training in falls management.		The UHB will benchmark practices against neighbouring health boards to identify processes to support the reduction in Injurious Falls	Falls Delivery Group		Sep-19	
		The department educations team have attended the Falls simulation suite 'train the trainers' session and are now undertaking a phased approach to training the department staff with Health Care Support Workers being trained initially. This has already been evaluated very successfully in the UHB	Department Education team	Review quarterly		Educators within the directorate have been trained and have started the training. A live database has all those who have been trained.
		Options for UHB wide online falls training are currently being explored by the Falls Strategy Lead in conjunction with the Falls Delivery Group.	Falls Strategy Lead	Review August 2019		
		The Falls delivery Group will ensure that lessons learnt from the inspection are disseminated across the health board	Falls delivery Group		Sep-19	
Cleaning schedules are completed robustly and audits of environment are undertaken regularly	2.4 Infection Prevention and Control (IPC) and Decontamination	Cleaning schedules are in place for the department. C4C undertake environmental audits on a weekly basis the nurse in charge will ensure that a member of the nursing team is delegated to support this audit process and highlight issues. The results of the environmental audits will be forwarded to the Lead nurse to review.	Operational Service Manager and Lead Nurse		Jul-19	A joint meeting to held to ensure co working when the audits are undertaken.
All staff are aware of the importance of continuous basic hand hygiene, and maintain hand hygiene at all times		All staff have been reminded of the importance of basic hand hygiene and the importance of washing and sanitising hands between patients	Lead Nurse	Complete		Meeting on the 20/09/2019 to arrange and support this.
All staff have updated knowledge and understanding in infection, prevention and control and complete training		Hand hygiene audits are undertaken monthly which includes episode of hand washing and being bare below the elbows. Compliance is reported and monitored through the Executive Performance Reviews. This will also now be reported through the monthly QSE meetings All staff are expected to complete level 1 IP&C mandatory training. Compliance was 70% in April. The department will work towards 100% compliance with mandatory IP&C training	Lead Nurse	Review end June 2019/keep under monthly review		
		All staff will be reminded of the need to complete the training and PADRs will not be signed off without completion of mandatory training.	Lead Nurse	Complete		
Nursing staff have completed nutritional risk assessments for patients and reassessed patients as appropriate	2.5 Nutrition and Hydration	Nutritional risk assessment must be completed within 24 hours of admission to the department. All staff have been reminded of this requirement. The education team will ensure that training around nutritional assessment and optimisation is available to all appropriate staff.	Lead Nurse Education team	Complete		
All patients must have an oral assessment and care plan implemented for oral care where applicable, on the AU and other inpatient areas.		Audit of compliance against this standard is undertaken monthly and results of the audit will now be reported through the department Q&S meeting Oral care is included on the intentional rounding document and as a result should be considered every two hours. Staff have been reminded of this requirement	Lead Nurse	Monthly QSE meetings		
		The UHB oral care assessment will be introduced into the department. The education team will undertake a teaching session and will develop a poster for staff to remind them to use the trigger questions to identify patients who need support with oral care and to trigger a full assessment. Oral packs are available across the department.	Education team		Sep-19	
Staff are always documenting consistently, all aspects of the medication charts	2.6 Medicine management	Pharmacy currently undertake monthly audits of prescribing and medication administration metrics in the assessment unit. These include: • Allergy status • VTE risk assessment • Prescribing Of thromboprohylaxis • Omitted doses • Critical Time Omitted doses The result of these audits are shared with the Clinical Directors and Senior Nurses. The results will now be reported and review at local Q&S forums and Consultant meetings.	Lead Nurse/Clinical Leads	Monthly		
		The importance of recording allergy status, administration of IV fluids and accurately prescribing oxygen will be raised by the Clinical Director at the next consultant meeting and at the department Q&S meeting	Clinical Director Lead Nurse		Jul-19	

The eye treatment area and all other drug cupboards are locked when not in use		The eye treatment area is now locked when not in use.	Lead Nurse	Complete	
Ensure all applicable staff are up to date in medicines management.		Medicines management practice will be considered as part of the PADR process and identified development needs addressed as appropriate)	Lead Nurse	Embedded as part of PADR process	
		Medicines related issues identified as a result of this inspection will be included in the next Patient Safety Newsletter and also in the next Medication Safety newsletter	Patient Safety team/Medication Safety Executive group	By end July 2019	14/08/19- meeting with Louise Williams- Nurse lead for Medicine Management. Next patient safety news letter will discuss safe storage of medicines.
The health board is required to ensure that all staff within the EU and AU and throughout the health board, have appropriate training with updates on the mental health act, and the DoLS process	2.7 Safeguarding children and adults at risk	A bespoke update session on the mental Health Act will be provided to all relevant EU/AU staff.	MH implementation manager	End of July 2019	To organise MH bespoke day.
		A bespoke update session on DoLS legislation will be provided to all relevant EU/AU staff	DoLS lead	End of July 2020	To liase with the DolS team to organise a date.
		In addition Mental Capacity Act training is mandated and the e-learning is accessible to all staff. Since the beginning of May completion of MCA training is recorded on individual ESR records. Historical attendance at training will be captured and departmental compliance will be reportable within a month. Compliance with MCA training will be reviewed and monitored through the performance reviews.	Education team	End of July 2021 Complete	
		The Mental Capacity Act manager delivered face to face training for all nursing staff last year. This is repeated intermittently. There is a mental health link worker and a consultant lead identified to support staff around issues relating to DoLs and Mental Capacity assessments.		Complete	
The health board is require to ensure that pain assessments are completed and documented with each patient where applicable	3.1 Safe and Clinically Effective care	The Service Improvement Team are currently undertaking a project to review the pain assessment documentation. The pain assessment will be incorporated at the bottom of the NEWS chart to increase visibility and improve compliance. The efficacy of the service improvement will be evaluated after 2 months of roll out of the document.	Lead Nurse EU/AU	Review September 2019	30/08/2019 Pain assessments are now being put in on the Observation chart to support better compliance
		A specific pain assessment tool is in place for patients with a learning disability. In paediatric EU the pain assessment tool is linked to guidance around prescribing of analgesia	Lead Nurse	Complete	
The health board is required to ensure that patient identifiable data and care records are kept securely at all times.	3.4 Information Governance and Communications Technology	The UHB has had recent discussions with the Information Commissioner around secure storage of patient information. This highlighted the need to balance risk of data breach with the clinical risk associated with difficulties in accessing records and specified that there was not an explicit requirement to keep notes in locked facilities if there was a detrimental risk around clinical care			
		All staff will be reminded to ensure that records are stored securely, that all records are returned to the notes trolley and that the trolley is kept closed when not in use.	Lead Nurse	Jun-19	
		All clinical staff should be wearing clearly visible ID and therefore be identifiable. Nursing stations in the Assessment unit are constantly attended by clinical staff and therefore medical records remain within sight at all times. This applies to records of patients currently being cared for in the department.			
		All records of patients who have been discharged from the department will be transferred to secure storage. All staff have been reminded of the need to protect patient identifiable information appropriately.	Lead Nurse	Complete	
The issues identified with low morale and motivation on AU or any other departments are explored and addressed where appropriate	Governance, Leadership and Accountability	There are a number of initiatives in place to support staff wellbeing and morale. • Wellbeing champions are in place across the department • A closed Facebook page is maintained to communicate with a staff members • A communication board is populated with up to date information • The Clinical Board undertake department walkrounds • The results of the UHB staff survey were reported at departmental level and reported to the EAMD. There is now a plan to undertake a Pulse Survey of staff within 2 months.	Lead Nurse	Monthly	Wellbeing was the focus of the nurses and consultant away day with plans for future events. Learning from Excellence has started in the directorate to learn and thank staff for the work. Staff are made aware of what is happening within the team . Awaiting the Pulse survey.
Low scores within the monthly care audits are addressed to ensure an improvement is made where appropriate		Health and Care monitoring audits results will now be reported through the Department Quality and Safety meetings.	Lead Nurse	Monthly	
Ward staff are able to attend regular ward meetings		There is a three monthly nursing away day and staff are rotated to ensure that everyone has the opportunity to attend. Minutes of every meeting are circulated to all staff.	Lead Nurse	Monthly	
Investigation is undertaken into errors, near misses or incidents in the last quarter, which could have hurt staff or patients		All Datix incidents are reported to a manager and feedback is sent to the reporter relating to the actions. A review of all the incidents reported will be undertaken to ensure that they have all/are all being appropriately investigated.	Lead Nurse EU/Patient Safety team	End of July 2019	
Investigation is undertaken in to the reasons why there is a perception by some staff, that the organisation would blame or punish the people who are involved in such incidents		The Head of Patient Safety and the Lead Nurse EU/AU are meeting to discuss governance, structure and process within EU to put in place a plan to strengthen current systems and to address any issues that staff are raising.	Lead Nurse EU/AU, Head of Patient Safety	End of June 2019	Lead nurse to organise a meeting
All staff are made aware of the revised Health and Care Standards that were introduced in April 2015.		The Patient Safety team will deliver a bespoke session for staff to cover: • Basic patient safety principles • Incident reporting, investigation and management • Safety culture and fair and just culture • Health and care Standards/Annual Quality Statement • Quality, Safety and improvement Framework • Clinical Audit	Head of patient safety	End of July	Alex Scott to organise a session on quality indicators for our October away day.
		The UHB Safety Valve processes is in place to support staff to raise concerns confidentially directly to the Chair. The safety Valve mechanism has been highlighted to staff across the department through all communication channels	Lead Nurse		
A robust plan for recruitment is in place to maintain compliance with the Nurse Staffing (Wales) Act 2016	7.1 Workforce	A nursing establishment is reviewed and agreed by the executive Nurse Director six monthly. Breaches of agreed staffing are highlighted to the deputy Executive Nurse Director on a daily basis.	Lead Nurse	In place and embedded as part of routine practice	
A robust process is in place to manage temporary staffing requirements to maintain compliance with the Nurse Staffing (Wales) Act 2016		Bank and agency fill rates are reported through the performance reviews monthly and risks are highlighted. Risk assess pressure on different areas within the department. Senior nurses will work clinically to fill, gaps where required and are available for escalation of risks.	Lead Nurse/Director of Nursing MCB	In place and embedded as part of routine practice	
Monitoring and auditing is undertaken on the fill rate of shifts against the increased staffing levels committed to for the lounge area of AU			Lead Nurse		AU nurse manager keeps a log and is sent monthly to the directorate team.
Consideration is given to completing an up-to-date staff satisfaction survey to include AU, EU, MEACU and Admissions Unit in Llandough		A Pulse Survey will be undertaken within 2 months and evaluated as to how often to undertake	Lead Nurse		Awiting start date from HR 29/08/2019 launch date for September set
A robust process is in place to enable all staff have the opportunity to have a formal personal annual appraisal.		The completion of PADRs by the band 7 has been highlighted as a priority and will be monitored through the performance reviews. Senior Nurses will raise individual performance around undertaking PADRs in the monthly 1:1 meetings	Senior Nurse	To be monitored on a monthly basis	All band 7 and 6+ staff have been requested to supply on a monthly basis where they are with their teams in regards to PADR, sickness and Annual leave.
		The UHB will prepare a summary of the lessons learned and develop an assurance tool for other areas in the UHB to ensure that the lessons learned are disseminated and implemented widely and as appropriate	Assistant Director Patient Safety and Quality	End of June 2019	

REPORT TITLE:	**PRIMARY CARE GENERAL MEDICAL SERVICES AND DENTAL GOVERNANCE HIW PRACTICE INSPECTION UPDATE REPORT – SEPTEMBER 2019**						
MEETING:	**QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE**				**MEETING DATE:**	**17- 09 -19**	
STATUS:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**
LEAD EXECUTIVE:	**EXECUTIVE NURSE DIRECTOR**						
REPORT AUTHOR (TITLE):	**PRIMARY, COMMUNITY AND INTERMEDIATE CARE QUALITY AND SAFETY MANAGER**						

PURPOSE OF REPORT:

SITUATION:

The routine Welsh Government practice and performer inspection programme was commissioned from Healthcare Inspectorate Wales (HIW) from August 2014. The UHB Primary Care Team seeks to provide assurance to the Executive Team that Inspection Reports have been received, reviewed and acted upon.

The purpose of this report is to provide an update on HIW activity in Primary care since the last report to the Committee in December 2018.

REPORT:

BACKGROUND:

All General Practices and General Dental Services/Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local Community Health Council. The HIW inspections produce an Action Plan which it then assesses and follows up. The UHB then ensures ongoing compliance with the outcomes of the inspection.

ASSESSMENT:

Any significant issues are reported to the Practice and UHB in the form of an Immediate Assurance letter. An initial report is sent to the Practice along with the HIW action plan. The Practice provides a response for each element of the Action Plan and, once HIW has approved the Practice feedback and actions, the report is released to the UHB and is sent for translation. The UHB Clinical Director for Clinical Governance for PCIC and Primary Care Dental Advisor review the Inspection Report and Action Plan and produce a RAG-rated summary including any additional actions for the UHB. HIW reviews each report; any responses from the Practice which HIW are not happy with are escalated internally to generate a more detailed response from the Practice. The outcome of the action plan is assessed by HIW and satisfaction with steps taken or proposed by the Practice are included in HIW's final report. The process is also overseen by the Assistant Director Patient Safety and Quality.

The Primary Care Team reviews each Practice report and any potential actions for follow-up required. These steps are in addition to any satisfaction HIW has with the outcome and so are managed with sensitivity. The review and summary of reports are attached (**GP Appendix 1, Dental Appendix 2**).

General Medical Services:
Since the last full report to the Committee in December 2018, there have been five General Medical Services inspectorate visits and three reports published. The following practices were visited:

- Clare Road Medical Centre
- Danescourt Surgery
- Pontprennau Medical Centre

Final reports are yet to be published following visits to:

- Birchgrove Surgery
- Waterfront Medical Centre

Since the last update, HIW have issued immediate assurance letters to Birchgrove Surgery and Danescourt Surgery, both of which were swiftly resolved by the practices. At Birchgrove Surgery it was evident that DBS checks were not routinely undertaken for any non-clinical members of staff such as, practice management, administrative and reception staff. The practice has since put in place a process for assessing the requirements for non-clinical staff to have DBS checks. In Danescourt Surgery, it was evident that drug fridge temperatures were not being checked and recorded on a daily basis. The practice has since conducted an internal audit and has addressed the gaps in fridge temperature readings by updating the record sheet used, and developed a process to handover responsibilities during staff absences.

It should be noted that the immediate assurance letter received by the Birchgrove practice was for the same issue highlighted in the visit report to Pontprennau Medical Centre and Clare Road Surgery, although immediate assurance letters were not issued in both these cases. .

General Dental Services (GDS) :
The following General Dental Services inspectorate reports have been published during the period since the last report:

- Windsor Road Dental Care
- Penylan Dental Practice
- Allison Jones, Barry
- Moorcastle Ltd
- Cathedral Dental Clinic
- Park Place Dental Practice
- Tynewdd Dental Practice
- Llanedeyrn Dental Practice
- High Street Dental Practice, Barry

- Cathays Dental Practice

All GDS HIW reports, have been reviewed by the Dental Practice Adviser, who advises the necessity of appropriate follow-up by the Primary Care Team. Outstanding actions from HIW visits highlighted in previous reports have been updated and included in Appendix 2.

Furthermore, since the last update report, HIW has also issued one Immediate Assurance Letter to High Street Dental Practice, Barry. This related to the storage of healthcare waste. A number of issues of concern were raised in relation to Windsor Road Dental Care. These related to the general environment as well as cleanliness of the surgery. In addition there were concerns about the quality of record keeping. The practice continues to be monitored through PCIC governance arrangements.

Receipt of reports from HIW

In the last report to Committee, it was noted that over the previous year the Health Board had not always been given prior notice of inspections occurring and had not always received embargoed reports in a timely way. Unfortunately the situation continues and to this end a formal meeting was held with HIW on 3-09-19 to agree how the situation could be improved. A number of actions has been agreed to improve the process in the future.

RECOMMENDATION:

The Quality, Safety and Patient Experience Committee is requested to **NOTE** the ongoing monitoring and performance management systems and outcomes for Primary Care Dentists and GMS contractors.

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information									
Sustainable development	Prevention	✓	Long term		Integration		Collaboration		Involvement

principle: 5 ways of working											
EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable										

APPENDIX 1

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions/Update*
Clare Road Medical Centre	22nd August 2018	1. The practice must update patient leaflet and promote MyHealthOnline 2. The practice should conduct formal peer review of patient referrals 3. The practice should manage concerns/complaints with accordance to Putting Things Right 4. The practice must provide evidence of action taken in regards to poor responders to Hep B vaccination 5. The practice must improve aspects of medicines management 6. The practice should improve safeguarding arrangements and include in risk register 7. The practice should review and improve data quality through audit and standardisation 8. The practice will develop a business continuity plan and update policies 9. The practice should improve staff understanding of GDPR 10. **The practice should develop robust staff recruitment arrangements** 11.The practice must comply with all aspects of health and safety legislation	G	1. Complete 2. The practice discussed referral management in house to promote best practice 3. The practice will conduct annual patient surveys and has adopted the Putting Things Right framework 4. The clinician has since received their Hep B vaccination 5. The practice provides monthly protected learning time, has added posters for staff information and completes regular clinical reviews to improve upon medicines management 6. The risk register has, and will continue to be, reviewed 7. The practice will set up an internal audit and review current processes 8. The practice will update BCP and policies 9. GDPR training session for all staff 10. CRB/DBS checks for all staff complete 11. The practice will review compliance and take appropriate action
Pontprennau Medical Centre	5th November 2018	1. The practice must promote and provide information regarding the availability of a chaperone	G	1. Promoted on information screens 2. Promoted in waiting rooms and added to leaflet

		2. The practice must adopt and promote Putting Things Right and update their leaflet with these details 3. The practice must adopt a new way of communicating urgent messages to GPs 4. The practice must develop a robust follow up process 5. The practice must ensure that hospital discharge summaries are reviewed 6.The practice must review booking system and inform patients of telephone only access between 5:30 and 6:30 7. The practice will consider improvement to doors and parking to improve access for patient with mobility issues 8. The practice is to update their business continuity plan 9. The practice is to update infection control policy 10. The practice should ensure all staff complete mandatory training 11. The practice should ensure that significant events and new guidelines are shared with staff 12. The practice is to install privacy screen filters and a door between office and reception 13. The practice is to conduct regular audits of data quality 14. **The practice needs to complete all appropriate recruitment checks**		3. The practice has trailed a daily workbook which is audited 4. Follow up process in place 5. Electronic reports are sent directly to relevant staff and illegible summaries are returned and requested again 6. The practice has reviewed booking system and enhanced flexible working. Phone message has been updated with OOH information 7. Complete 8. Complete 9. Policy to be updated 10. All training complete as of April 19 11. All significant events are documented and staff are notified 12. The doors and screens have been installed 13. The practice will audit every 6 months 14. Complete The practice has had a visit from a member of the Primary Care Team to confirm actions are complete.
Danescourt Surgery	18th March 2019	1. The practice is to consider internal and external signage 2. The practice must display information on Putting Things Right 3. The practice must ensure that the fridge in stairway area is locked or moved to secure area	G	1. The practice will provide new external signage 2. Information is on website and leaflets are available in waiting rooms 3. The fridge has been moved 4. Staff have been reminded that it

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

		4. The practice must make sure that clinical waste bins are locked at all times. 5. The practice must keep a record of staff Hepatitis B immunisations status 6. The practice must have process for sharing NICE guidelines 7. The practice must record when a chaperone is offered, and if it was accepted or declined 8. The practice must ensure that there is clinical oversight to patient record summarising		must be locked 5. The Hep B document has been updated 6. GP has registered for updates and shared during clinical meetings 7. To be discussed at clinical meetings 8. The summarising policy will be updated to include audit The practice has had a visit from a member of the Primary Care Team to confirm actions are now complete.
Birchgrove Surgery	10th July 2019	Full report has not been published		
Waterfront Medical Centre	12th August 2019	Full report has not been published		
HIW Immediate Assurance Letters (received since last SBAR update)				
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*	
Birchgrove Surgery	10th July 2019	The practice manager confirmed that DBS checks were not routinely undertaken for any non-clinical members of staff such as, practice management, administrative and reception staff. **<u>Improvement needed</u>** The practice must implement a process to ensure that:	The practice has developed a process for assessing the requirements for non-clinical staff to have DBS checks. The Primary Care team will advise all practices how they might confirm the level of DBS checks required for employed staff via the DBS eligibility tool on NHS Employers.	

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

		• **Pre-employment checks for all staff include the need for a DBS check appropriate to their roles** • All current members of staff have a DBS check undertaken urgently, appropriate to their roles. A record must be kept within the practice.	
Danescourt Surgery	18th March 2019	The practice must ensure that drug fridge temperatures are checked and recorded on a daily basis.	The practice has conducted an internal audit and has addressed the gaps in fridge temperature readings by updating the record sheet used, and developed a process to handover responsibilities during staff absences. The Primary Care team has also audited fridge temperature logs and noted that temperatures were recorded on all working days.
HIW Immediate Concerns raised (received since last SBAR update)			
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*
Danescourt Surgery	18th March 2019	During a tour of the practice, HIW found that bins used to store clinical waste were unlocked. These were located under the stairs in an open passageway used by patients.	This was raised immediately with the practice manager at the time. The practice manager immediately locked the bins. Practice staff have been notified that the bin should remain locked when not in use.

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
Cathays Dental Practice (Gracias, Kevin)	06/08/19 Improvement letter 08/08/19	• The service must ensure healthcare waste is being stored appropriately and securely within the dental practice premises in line with best practice guidelines.		• Practice emailed 09/08/19 for confirmation of action.	• Email response received 09/08/19 • HIW email response 12/08/19 • Awaiting HIW response
Llanedeyrn Dental Practice (RWH Ltd)	23/05/19 Improvement plan issued from HIW Final report received 22/07/19	• Greater selection of info leaflets • Display GDC 9 principles, layout of reception to ensure confidential conversations • Display private fees • Language line access • Update patients if delayed appointment • Complaints procedure displayed and patient feedback system • Risk management procedures including fire safety policy, training and drill • Ensure decontamination room and surgery htm0105 compatible • Medical emergency drugs dates checked and policies read • Scripts locked centrally overnight • Temp controlled fridge for medicines checked regularly • Safeguarding contact details and staff training required • To complete heiw QI tool for ionising radiation • Regular Audit and peer review including		• DPA Letter 16/08/19 requesting confirmation of action. • Visit in 3 months (October 19)	• HIW Satisfied with improvement plan submitted 18/07/19 • Awaiting response

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		record keeping • GDPR training all staff • System to review, update and staff read all relevant policies • Ensure cpd up to date, staff appraisals, appoint leads, regular meetings and 2 references for new staff			
Park Place Dental Practice (MA &ST Hill)	01/05/19 Improvement plan issued from HIW Final report received 08/07/19	• Display changes from patient feedback • Storage of emergency drugs and appropriate alogorithms stored safe environment • Remove out of date syringes from emergency kit and put in place appropriate system to check drugs		• DPA: No action required	• HIW Satisfied with improvement plan submitted 24/06/19
Cathedral Dental Clinic	26/03/2019 Improvement Plan issued from HIW	Overall, Cathedral Dental Clinic was working hard to provide a high quality experience for their patient population. • Update practice leaflet with current staff and Violent and abusive behaviour policy • Statement of purpose on website and available on request • Clear and prominent signage stating CCTV in operation • Update CCTV policy and guidance including storage, retention and disclosure • Fire safety training, exit signage throughout practice and risk assessment submitted to		• Letter sent to practice 28/6/2019 requesting confirmation / evidence of completed improvement plan	• HIW satisfied with improvement plan submitted 29th April 2019 •

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		HIW • HTM01-05 guidance to be followed including dirty to clean workflow and clearly marked transport boxes • Emergency drugs and emergency flow charts kept in clear folders • System to check use by dates for emergency drugs and equipment • Review adequacy of private consent forms • Performers require annual documented appraisal			
Tynewydd Dental Care	13/05/2019 Immediate Improvement plan issued from HIW 15/05/2019 Final report received 08/07/19	• HIW could not be assured that a member of the clinical staff had sufficient protection against contracting Hepatitis B, posing a potential risk to patient safety. • HIW could not be assured that the registered managers were ensuring that adequate precautions have been taken to ensure the safety of staff and patients in the event of fire.		• Letter sent to practice 22/05/2019 requesting confirmation/evidence of completed improvement plan	• HIW satisfied with improvement plan submitted 24th May 2019 • Response received 12/06/19
Alison Jones Barry	17/12/2018 Full report found on website 12/04/2019	The HIW report was complementary in many areas and the concerns mentioned are not of substantial concern. • Works suggested to decontamination room walls have been addressed and wash hand basin considered • First aid kit has been updated		• Letter sent to practice 17/04/2019 requesting confirmation/ Evidence of completed	• Satisfactory response received from practice 15th May 2019

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		• Medical emergency kit and drug list protocols and policies have been adopted and are up to date • Confirm staff training in POVA and Child Protection has been addressed • Clinical staff undertaking radiographic exposures have up to date IR(ME)R training • Information security has been adopted • Staff appraisal and PDPs under development		Improvement plan	
Penylan Dental Practice	28/11/2018 Full report found on website 12/04/2019	Very nice to read such a positive report. • Placement of feminine hygiene bin in lavatory • Ensure medical emergency kit is in central accessible place and has suitable algorithms • Complete children protection and POVA training for all staff		• Letter sent to practice 17/04/2019 requesting confirmation/ Evidence of completed Improvement plan	• Satisfactory response received from practice – 7th May 2019
Moorcastle Ltd	31/01/2019 Full report received 25/03/2019	It is nice to see a practice report which shows a well-established and well-run practice. • The practice should provide a wide range of information to patients to support them to make good oral health choices • We recommend that all practices who treat children should have age appropriate resuscitation equipment in place, or a risk assessment to evidence why this is not required, in line with Resuscitation Council		• Letter sent to practice 03/04/2019 requesting confirmation/ Evidence of completed Improvement plan.	• HIW satisfied with improvement plan submitted 20/03/2019 • Satisfactory response received from practice – 8th April 2019

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		Quality Standards • The practice must ensure that regular servicing and maintenance of equipment is maintained as per manufacturers guidelines • The practice must ensure that all staff have appropriate radiation protection training. • The practice should undertake a broad range of audits to promote patient safety. • The practice should consider using a Quality Improvement tool in the practice • The practice was recommended to record extra oral and intra oral examination separately as part of record keeping in line with professional guidelines.			
Cox & Hitchcock	20/08/2018 Full report received 20/11/2018	It was nice to read the practice inspection report which describes a friendly and good quality environment for dental surgery to take place and the practice team should feel pleased with the outcome. As a health board we need to confirm the improvement points have been actioned. • The practice should make available for patients a selection of health promotion information, including leaflets about treatments and preventative advice • Staff to ensure that all computers are locked to ensure no unauthorised access to patient information		• Letter sent to practice 21/11/2018 requesting confirmation/ Evidence of completed Improvement plan. 12/12/2018	• HIW satisfied with improvement plan submitted 16/11/2018 • Satisfactory response received from practice – 11th December 2018

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		• The practice to provide a patient information leaflet setting out risks, benefits, describing treatment and side effects of receiving treatment from the surgical laser. • The website is updated to include details of the practice's complaints process. • The practice to maintain a complaints folder, ensuring the nature of the complaint, action taken and outcome are recorded • The practice to ensure that patients receiving laser treatment are asked about any changes to their medical histories and that this is recorded in the patient notes • To have a process to ensure consumables and materials are traced by use by date and not beyond.			
Windsor Road Dental Care	29/10/2018 Awaiting full report Full report received from HIW 17/01/2019	The HIW inspection has highlighted a number of areas of concern not least cross infection control. In response to these concerns an unannounced visit was carried out and immediate interim measure put in place to ensure patient safety. The practice is addressing the structural changes needed to develop a decontamination room and advice has been offered for support. On completion of the works a practice inspection will be carried out to ensure the responses from the practice to the HIW report		• Letter sent to practice 3/4/2019 requesting evidence/ confirmation of improvements • Practice visit 10/07/19 • Review 6 months	• HIW satisfied with improvement plan submitted 14/1/2019 • Practice Visit planned 10/07/2019 • Practice visit carried out 10/07/19 • Visit carried out 10/07/19. Satisfied recommendations taken on board Review 6/12

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		have been carried out. • Practice must ensure it is providing a clean, safe and secure environment, and that the premises are kept in a good state of repair externally and internally. • The dentist must ensure he is keeping comprehensive, succinct and contemporaneous records for the consultations and treatments of patients. • The practice must feedback outcomes from the questionnaires to patients. • The practice must ensure that the decontamination areas are kept clean, free of clutter as per WHTM 01-05. The practice must ensure that all pieces of equipment are kept sterile, bagged and dated in accordance with WHTM 01-05. The practice must ensure that feminine hygiene bins are placed in all toilets. The practice must ensure that the seal between the floor and the wall is properly repaired. The practice must ensure that the walls in the surgeries are repaired. • The practice must ensure that all emergency equipment, including airways for the emergency oxygen, is appropriately sterilised and bagged to ensure it is ready for use. The practice must ensure that all items are regularly checked to ensure that they are in date.			

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		• The safeguarding policies must include details of the relevant safeguarding authorities. All staff should undertake safeguarding training. • The practice should undertake a broad range of audits, to ensure they are meeting with best practice • The practice should develop a system of peer reviews for staff. • The practice should ensure that meetings are held and minutes are kept regularly. • The practice should include details of the arrangements for dealing with patients who are violent or abusive to staff in the patient information leaflet.			
Bay House Dental Practice	06/08/2018 Full report received from HIW 26/10/2018	This is a well-run and well led practice. Patients describe a high degree of satisfaction and are well-supported by the practice. Clinical records are very thorough and well-kept. Immediate Improvement Plan issued- One set of protective eyewear was damaged and unsuitable for use, and there was not sufficient eyewear for a parent or chaperone. One set needs to be replaced and a spare set acquired. The machine was also not located within a suitably secure environment when not in use.		• Response requested by: 24/09/2018 • Letter sent to practice 01/11/2018 requesting confirmation/Evidence of completed Improvement Plan	• Satisfactory response received from practice – 19th November 2018

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		The machine should be kept in a secure location at the practice where possible. There is no service, maintenance and calibration agreement in place. The machine needs to be serviced and calibrated in line with manufacturers' guidelines prior to use. • The practice make available for patients a selection of health promotion information, including leaflets about treatments and preventative advice leaflets • Staff ensure that all computers are locked to ensure no unauthorised access to patient information • The practice to provide a patient information leaflet setting out risks, benefits, describing treatment and side effects of receiving treatment from the surgical laser and records patient consent to treatment. • The practice to ensure its Patient Information Leaflet meets the requirements of Schedule 2 of the Private Dental Regulations 2017 • The practice to update its website to include details of all clinical staff, the relevant contact numbers for obtaining emergency dental treatment, and the practice's current complaints policy • The practice to ensure that all clinical staff have undertaken training in infection control			

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		• The practice to store the oxygen and related equipment together. • The practice to ensure that all staff know where the emergency kit, emergency drugs and oxygen are located. • The practice to store the drugs and their respective algorithms in clearly labelled wallets for ease of identification and access • The practice to ensure regular checks are undertaken of all medication and equipment to make sure they are in date. • DBS check and Hepatitis Certification needed for a staff member			
Castle Court Dental Practice	31/07/2018	Overall evidence that Castle Court Dental Practice provided a friendly and professional service to their patients. Improvements Required • Patient information leaflet to be made readily available for patients. • To replace surgery chairs with non-fabric versions The practice to ensure that all areas of the clinical areas are dust free • Feminine hygiene bin to be placed in staff toilet • Replace hand towel in staff toilet with paper towels or hand dryer.		• Letter sent to practice 01/11/2018 requesting confirmation/Evidence of completed Improvement Plan	• HIW satisfied with Improvement Plan submitted by practice (25/09/2018) • Satisfactory response received from practice – 21st November 2018

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		• Clinical waste bins to be liner with correct clinical waste bags • To fit lock to x-ray room door where emergency kit and emergency drugs are stored to ensure their security • To ensure prescription pads are kept securely • The dentists to arrange regular peer review meetings • Both Statements of Purpose are to be amended to provide further information on the process for dealing with patient complaints.			
Smiles Studio Penarth	02/07/2018	Good leadership and communication. Friendly and professional service with good medical record keeping. Improvements Required • The practice to amend the Practice Information Leaflet to ensure it complies with current guidance. • In accordance with the Private Dentistry Regulations 8 (1)(b) the practice to develop a policy setting out the arrangements for the assessment, diagnosis and treatment of patients • The practice to ensure the following faults are remedied:		• Letter sent to practice 01/11/2018 requesting confirmation/Evidence of completed Improvement Plan	• Satisfactory response received from practice – 15th November 2018

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		1.Areas of the flooring in surgery 1 and in the hygienist's room to be sealed 2. The damaged flooring in the decontamination room to be replaced 3. The chipped work surface in the decontamination room to be addressed 4. The gap between the electrical housing and work surfaces in surgery 2 to be sealed or eliminated 5. The carpet in surgery 1 to be replaced with appropriate flooring 6. The fabric sofa in surgery to be replaced with one that is washable or as a minimum, the practice develop a disinfection protocol 7. The network cable box in the hygienist's room to be securely fixed 8. Sharps bins in the surgeries should be wall mounted • The practice to ensure that all areas of the clinical areas are dust free • The practice to ensure that the corridor in the basement that is one of its fire exit routes, is clear of rubbish and potential hazards. The door should be secured • Practice to remove all portable fans from surgeries. • Practice to undertake an environmental risk			

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		assessment • The practice to ensure that all fire exits are signposted • The practice to ensure that the emergency equipment and emergency drugs are stored together and securely • The practice is to put in place a policy for monitoring the quality and suitability of facilities and equipment including maintenance of such equipment. • The practice put in place a programme of clinical audits. • The practice to develop a clinical audit policy. • Dentists to organise peer review group • The practice to make provision for staff to evidence that they had read and understood the policies. • The practice to put in place an emergency contingency procedure • The practice ensure that all temporary staff have the necessary pre-employment checks in place and have completed the required training			
Integrated Dental Facility, Plas Iona	11/06/2018	Friendly staff providing high quality care and happy patients. Very conscientious in talking to patients about prevention. Instruments cleaned and sterilised in accordance with WHTM01-05.		• Letter sent to practice 01/11/2018 requesting	• HIW satisfied with Improvement Plan submitted by practice (27/07/2018)

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
(Butetown)		• Display list of private prices • Ensure wide range of robust audits to assess procedures and improve services • Formalise arrangements with health board and property management company to ensure maintenance and inspection certificates are shared.		confirmation/Evidence of completed Improvement Plan	• Satisfactory response received from practice – 5th December 2018

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
Church Road Dental Practice	05/02/18 (published 08/05/18)	*Improvements Required* • Review /update website to include information about NHS dental provision • Amend its complaints policy to include relevant and up to date contact information. • Develop process for recording patient concerns • Suitably qualified person to undertake PAT testing • Ensure all clinical staff received appropriate infection control training • Undertake audits in line with WHTM 01-05 • All staff to receive CPR training • Ensure all staff have access /complete relevant safeguarding training. • Record keeping: o Basis Periodontal Examination (BPE) o Medical histories signed by patient and countersigned by the dentist • Appropriate health and safety risk assessments • Records to evidence policies read and understood by all staff *Positive Findings* • Staff interaction with patients was professional, kind and courteous • Dental equipment was well maintained and		• Response requested by: 30/06/18 • Reminder letter sent to practice 02/11/2018	• HIW satisfied with Action Plan submitted by practice (18/04/18) • Satisfactory response received from practice – 21st November 2018

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
		regularly serviced • Clinical facilities were well equipped and were visibly clean and tidy			

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

33	{my}dentist (Countisbury Avenue, Llanrumney)	17/07/17 (published: 18/10/17	A reasonable report overall *Improvements Required* • Review storage of hazardous and non-hazardous waste • WHTM 01-05 Issues (decontamination training) • DBS certification for all dentists Review storage and access of patient records • Administrative (centralised training records)		• HIW satisfied with outcome of Action Plan submitted by practice • Response requested by: 31/01/18	• Satisfactory response received from practice - 18th June 2018
32	Restore Dental Group (215 & 354 Whitchurch Road)	28/06/17 (published: 29/09/17)	An overall poor report, with a significant number of areas of improvement identified being described below: • System checking medical emergency equipment and drugs • Health promotion information to be available for patients • Private patient's price list displayed • Patient information provided in language/ format meeting needs of patients • Review NHS complaints procedure to : - Compliance with NHS 'PTR' - Complaints handling processes (Cont'd.) - Recording and audit trails • System for recording views of patients • Five yearly electrical testing certificate • Fire risk assessment review • Review access to stock room and decontamination room • Decontamination training required for relevant staff. • Review resuscitation policy for both premises		• HIW satisfied with outcome of Action Plan submitted by practice • Originally categorised as Red. • Letter sent to practice (29/08/17) by UHB to seek written assurances on issues outlined in Action Plan with a request to follow up the process with a meeting within six months. • Response received	~~Practice visit to be arranged for February 2018.~~ Practice visit rescheduled for Spring. Following resignation of DPA practice visit will be undertaken when the new DPA is in post. Interviews November 2018. • Email to practice 09/08/19 to follow up. Awaiting response.

			• Review stock control processes: - Materials - Anaesthetics • Child protection/POVA training needed for relevant staff • Review location of X-ray isolation switches • Review appropriate IR(ME)R training for dental nurses • Formalise QA arrangements • Patient records: - Patient medical histories - FP17s for banded NHS COTs - Justification and reporting of radiographs - Treatment plans and options • Clinical Issues: - Clinically necessary treatment carried out under private arrangements - Frequency of BW radiographs • DBS required for five dentists • Staff appraisals on an annual basis. • Practice management and leadership in this practice need to be reviewed and strengthened		19/09/17 • Re-categorised as Amber	

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

29	Calgary Dental Practice (Llantwit Major)	08/05/17 (published: 09/08/17)	A positive report overall *Improvements Required* • OOH number for private patients • Update complaint process to include ""Putting Things Right"". • Surgery floor needs to be appropriately sealed • Update Adult and Child Safeguarding policies • Explore relocation of isolation switch for X-ray unit & radiograph processing audit • QA Audit • Immunisation Records need to be retained • Updated DBS certificates for HIW registered dentists.		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan once Report has been formally published. • New practice owner. Letter to new owner to check that improvement plan is being followed through on. • Correspondence sent to the new practice 02/11/2018 – response requested by 16/11/2018	• Satisfactory response received from practice – 13th November 2018
27	Gwena Dental Care	02/03/17 (published 05/06/17)	Report found on HIW website – June 2017. **Not notified.** A positive report overall *Improvements Required* • Update complaint policy to reflect correct timescales. • Complaint policy on the website • Methods for regular checks of Emergency Drugs		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response	Awaiting Response • Satisfactory response received from practice – 19th November 2018

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

			• IR(Me)R Training for all relevant staff • Patient records quality		requested for ongoing work. Response requested by: 31/01/18 • Reminder letter sent to practice 02/11/2018	
26	Wilton House Dental Practice	28/02/17 (published 31/05/17)	Report found on HIW website – July 2017. **Not notified.** A number of areas of improvement were identified, with the main issues being described below: • Separate NHS and Private complaints procedures needed • Private Price List • WHTM 01-05 Audits • WHTM 01-05 (dirty to clean workflow signs, instruments to be cleaned and sterilised properly, single use items not reused on same patients) • Checks on Emergency Drugs expiration dates • Radiographic Audit (Cont'd.) • Patient Record Improvements • Implement Resuscitation Policy • POVA Training • Child Protection Training		• HIW issued satisfactory assurance • Practice written to by UHB to seek assurances on issues outlined in Action Plan. • Practice under new management (01/12/17)	Meeting to be arranged with the new owners for July 2018 Following resignation of DPA practice visit will be undertaken when the new DPA is in post. Interviews November 2018. Practice visit by DPA 14/06/2019 – all issues resolved

APPENDIX 2

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

22	Wilson Road Dental Surgery	18/11/16 (published 20/02/17)	Notified to UHB – 15th May 2017 A positive report overall *Improvements Required* • Clinical/hazardous waste storage needs to be safely stored • Review of cleaners handling clinical waste • Review clinical facilities to ensure safety and condition. Specific attention: worktops and handles/flooring sealed in the surgeries/ repairing or replacing the light unit, suction pipe, upholstery/rusting or damage to the dental chair. • WHTM 01-05 Compliance (separation of clean/dirty areas, dental impressions and disinfection, autoclave data logger not being used correctly) • Confirmation letter to HSE • IR(ME)R training certificates obtained and kept on file • Patient records administration • Radiography: • Review of policies		• HIW issued satisfactory assurance • Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	Meeting scheduled with the practice 12/06/18 Following resignation of DPA practice visit will be undertaken when the new DPA is in post. Interviews November 2018. Practice visit by DPA 7/06/2019 – all issues resolved
20	Ellen Davies Dental Practice	27/10/16 (published 30/01/17)	A positive report overall *Improvements Required* • Informing patients and visitors of the CCTV in operation • Ensure full compliance with WHTM 01-05 • Resuscitation equipment needs to be checked • First Aider: certificates obtained held/first aid box needs to be checked regularly • IR(ME)R for dental nurses • Patient records: - Medical histories countersigned		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	No Updates Practice under new ownership – Letter to be sent 9th November 2018 • Practice emailed 09/08/19 awaiting response.

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

			- Medical histories are updated - Soft tissue examinations • Justification for x-rays • Review of all staff training needs required and courses • Policies and procedures need to be consistent with version and review dates			
19	Nicola Taaffe @ West Grove	26/09/16 (published 29/12/16)	A weak report overall *Improvements Required* • Practice's complaints procedures need updating • Compliance with WHTM 01-05 in respect of: - Autoclave tests - Procedures on Ultrasonic Bath - Maintaining records • Ensure floors are appropriately sealed between the cabinets and walls • Implement system regular checks on the emergency equipment • Review storage of emergency drugs and equipment in one location for easy access • Review safeguarding procedures: • Ensure staff complete training • Patient records issues: - Medical histories - Use of templates - Treatment planning - Consent - Radiographic reports • Review of all policies, procedures and demonstrate implementation		• Originally categorised as Red • HIW satisfied with outcome of Action Plan submitted by practice • Practice written to by UHB to seek assurances on issues outlined in Action Plan. • Assurances received from practice. • Re-categorised as Yellow • Re-categorised as Green	Practice Meeting to be arranged Following resignation of DPA practice visit will be undertaken when the new DPA is in post. Interviews November 2018. Practice visit by DPA 31/05/2019 – All issues resolved

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

			• Training certificates for all clinical staff • Confirmation of the Hepatitis B immunisation for all staff			

HIW Immediate Assurance Letters (received since last update)

Members should note that Immediate Assurance letters for Primary Care are *issued* to the Practice for response and *copied* to the UHB for Information and to feed into the broad Performance Management of the practice.

	Practice Name	*Inspection Date*	*IA Letter Date*	*Summary*	*UHB Actions*
2	High street Dental Practice Barry (Close, R)	23/07/19 Immediate Improvement plan Issues from HIW on 25/07/19	25/07/19	Immediate Improvement plan Issued - The service must ensure healthcare waste is being stored appropriately and securely within the dental practice in line with best practice guidelines	• Email sent to practice • Response received 29/07/18 confirming action

HIW Concerns Raised (received since last update)

	Practice Name	*Contact from HIW*	*Follow Up*	*Summary of Concerns*	*Summary of UHB Actions*
2	Windsor Road Dental Care	Inspection date 29/10/18 Non-compliance notice received from HIW 31/10/18		The service is non-compliant with Regulation 22(2)(a) & (b) regarding the Fitness of the premises This is because HIW could not be assured that the practice was providing a clean, safe and secure environment, or that the premises were kept in a good state of repair externally and internally. □ The practice was not up to a suitable standard of cleanliness, and there was significant dust and debris found in both surgeries including dust on the	• Planned unannounced visit 07/11/18 to inspect the surgery (MA/JW) • Request sent to NHS DS 01/11/18 for record card check on the performer where record card issues were identified. • Letter sent to practice 07/11/18 detailing improvements needed. • 21/11/2018 DPA phoned and spoke to Mr Capron. Report of telephone conversation documented. • 02/01/2019 Email from practice detailing

				x-ray equipment, dirt along the tops of the splashbacks, dirt within drawers and in cupboards, and significant dust and dirt in corners and below the worktops □ Paperwork had been stored on the floor within the surgery, and there was no evidence that this area had been cleaned. There was also evidence that items such as a radio and the PC unit were also kept on the floor, prohibiting effective cleaning □ There were no seals between the walls and the floor in either surgery, and in the rear surgery the flooring was damaged □ There was evidence that previous damp within the walls had left the walls in the rear surgery uneven, which was causing the wallpaper to peel in various places. This could pose an infection control risk □ The decontamination room was full of clutter, had open areas under the worktops with items such as the compressor below, and was not conducive to an environment for sterilising equipment. These will prohibit effective cleaning and as a result could pose an infection control risk to patients and staff. **The service is non compliant with Regulation 20(1)(a) regarding Records** This is because we could not be assured on the day that the dentist was keeping comprehensive, succinct and contemporaneous records for the consultations and treatments of patients. During an examination of patient records it was	plans for commissioning of decontamination room & update of changes made to date.

				found there were significant shortcomings in the patient records kept for one of the dentists at the practice. Some of the missing sections included, but are not exclusive to: o Previous dental history o Social history, oral and diet advice, and smoking cessation advice o Symptoms o Signed medical histories for both initial checks and updated at each appointment o Full base and updated charting o Baseline BPE o Examinations including extra oral, intra oral and cancer screening; o Treatment plans, options discussions o Informed consent o Referrals information o Radiographs justification, frequency and clinical findings; and o Antibiotic prescribing. For both Private and NHS treatments, patient records should include contemporaneous and accurate notes of all assessment, treatment planning and treatment provided to patients. A lack of comprehensive, accurate and contemporaneous records can have serious patient safety implications for any ongoing or future care and treatment decisions. Care, treatment and decision making must be supported	

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

				by structured, accurate and accessible clinical records, to ensure that people receive effective and safe care.	

KEY

Issues	Status
Minor issue e .g : Price list not displayed - Translation services not present - Patient Feedback	**GREEN**
Issue requiring remediation, but not likely to pose patient safety issue. E. g - QA arrangements - Policies updating and signing - Complaints Processes	**YELLOW**
Serious Issue requiring remediation due to **potential** patient safety concern. e.g: - Safeguarding procedures - IR(Me)R Issues - Record Keeping Issues - Staff Training Records - Access to staff areas - HTM 01-05 issue : Minor	**AMBER**
Serious Issue requiring immediate remediation due to present patient safety issue:, e. g : - Decontamination processes - Cross Infection control - Emergency Drugs/Equipment - HTM 01-05 : Major	**RED**

REPORT TITLE:	**CARER MEASURES**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**13/08/19**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	✓	
LEAD EXECUTIVE:	Executive Nurse Director, Cardiff and Vale University Health Board								
REPORT AUTHOR:	**Assistant Director of Patient Expereince**								
PURPOSE OF REPORT:									

SITUATION:

The purpose of this report is to present the Annual Carers Report 2018-2019. It sets out the achievements of the UHB, Cardiff and Vale of Glamorgan Local Authorities, Cardiff Third Sector council and Glamorgan Voluntary Services, during 2018-2019.

BACKGROUND:
There are clear objectives that organisations must deliver for carers

A – Supporting life alongside caring – All carers must have reasonable breaks from their caring role to enable them to maintain their capacity to care and to have a life beyond caring.

B – Identifying and recognising carers – Fundamental to the success of delivering improved outcomes for carers is the need to improve carers recognition of their role and to ensure they can access the necessary support.

C – Providing information, advice and assistance – It is important that carers receive the appropriate information and advice where and when they need it. The purpose of this paper is to present the UHB 2018 / 2019 Carers activity developed in consultation with the local authorities.

In 2019 an additional focus was added to eligible activity

Eligible activity:
1) Supporting carers in general practice - working with your partners, through the primary care clusters, to implement a scheme that supports health professionals working in primary care and community care to develop their carer awareness and understanding of how to identify carers, the issues that carers face and ways of working to better support carers; **and**

2) Discharge from hospital planning - taking steps to support and engage carers in the patient's discharge planning, for example better information, advice and assistance (IAA) provided to all carers when the person they care for is discharged from hospital.

This document sets out the report for 2018/19 of the Cardiff and Vale University Health Board, Cardiff and the Vale of Glamorgan Local Authorities, Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS), highlighting the progress made towards full implementation of the Social Services and Well- Being (Wales) Act 2014. It describes how the transitional funding, provided by Welsh Government, has been utilised, to embed the Act into

general practice and support carers within Cardiff and the Vale.

ASSESSMENT AND ASSURANCE

There is much work on going in the community via GP practices and Schools and in the Health Board to recognise Carers, to value their contribution, to support their caring role and to maintain their health and well being. We also recognize our responsibilities as an employer for the growing numbers of staff who are also carers and recognizing the support that should be offered as an employer.

Much of the work from the previous year i.e. young carers in schools, Health and social care accreditation, GP Champions ETC will continue. In addition a post to focus upon discharge will be piloted in University Hospital Llandough to focus upon carers involvement in the discharge process.

REPORT:

RECOMMENDATION: to Note the ongoing work.

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

Carers Information and Consultation Strategy

Annual Carers Report MAY 2018 - APRIL 2019

VALE of GLAMORGAN
BRO MORGANNWG

CARDIFF
CAERDYDD

GIG CYMRU NHS WALES

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

Forward

This document sets out the work undertaken in 2018/19 by the Cardiff and Vale University Health Board, Cardiff and Vale of Glamorgan Local Authorities, Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS), highlighting the achievements that aligns to the three national priorities set out in 2018:

- Supporting life alongside caring
- Identifying and recognising carers
- Providing information, advice and assistance

It will also describe how the funding allocation from Welsh Government has been utilised to support carers throughout Cardiff and the Vale of Glamorgan.

Cardiff and the Vale of Glamorgan have approximately 50,580 carers, based on the 2011 census, which is a 12% rise in the last 10 years. The percentage of the population who identify as carers is above the Welsh average in both Cardiff and the Vale of Glamorgan. The figure for young carers is approximately 1579.

However, the likelihood is that the actual figures for both adult and young carers are much higher than those recorded.

The aim of the Welsh Governments 'A Healthier Wales Plan' is to provide care to patients closer to home. This shift in focus of care provision will have a huge impact on carers, therefore it is essential that we are assessing their needs and providing them with the support they need.

It is a priority of Cardiff and Vale University Health Board, Cardiff and Vale of Glamorgan Local Authorities, Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS) to provide that support for all carers across Cardiff and the Vale of Glamorgan, ensuring they feel their contribution is valued and appreciated. Carers leads from each organisation have been working together to raise awareness of carers and their role, improve the information and signposting provided, as well as looking at how they can improve the support given to ensure a seamless service.

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

C3SC
Cardiff Third Sector Council
Cyngor Trydydd Sector Caerdydd

GVS

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VALE of GLAMORGAN
BRO MORGANNWG

Introduction

The Cardiff and Vale Population Needs Assessment in 2017 provided information on the views of carers. They expressed that they often had difficulty in finding information on services and the direct payments process as well as in accessing carer assessments. These difficulties were enhanced by issues regarding navigation of a complex system in both Heath and Social Care. These findings were echoed in the 2018 Carers Wales, State of Caring Wales Report where over half of the carers who responded to the Track the Act Survey said they had not been offered or requested a needs assessment.

Funding has been provided for a third year by Welsh Government to facilitate partnership working towards the national priorities set out by the Director of Social Services and Integration in 2018. In Cardiff and the Vale of Glamorgan the main investment to date has been used to commission the Third Sector to continue to undertake three projects. The projects are aimed at raising awareness of carers, improving information and support via initiatives such as the Young Carers in Schools Award and the Carer Friendly Accreditation within Health and Social Care Settings.

In late 2017 the Carers Work-Stream was formed. The group consists of Health, Social Services, integrated Partnership programme board and Third sector. The group will oversee the work being undertaking to support carers across Cardiff and the Vale of Glamorgan, more specifically the projects that are funded using the funding provided by Welsh Government.

This report details the collaborative work that has been undertaken between May 2018 and April 2019.

The Carers Work-Stream Vision:

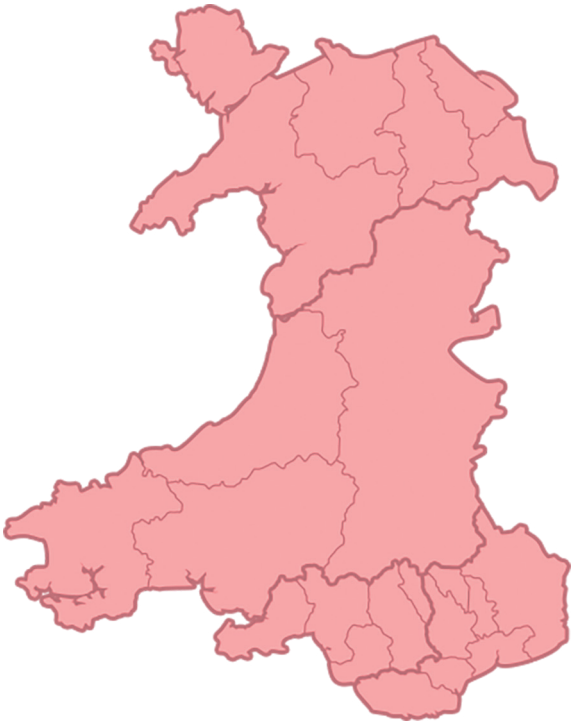
"To identify and recognise carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring."

The Real Cost of Caring

Each year it is estimated that the support provided by unpaid carers in Wales is worth £8.1 billion. Despite this carers are still reporting that they do not feel valued or appreciated. Carers are telling us that the cost the caring role can have on their own emotional and physical health is high. The latest Carers Wales, State of Caring Wales Report 2018, states that **75%** of carers who responded to their survey have suffered mental ill health, and **61%** have suffered physical ill health as a result of their caring role. The harsh reality is that without timely support these carers may not be able to continue their caring role.

In addition, despite the contribution that carers make to society, around a third of carers in Wales are 'struggling to make ends meet'. A continuing rises in the cost of living have meant that some carers are cutting back on hobbies, and seeing family and friends. This lack of social interaction can lead to feelings of isolation and loneliness. All this combined is contributing to the significant detrimental health impacts that carers are facing.

Due to the issues that carers are facing locally Cardiff and Vale Health Board, Cardiff Council, Vale of Glamorgan Council, and our Third Sector partners are committed to working together to improve services and identify and support our carers.



75%
of carers in Wales have suffered mental ill health as a result of caring

61%
of carers in Wales have suffered physical ill health as a result of caring

34%
of carers in Wales are 'struggling to make ends meet'

Support Life Alongside Caring

When you are caring for someone else it can be all too easy to ignore your own needs. In order to look after their mental and physical health it is important that carers have the breaks and support to be able to do more of the things that matter to them.

Balancing a life of your own alongside caring is important, but unfortunately not all carers are able to maintain this. The Carers Wales, State of Caring Report 2017 highlighted that the majority of carers are not getting a break from their caring role, with **83%** stating that they had not had a week off in a year and **62%** had not even had a weekend off in that time.

The same report also showed the difficulties that carers face when trying to juggle work and their caring role. It stated that many carers feel there is a lack of support and understanding of their caring role from colleagues and managers. This lack of support and the responsibilities of the caring role can have a negative impact on work with some carers reporting they are tired and lack concentration.

Although a life alongside a caring role can be difficult it is important that we are working in partnership to help carers to achieve this. The following section sets out the work that has been undertaken to support carers in having a life alongside their caring role.

40%
of carers in Wales have reported they have had to give up work to provide care

20%
of carers in Wales have taken a less qualified role or turned down promotion

83%
of carers in Wales have not had a week off in over a year

62%
of carers in Wales have not had a weekend off in over a year

Solace Carer Education Forum

The carer's education forum, run by Solace, is an opportunity for the Patient Experience Support Advisor to meet carers of people living with dementia. At the forum the carers are given advice and information on the services available to support them in maintaining their own health and well-being as well as on their caring role.

"I already knew about some of these services, but not all of them. I'm still learning what is out there to help us"

Solace carer

Working Carers

In 2018 Cardiff Council re-launched their Carers Network. This is a network to support any carer who works for Cardiff Council. The network's Champion is our Social Services Director and the first meeting was used to relaunch a revised Carers Policy. The network has regular meetings and hold events to raise awareness. For carers who are unable to, or choose not to attend the meetings, they have the opportunity to be on the mailing list and are provided with regular information which may support them in their caring role. The Cardiff Council's Carers Team attend all events to share advice and information. Cardiff Council were also the first Welsh local authority to partner with Employers for Carers to support our own carers, but other employers in Cardiff to support their working carers.

The Cardiff and Vale University Health Board has continued to focus on its staff carers. The 2018 State of Caring Wales report states that:

- 40% of carers had given up work to provide care
- 14% had reduced their hours
- 20% had taken a less qualified job or turned down promotion
- 11% worked the same hours but their job had negatively been affected

With this data in mind the Patient Experience Team have amended their Skills to Manage training, for potential mangers, to raise awareness of this type of carer and the mechanisms for supporting them while in the work place.

Links have also been strengthened with the Occupational Health team to ensure any carers they identify are given the Patient Experience Support Advisors number if they need any further assistance or support, with regards to carer's policies within the Cardiff and Vale University Health Board.

Carers Education

The Cardiff and Vale Regional Workforce Partnership has a sub group which is looking at training and development opportunities for unpaid carers. The sub group has spent some time over the past 18 months identifying training and development opportunities, how best to promote them and what gaps there are. In future, all identified training and development opportunities will be promoted via a web-page linked to the Regional Workforce Partnership website.

Carer Support Workers

The Carer Support Workers in the Vale of Glamorgan and Carer Assessment Workers in Cardiff support carers by undertaking Carers Assessments, for carers over the age of 18, to look at their needs.

The Carer Assessment Workers contact the carer to talk about, the help the cared for person needs, the type of help the carer is providing and the amount of care they are giving.

These discussions help the carer and Carer Support Worker to identify how the caring role is affecting the carers;

- Health and wellbeing
- Job and work life balance,
- Social life and/or potential loneliness and isolation,
- and personal life in general.

Depending on the outcome of the carer's assessment the assessors are able to signpost the carer to local groups, activities and services to ensure that they are able to continue to have a life alongside the caring role.

Case Study

The Carer Support Worker met with a carer who had a grown up child who had a learning disability.

The carer had been working full time but had given up work a year or so before, due to a family bereavement. The relative who had died provided the carers grown up child with support whilst the carer was at work, therefore their bereavement had a drastic impact on the family's life.

The family had settled into their new routine when the Carer Support Worker went to visit them and the carer felt their family no longer required as much support as they had initially. The carer was thinking of getting back into employment/running a small business. They were uncertain of how best to do this as they would need a job that worked around their caring responsibilities.

The carer explained that their confidence had taken a bit of a knock in the time they had been away from the work place. The Carer Support Worker referred the carer to the Disability Advice Project which supports carers to find work or self-employment opportunities.

The carer later contacted the Carer Support Worker to say that they had found the support invaluable and as a result were in the process of setting up a small business, something that they had hoped to do for a number of years.

Case Study

The carer is the main carer for their spouse whom they have been married to for over 50 years.

During the carers assessment the carer advised that they did not feel they required any support from social services to help to care for their spouse but wished to carry out activities as husband and wife once again.

The carer went on to explain that they were both very sociable when they were younger and went out dancing with friends every weekend, however, this became less and less frequent the more unwell their spouse became, until eventually it stopped entirely.

The carer advised that they often felt socially isolated and the cared for stated that they missed socializing with others. The carer explained that they still drive so is able to access groups and services further afield but was unsure as to what was out there. The Carer Support Worker sat with the couple and discussed numerous services and groups within the area that they would both enjoy, taking the cared for's medical conditions into consideration.

The carer contacted the Carer Support Worker sometime after the assessment to advise that they now attend Goldies singing group on a weekly basis, the cared for was has regular over the phone befriending which was lifting their mood considerably and have attended a number of coffee mornings and lunches as a couple rather than carer and cared for person.

Case Study

The carer was the main carer for their spouse who had been diagnosed with early onset dementia in their late 40's.

The carer was currently receiving 16 hours' worth of direct payments when the Carer Support Worker went to visit. This meant that all of the cared for needs were being met, however, the carer advised that emotionally the cared for had deteriorated drastically in the last few months which was having a negative impact on the carers wellbeing. They went on to explain that if they left their spouse alone in a room for more than 5 minutes they would cry out for the carer which meant completing household chores was incredibly difficult. The carer explained that leaving the cared for at home, even for a short while, to complete errands was impossible.

In addition to this the carer advised that their spouse no longer slept through the night explaining that they would wake during the night and sit up trying to work out where they were. Despite these disruptions lasting only moments due to them occurring numerous times throughout the night the carer advised that morning would come and they'd feel they had had no sleep at all. The cared for also refused to go to bed without their spouse which meant the carer had no time to complete tasks or simply have some time to themselves while the cared for slept.

Following on from the carers assessment the Carer Support Worker made a request for respite in addition to the direct payments, as a result the 16 hours of direct payments are still in place but 9 of these are now used for respite and an additional 3.5 hours respite per week has been added to the patients care plan.

Cardiff Carers Team

The Carers Team in Cardiff's Adult Social Services have developed a wider range of support to carers in Cardiff. They hold a number of Carer Advice Clinics in Community Hubs each month, attend local support groups such as Parkinsons and Goldies and hold regular stands at Cardiff GP surgeries. The team provide advice and signposting services to carers and take referrals for Carers Assessments. This has meant carers can talk to the team face to face and at a venue that is convenient to them.

The team have made the process of requesting a Carers Assessment much easier by taking referrals directly from carers and other professionals. Carers can contact the team at any time for advice and information even if they choose not to have a Carers Assessment.

Citizen's Advice and Tenovus Cancer Care

Both Cardiff and Vale Citizens Advice and Tenovus Cancer Care continue to provide a service at University Hospital of Wales and University Hospital Llandough.

Citizens Advice provide a mixture drop-in and appointment based sessions and Tenovus Cancer Care take referrals from staff and visit wards and out-patient clinics where requested.

Both services provide welfare and benefit advice.

Case Study

The Tenovus Cancer Care Support Advisor met a patient who had been diagnosed with Acute Myleoid Leukaemia and who had a spouse who had been unable to work for many years due to their own disabilities. The carer's only income was their Personal Independent Payment (PIP) as their Employment and Support Allowance had ended as they had received it for one year (and was not in a support group).

The carer was now caring for their spouse full time and had concerns about their financial situation.

The Tenovus Cancer Care Support Advisor was able to help the patient complete the paperwork to access PIP which meant their carer would also be able to get carer's allowance, helping to reduce some of the financial burden.

Carers Training

As a result of attending a GP Carers Champion meeting Carers Wales was able to partner up with a Cardiff GP Surgery to run a training course for local carers. As well as receiving information about support in general, from Carers Wales, the carers were also given first aid training.

This training was provided by the Red Cross and has been developed especially with carers in mind. In addition Carers were able to undertake a short Health and Well-being course, which looked at ways carers could incorporate mindfulness in to their day to day lives. It also highlighted the importance of carers looking after their own health both physical and mental.

> "The training went really well we had 18 carers and all but 2 were new to Carers Wales. None of them had previously received any support in their caring role so it was great we could support them"
>
> *Carers Wales Facilitator*

The Health Board's Education Programme for Patients and Carers (EPP) also run two 2 hour carers workshops, focusing on mental health and well-being and physical health and well-being.

It is recognised that although caring can be very rewarding, it can also be very stressful. Therefore, workshop one looks at how to cope with stress, improving sleep, breathing techniques, relaxing and letting go of tension, and how to build these techniques into your working day.

The second workshop focuses on how you can look after your physical health while caring. The team talk through the importance of eating well food as well as, mood and energy, practical help, fitness, time management and getting some "me" relaxation time.

The courses are run four times a year across Cardiff and the Vale of Glamorgan.

Identifying and Recognising Carers

The latest 'State of Caring Wales' (2018) report calls for us to deliver a Health Service in Wales that recognises, values and supports carers. This is by increasing efforts to identify carers and ensuring that they are signposted to appropriate support. They state that in order to achieve this policies need to be in place to identify carer's, promote carers health and well- being, and ensure all staff are trained to know what a carer is and how signpost and support them.

In 2016 the Carers UK report, 'Missing Out; the Identification Challenge' highlighted that although during identification of carers is improving we still have a way to go. Worryingly the report states that 54% of adult carers took over a year to identify and 24% took over 5 years. Therefore it is vital that the staff members in both Health and Social Care settings are able to identify carers as early as possible and provide them with up to date and relevant information.

Identifying carers means that we are able to support them to maintain their own health and well-being. We understand from the Missing out: the identification challenge report, Carers Wales 2016 that many carers will not self-identify. Therefore, it is important that staff in both Local Authorities, the Cardiff and Vale Health Board and in the Third Sector feel confident to recognise carers and where to signpost them for support.

The following section sets out the work that has been undertaken to raise awareness of carers so that we can identify them early and provide the vital support that they need.

54%
of adult carers in the UK take over a year to identify as a carer

24%
of adult carers in the UK take over 5 years to identify as a carer

Carers Events

Throughout the year Cardiff and Vale UHB and both Local Authorities joined together to host a number of awareness raising events across Cardiff and the Vale. The events have been held in a variety of places such as the University Hospital Llandough, University Hospital of Wales, GP Surgeries, Cardiff County Hall, as well as a number of supermarkets across the Vale of Glamorgan, arranged by the Vale's Carer Development Officer.

> "I saw that you were going to be here (Waitrose) on twitter. It's a great idea to be in the Supermarket, sometimes it difficult to get out to see people, but I come here most mornings for my mother's paper"
>
> *Carer at Vale Carers Rights Day Event*

The aim of the events is to raise awareness and help the general public and organisations understand what a carer is, enabling them to identify themselves or others, as carers.

Throughout the year Cardiff and Vale University Health Board and the two Local Authorities have jointly run **9** events and over **200** carers were spoken to and provided with information. Many of these were carers who were unaware of the support available to them in their community, and some were identifying as a carer for the first time.

Carers Rights Day Event in Waitrose Vale of Glamorgan

Case Study

A carer attended one of the Supermarket events, in the Vale of Glamorgan, on Carers Rights Day for some support, as they were looking after their child who had a Mental Health Condition.

The carer broke down crying explaining that it had taken all day for them to build up the courage to come and speak to the team.

Both the Health Board's Patient Experience Support Advisor and a Vale of Glamorgan Carer Support Worker took time to speak to the carer about their increased caring responsibilities and how they were beginning to struggle. The carer was provided with information on relevant organisations that could support them and the number to call to arrange a carer's assessment. They said, as they left, that they felt much more positive having seen the team that day.

Carers Week Event in University Hospital of Wales

Health Board Staff Training and Awareness Sessions

The Health Board continues to provide a carer awareness session to all newly appointed staff and an hour long training session to qualified members of staff who undertake the Skills to Manage and Leadership and Mentoring Programmes.

In addition the Patient Experience Team also provides bespoke training sessions when requested. This year the Patent Experience Support Advisor has delivered carers training at two ward away days that had been arranged by the Practice Development Nurse for Clinical Gerontology.

In addition carers and the John's Campaign awareness training has been a regular feature on the 'Get Me Home' workshops, which is attended by multi professionals looking at how the discharge process can be improved for patients and their carers.

Skills to Manage

The hour long training session given on the Skills to Manage Programme is aimed at qualified staff from all disciplines within Cardiff and the Vale Health Board.

The aim of the programme is to:

- Define what a carer is
- Understand some of the issues young and adult carers may face
- Understand carers rights under the new Social Services and Well-being (Wales) Act 2014 (ie carers assessments)
- Understand the issues that working carers may face and how to support them
- Signpost to information and support where needed
- Involve carers in relation to ongoing carer/ discharge planning care issues

These training sessions give the opportunity to discuss with senior managers, nursing and therapy staff who often need to engage with and support carers.

From April 2108 to May 2019 **93** staff have taken part in the full training.

To date since 2012 **741** of staff have undertaken the hour long session.

Carer Awareness Sessions

This session is aimed at staff of all bands in the Cardiff and Vale Health Board, and is part of the corporate induction programme for all newly appointed staff. Outcomes of the programme are to enable staff to:

- Define what a carer is
- Understand some of the issues young and adult carers may face
- Signpost to information and support where needed

During the period of this report **402** newly appointed Health Board staff, including Senior Medical staff, have undertaken the carer awareness session.

To date since 2012, **3193** Health Board staff members have taken part in the awareness sessions.

3193
newly appointed Health Board staff have undertaken the carer awareness session

741
staff have undertaken the Skills to Manage Carers session

John's Campaign

In February 2018 the Health Board introduced the principles of John's Campaign, looking at how we can support carers when the person they care for is admitted into hospital, and value their input in to the patients care plan.

The campaign was developed in collaboration with senior staff representing the Clinical Boards and Third Sector organisation, and carers themselves.

Following the consultation a poster incorporating 'Four P's' was co-produced; ensuring the principles adopted were affiliated to the 'Social Services and Wellbeing (Wales) Act 2014'. The elements are:

- **Priority** – early identification of carers
- **Principles** – ensuring a carer voice, and that they are informed and communicated with
- Our **Promises** – that carers are welcome and that they can continue their caring role if they wish e.g. in mealtimes, personal care and medicines management
- **Please** – respect other patients privacy, ward issues and tell us if you need our help and support

Two staff members, a registered nurse and a healthcare support worker are identified as Carers Support leads within the clinical areas.

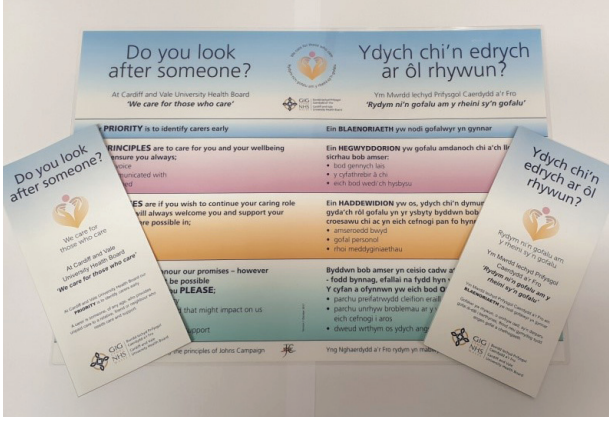
In addition it was ensured that this initiative aligned and works in collaboration with our other Health Board agendas, for example, the 'Read about Me' toolkit, the 'Promoting Independence' agenda, the Model Ward and the 'Carer Agreement'. This aim of the campaign is

to help with early identification of carers, help us understand their carer experience and improve the knowledge base of staff.

The campaign is being rolled out as a phased approach to ensure that the patient Experience Support Advisor can go out to each individual ward to discuss how the campaign can be adopted on the ward.

To date **12** wards are undertaking the campaign with a further **4** wards expressing an interest.

The campaign is also currently being amended to cover outpatient areas and will be piloted in two areas later on in the year.



We care for those who care
Rydym ni'n gofalu am y rheini sy'n gofalu

Social Media

With an increasing number of people using the internet as a source of information the Cardiff and Vale University Health Board along with both local Authorities have been using social media as a way of raising awareness of carers and providing information.

All carers events are advertised on both Twitter and Facebook and national campaigns such as Carers Week and Carers Rights Day are promoted. The use of social media has helped to increase the amount of people we can reach with our messages, with often over **1000** views on information sent out via Twitter.

Within Cardiff and Vale University Health Board a comprehensive social media communications plan is developed for all national campaigns to ensure that consistent messaging is being used in the build up to and during the campaign.

Providing Information, Advice and Assistance

Carers can often find it difficult to locate information about the services in their local area that are available to support them. This can be due to a number of reasons such as out of date information on display, complex information systems or just not know wing where to start looking.

The Carers Wales, State of Caring Report 2018, illustrates that the majority of carers access the internet as a source of information. Therefore it is vital that we ensure they are signposted to reliable, relevant and up to date information about their rights, entitlements and services locally to support them in their role.

We are also aware that for 4 out of 5 of carers in Wales their first access point of contact, in to carer's services, is through Primary care. Yet the latest statistics tell us that even half of the carers who have stated they have informed their GP that they are in a caring role were not provided with any further advice or assistance. This just highlights the need for initiatives such as the GP Carer Accreditation to ensure front line staff are confident in signposting carers to support.

The following section sets out the work that has been undertaken to improve information and signposting for carers. This will enable them to access the vital support services that they need, when they need them.

85%
of carers use the internet as a source of information

68%
said their GP was aware they were a carer

41%
of carers use the internet as a form of communication

50%
were not given any further information or advice from their GP

Carers Factsheets and Carers Directory

The Carers Factsheets have been developed collaboratively drawing on the information that was contained in the Carers Handbook. There are 14 factsheets covering issues such as 'Am I a carer?' 'Getting help from Social Services', 'Finance', and 'Getting help in the community'. The factsheets are easier to read than the handbook, more cost effective and carers can access elements relevant to their individual requirements.

The Directory of Services for Carers, which contains information about a range of third sector, local authority and health services for carers in the region, has also been updated. The Directory was produced by Glamorgan Voluntary Services (GVS) in liaison with statutory partners and has proved popular with carers and front line staff who support carers. GVS continues to encourage all organisations which are listed to include their services on the Dewis Cymru information portal.

Cardiff and the Vale Carers Support and Information Network Group (CSING)

Cardiff and Vale Carers Support and Information Network Group (CSING) brings together staff from the Third Sector, Local Authorities and Health Board who plan and deliver services for carers in the region. CSING is a good opportunity to share information, highlight current and new services, identify gaps and issues which affect carers and support partnership working across sectors. Issues raised can be highlighted via regional partnerships and planning groups.

CSING was also instrumental in ensuring that members were aware of the development of the Cardiff and Vale of Glamorgan Area Plan. The priorities for carers outlined in the Area Plan are based on the Population Needs Assessment and on feedback from carers, carers organisations and CSING.

CSING is facilitated by GVS, in liaison with C3SC, and has been meeting for over 10 years, beginning as a Vale group before expanding to Cardiff. It now has over 40 members. Over the last year there have been presentations from the Carers Trust South East Wales and Connected Carers Lottery Funded Project.

Case Study

A distressed carer contacted the Health Board's Macmillan Information and Support Facilitator as their spouse had cancer and was at end of life.

The patient was on the gastroenterology ward at the University Hospital Llandough and the carer felt very ill informed about what was going to happen next. The carer thought that the doctors were telling the patient what the care plan was but they had memory loss so the carer or the family were not getting the information.

The facilitator arranged to meet the carer and go to the ward with them. The Ward Sister was unavailable at the time but they were able to speak to the doctor who was looking after the patient. The facilitator explained that the carer was distressed and did not have all the information with regards to the patients care plan. The doctor then met with the carer that afternoon and explained the patient would be coming home and that the palliative care team would be in contact.

The carer was much more positive and able to cope. They knew the patient was terminal, but felt they could cope as they knew they would be having support and thanked the facilitator for assisting them.

Information and Support Centres

The three Information and Support Centres across Cardiff and Vale University Health Board continue to be a great resource, providing information for patients, carers and staff.

Regular information sessions are also held by the Credit Union, Dinas Powys Voluntary Concern, Meals on Wheel and Carers Wales in the University Hospital Llandough Information and Support Centre. These organisations are providing advice on issues such as finance, connecting with services and carers rights to patients, carers, visitors and staff.

Each of our Information and Support Centres has an area dedicated to carers which includes information such as copies of the Carers Directory, Carers Handbook and Carers Wales information.

There is also a wide range of additional carer information from organisations such as Arthritis UK, Asbestos UK, Alzheimer's Society, Bi-polar UK and British Heart Foundation. Over the past year approximately **197** known carers have attended the three Centres receiving support, signposting services and advice.

GP Carers Accreditation

The GP Accreditation scheme was collaboratively developed during 2015. It was recognised that for many carers, GP Practices are often the first point of contact, in developing relationships and providing resources and signposting opportunities.

GP Practices nominate a carers champion to liaise with the Patient Experience Support Advisor in Cardiff and the Carer Development Officer, in the Vale of Glamorgan. GP carer champion meetings are held throughout the year and offer the opportunity for the carer champions to discuss issues, share good practice, learn about services in the community to support carers, influence Practices to replicate exemplars, and to develop a relationship between both areas of care and local authorities. Existing champions have become an expert resource within their practices and are supported to be able to identify, support and signpost carers appropriately.

Since its inception the level of engagement from GP Surgeries has increased, in Cardiff and Vale of Glamorgan we currently have **66%** of Surgeries engaged with the scheme, **23** GP Surgeries are currently compliant with bronze criteria and a further **26** surgeries are working towards their bronze certificate. In addition **3** have achieved their silver level award.

Due to its success the GP carers Accreditation Scheme was shortlisted in for two categories in the Patient Experience Network National Awards (PENNA):

- Support for carer givers
- Integration and Continuity of care

Unfortunately the scheme did not win, however feedback from the judging panel was very positive. We will also be using the judges' comments to make improvements to the scheme and its evaluation.

"This is an excellent idea and equips GP practices to ensure carers can be identified at the earliest opportunity which is ideal. It does require a high level of commitment from primary care staff, but the training and accreditation is well set out and clear."

PENNA Judge

"Overall, I feel this project will have a significant impact on the number of carers identified, recognised and supported by GP practices and as long as this information is communicated through secondary care should impact on the whole carer journey."

PENNA Judge

Health and Social Care, Carer Friendly Accreditation

In September 2016 Cardiff and the Vale of Glamorgan Councils and Cardiff and Vale University Health Board commissioned Carers Trust South East Wales (CTSEW) to research and develop a Carers Accreditation Framework across Cardiff and the Vale Health and Social Care settings.

The Health and Social Care, Carer Friendly Accreditation aims to improve, share and recognise support for carers in health and social care service areas. There are three levels to the accreditation: Bronze, Silver and Gold. The accreditation criteria are broken down into five standards:

Service areas complete a self-assessment tool, provide a portfolio of evidence to prove that they meet the criteria and that portfolio is then put forward to a Carers Review Panel (detailed right) who review the portfolios and either approve the accreditation or provide constructive feedback on areas for improvement.

Currently across Health, Social Care and the Third Sector there are 10 service areas taking part in the project and working towards their bronze certificate.

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Carers Expert Panel

In July 2018 the Carers Expert Panel was established with carers from across Cardiff and the Vale. The panel was set up to ensure partnership working with carers, ensuring their voices are heard and enabling them to influence, shape and change services that affect them.

The members of the panel provide feedback on the Health and Social Care accreditation, as well as a variety of other topics affecting carers. The views of the panel are listened to, represented, valued and taken forward by CTSEW to help improve services for all carers across Cardiff and the Vale, as well as influencing change nationally.

Since its inception **5** Carers Expert Panel meetings have taken place with **16** carers from across Cardiff and the Vale in attendance. CTSEW, the Health Board, both Local Authorities and Third Sector partners continue advertise the meetings widely to improve the number of carers attending.

Young Carers

Over the last year we have continued to build upon the projects to improve the experiences of young carers. Following an extensive listening exercise with young carers, and subsequent publication of the 'Young Carers Speak Out' report in March 2016 many young carers had expressed a lack of awareness of their role as well as a lack of support both with practical issues and issues regarding their health and emotional well-being.

In 2011 the national census identified **1,579** young carers within the Cardiff and Vale of Glamorgan, however, it is recognised that this number is an underestimation of the numbers of young carers when compared with other surveys of school children across the UK.

Cardiff and Vale University Health Board and both of the Local Authorities have been working on raising awareness of young carers the roles they undertake and the issues they face. Working with Third Sector partners training has been provided to schools and health colleagues.

The following sets out the work being undertaken to strengthen the young carer's agenda.

Young Carers Awareness Day

In January 2019 Young Carers Awareness Day was celebrated across Cardiff and the Vale of Glamorgan. A communications plan was put in place across the Health Board which included raising awareness of young carers via the Information and Support Centres and Media Screens, on both the Internet and intranet and over social media.

The Vale Local Authority had a young carers stand at Central South Consortia (@CSCJES)

700,000 reasons to support Young Carers Awareness Day

Conference at Cardiff City Stadium, sharing good practice and supporting vulnerable learners.

The Carers Development Officer, in the Vale, along with colleagues from CTSEW and YMCA gave a young carers presentation to the Vale Governors. The aim of the presentation was to give an overview of the projects being undertaken for young carers in Vale, including Young Carers in Schools Programme in Secondary Schools and various young carer projects run by YMCA.

The Carers Development Officer also gave talks about young carers at the Vale Health Schools and PSE meetings in two schools in the Vale.

Young Carers in Schools Programme

The Carers Trust South East Wales (CTSEW) Young Carers in Schools Programme provides schools with the tools and resources to support young carers, giving them the same access to education, opportunities and future life chances as their peers. Schools are asked to produce, collate and submit evidence around five key themes which is reviewed by the Peer Review Panel.

There are three stages of the Young Carers in Schools Programme:

The Basics

Beyond the Basics

Best Practice

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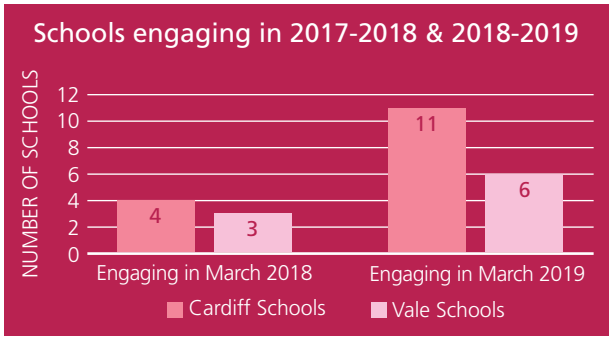
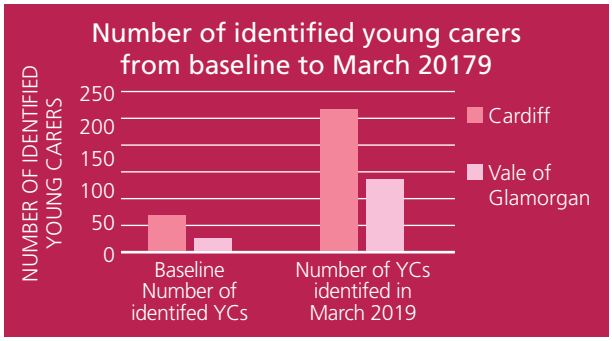
Over the last year the Young Carers in Schools Programme has seen an increase in engagement and achievement, with **10** schools achieving the Basics and **3** moving to the next stage and achieving Beyond the Basics.

Schools have been committed to supporting young carers and ensuring their staff have awareness and an understanding of the support young carers require. This is seen through the number of staff receiving training on 'Young Carers who we are and how to identify us' and the increase in levels of identification across Cardiff and the Vale of Glamorgan. Schools have been supported by the Young Carers Team to better, understand, inform, identify, support and listen to young carers.



This year has seen an increase in participation, **11** of the **18** schools in Cardiff **61%** are participating in the Programme. The Vale of Glamorgan have also had an increase in participation with 6 of the 8 schools in the Vale of Glamorgan **75%** participating.

The programme has seen a dramatic rise in the numbers of young people identified, in schools as carers, from the baseline audit in 2017.



Over the next year the CTSEW team will be meeting schools working towards their YCISP the basis, to review their evidence as well as supporting those schools to move forward to the next stages of Beyond the Basics and Best Practice. The CTSEW Team will also be contacting those schools that have yet to engage with the programme.

Peer Review Panel

As part of the Young Carers in Schools Programme a Peer Review Panel was established made up of young carers. The panel review and discuss the evidence submitted by schools and decide if an application is successful. The young carers involved with the panel are from Monmouthshire, Newport, Cardiff and the Vale of Glamorgan. Since July 2018 two Peer Review Panel meetings have taken place with six young carers in attendance.

> "Being part of the panel has given me a newfound confidence in my knowledge as a young carer – so much so that it has pushed me to consider becoming a young carers ambassador for my school."
>
> *Quote taken from CTSEW Report*

Young Carers Training module

The Vale of Glamorgan Local Authority have led on the updating of a young carers awareness e-module. The module is available for staff on their internal learning hub, and takes around 15-20 minutes. It enables staff to find out more about what young carers cope with in their caring roles. This e-module has been shared with Cardiff Council and the Health Board for them to make available of their staff learning platforms.

Young Carers Working Group

The Young Carers Working Group was established in 2017 and continues to meet to work towards improving the experience of young carers. The Group has representatives from Cardiff and Vale University Health Board and Local Authorities, Cardiff and Vale Social Services and Education, Youth Workers from across Cardiff and Vale and members of the YMCA Cardiff team.

The Working Group developed the Young Carers Action Plan to address some of the issues raised by young carers, for example;

- Lack of awareness of their role
- Lack support with practical issues
- Lack of support maintaining their health and emotional well-being

A young carers plan that was developed has been updated and consulted on by young carers to ensure that the actions included are relevant to their needs and the issues they had identified.

Expenditure and Financial Projection

The Cardiff and Vale partnership was allocated a transitional funding of £144,000. This table below illustrates how the funding was utilised.

Work stream	Priorities addressed
Young Carers in Schools Accreditation Scheme	• Identify and recognise carers • Supporting life alongside caring • Providing information, advice and assistance
Health & Social Care Accreditation Schemes	• Providing information, advice and assistance • Supporting life alongside caring
Pilot of the Carers centre	• Providing information, advice and assistance • Supporting life alongside caring • Identify and recognise carers

Conclusion

This report illustrates the partnership work being undertaken during 2018/19, which has been over seen by the Cardiff and Vale working group, in line with the three national priorities set out in 2018. It highlights new initiatives as well as ongoing progress in multiple areas supporting young carers as well as adult and working carers. For more information on any of the work set out in the report please email:

Cardiffandvale.Patientinformation@wales.nhs.uk

Report Title:	**DELIVERY UNIT REPORT: IMPACT OF LONG WAITS**						
Meeting:	Quality, Safety and Experience Committee				**Meeting Date:**	**17/09/19**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Chief Operating Officer						
Report Author (Title):	Deputy Chief Operating Officer – Tel: 029 218 44120						

SITUATION

In response to concerns regarding an increasing number of patients across Wales waiting greater than 52 weeks on a Referral to Treatment Time (RTT) pathway, the Delivery Unit undertook a Wales-wide review of long waits for Planned care. The Health Board received a final copy of the Delivery Unit's report for Cardiff and Vale Health Board at the end of January 2019. The purpose of this report is to share the Delivery Unit's report and the Health Board's action plan with the Committee for information and consideration.

REPORT

BACKGROUND

In response to concern regarding an increasing number of patients across Wales waiting greater than 52 weeks on a Referral to Treatment Time (RTT) pathway, the Delivery Unit undertook a Wales-wide review of long waits for Planned care. The review sought to assess the impact of long waits for patients in terms of potential harm and adverse outcomes and to seek assurance that organisations have robust processes in place to safeguard patients and to address the issues underlying extnded waits for treatment. At the end of January 2019, the Delivery Unit shared their final report outling their specifc findings and recommendations for the Health Board.

ASSESSMENT

The Delivery Unit report on the Review of the impact of Long Waits for Planned Care on Patients is attached in Appendix 1.

The review comprised a three stage approach – (i) data analysis of both waiting lists (as at September and December 2017) alongside national emergency and deaths datasets and a review of concerns data (ii) Site visits comprising of meetings with Health Board teams and case note and Patient Administration System (PAS) records review (iii) Patient feedback through issuing of questionnaires to a random sample of patients who had waited 52 weeks or more at the end of September 2017.

The Delivery Unit concluded for Cardiff and Vale University Health Board that:

- 'The Health Board is aware of the factors affecting waits for planned care and has made progress in improving waiting times with further action to improve access planned. There remains considerable work to achieve sustainable delivery of timely planned care across all specialities.'

- ‘Therefore, it is fundamental that the Health Board prioritises review of its practices to safeguard patients while they await planned care. The current system does not proactively review patients regularly on their pathway and the review evidenced that some patients are coming to harm while they wait and many are experiencing adverse impacts daily.’
- ‘Current systems and processes do not support the Health Board to understand the impact of prolonged waits for treatment on patients and address this accordingly; this can be achieved through proactive patient review, supported by improved communication with patients throughout their pathway and enhanced learning from concerns.’

The Delivery Unit made a number of recommendations – one related to presenting the report to the Health Board’s Quality, Safety and Experience Committee and a further eleven related to its findings. The Health Board has developed an action plan – see Appendix 2. This focuses on the finding and recommendations from the Delivery Unit report and builds on actions previously agreed and reported to the Quality and Safety Committee in September 2018 as a result of similar themes highlighted by the Community Health Council (CHC) Report ‘Our lives on hold….Impact of NHS waiting time on patients’ quality of life’ (May 2018) and the report by the Public Services Ombudsman for Wales following an investigation into a complaint regarding a patient who waited nearly three years for urgent Paediatric surgery i.e. monitoring of long waits and communication.

Finally, it is also worth noting that the Health Board’s plan for 2019-20 is to eliminate 52 week waits and is also intending to go further by having no patient waiting greater than 36 weeks by 31st March 2020, progress against which is monitored via the Health Board’s Strategy and Delivery Committee.

ASSURANCE is provided by:

- The actions agreed and outlined in the Health Board’s response to the Delivery Unit report

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the findings and recommendations of the Delivery Unit’s review of the impact of long waits for Planned Care on patients
- **NOTE** the action plan developed in response to the recommendations made

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
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	x	Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Review of the Impact of Long Waits for Planned Care on Patients

CARDIFF AND VALE ULHB REPORT

November 2018

Review Lead: Elizabeth Beadle, Performance Improvement Manager
Assistant Director Leads: Philip Barry, Assistant Director – Scheduled Care
Julie Parry, Assistant Director – Quality and Safety
Delivery Unit Director Jeremy Griffith

EXECUTIVE SUMMARY

BACKGROUND

In response to concern about increasing numbers of patients waiting 52 or more weeks for planned care, for whom the impact was not widely understood, the NHS Wales Delivery Unit (DU) undertook a Wales-wide review of long waits for planned care. The review sought to assess the impact of long waits for patients in terms of potential harm and adverse outcomes and to seek assurance that organisations have robust processes in place to safeguard patients and to address the issues underlying extended waits for treatment.

This report sets out the review's specific findings in relation to Cardiff and Vale University Health Board. The key messages from the review relate to the examination of waiting lists with patients waiting greater than 52 weeks at the end of September 2017, case notes review for a sample of these patients, patient feedback and discussions with Health Board staff. The feedback is representative of the findings relating to this cohort of patients.

KEY MESSAGES

Patient Impact

Long waiting patients were not found to be at any higher risk of an emergency attendance at hospital and/or inpatient admission than patients waiting fewer than 52 weeks. However, the review evidenced that that significant numbers of long-waiting patients are experiencing low-level harm with smaller numbers experiencing moderate (to severe) harm.

Impacts were found to be multifaceted; many patients reported constant or frequent adverse effects on their daily lives including pain, worsening symptoms, reduced physical function and emotional distress. Case review backed these findings but to a smaller extent, due to limited review points in the patient pathway. The limited information on patient-reported impact in case notes highlighted the need for improved (and more proactive patient contact) during long waits for treatment.

Patients on multiple pathways

While some patients had positive outcomes from treatment despite their protracted wait, others had poor experiences. This was particularly evident for patients on multiple RTT pathways where the DU found scope to improve coordination of activity for patient benefit and to reduce risk of adverse outcomes. Whilst small in number, the starkest examples were of patients becoming unfit for surgery by the time they reached the top of the waiting list.

Management of clinical risk

Processes to manage risk while patients wait are generally reactive relying on patient feedback or primary care expedite referrals, with a subsequent impact on primary care capacity and risk that some patients may not seek assistance when required, or until harm has already occurred. Significant gaps between service contacts with patients exacerbate the potential for patients to experience avoidable harm; gaps between contacts greater than 12 months were commonplace in the case review sample. A notable exception is the Neurosurgery team's intention to institute a planned proactive review process for all patients at 26 weeks.

Resource utilisation

The DU observed instances of repeat investigations and of multiple cancellations of surgery with associated repeated cycles of pre-assessment, detracting from patients' experience and resulting in avoidable cost to the Health Board in terms of additional secondary care appointments.

Governance

Clear performance management and quality and safety structures were described and there was demonstrable awareness of some of the key areas of risk for planned care. Nonetheless, the DU found scope to improve connectivity between these processes to ensure that risk and safety considerations fully inform performance decisions and vice versa. Similarly, there is potential to improve the dissemination of learning between Clinical Boards to share good practice.

Concerns information provided to the DU highlighted that whilst the complaints data reflected a body of concern from patients about the length of waits for planned care, a nil return on incident reporting did not tally with the DU's findings in terms of adverse patient impact from long waits.

Improvement action

Health Board colleagues informed the DU of improvement plans in place for a number of specialities of concern and in some instances described a supporting infrastructure to deliver these plans. However, staff described a range of factors affecting delivery of planned care and there remains considerable work to achieve fully sustainable planned care services. Consequently, strengthening the risk management processes to safeguard patients while they await treatment is vital.

Limitations described in (or absence of) thresholds for referral and listing patients correlate with a relatively high rate of removals other than treatment (ROTT) from the list in the sample cohort.

Notable practice

Concerted efforts to change practice in Neurosurgery comprising a number of actions (including patient case review, pooling procedure lists and embedding a focus on treating long waiters) have borne fruit in facilitating reduction of patients waiting over 52-weeks. Lessons learned potentially have wider applicability for other specialities.

RECOMMENDATIONS

The Delivery Unit's recommendations to Cardiff and Vale University Health Board are listed below, in the order that they appear in this report. Please refer to the relevant pages of the report for the supporting evidence and conclusions. It is recommended that this report be presented to the Health Board's Executive Board's quality and patient safety committee for consideration of the findings and recommendations for action.

It is recommended that the Health Board:

1. Implements a proactive review of patients at clinically determined points during the pathway, and at 52-weeks as a minimum. Harm review literature from NHS England provides an evidence base for the value of undertaking such views to identify whether patients have experienced any harm/adverse impacts. The DU is proposing Wales-wide debate to construct and implement a proactive harm review process.
2. Seeks to install a PAS system alert for patients with more than one RTT pathway and reviews processes to ensure that a discussion is held between the multi-disciplinary teams to manage interdependencies in the patient's care and to support the patient to prioritise treatment.
3. Reviews processes for primary and secondary care collaboration for complex patients on more than one pathway.
4. Reviews its communication and engagement processes for patients on RTT pathways, with a particular focus on ensuring that contacts and appointments with patients facilitate patients' feedback, and patients are made aware of how to contact the Health Board in the event of a change in their condition/symptoms. The national work on patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) provides a framework for some planned care pathways; there may scope for the Health Board to expand its use of this framework.
5. Reviews how concerns data (including incidents and near misses) for long waits is recorded and used at quality & safety meetings and how widely this is disseminated for planning service improvement.
6. Reviews the use of local risk managements systems to ensure that incident and complaint data can be identified for the same episode of care.
7. Raises awareness amongst staff of the importance of reporting near misses.
8. Reviews the use of concerns data to identify trends and share learning for a range of specialities across the Health Board.
9. Reviews the criteria for acceptance of referrals and listing for treatments with a high volume of ROTT, with a particular focus on those that have long waiters.
10. Noting staff feedback that there are not clearly designated thresholds for accepting referrals for all conditions, further review of expectations for primary care consultations prior to referral for planned care is recommended, to assist with improved management of patient expectation and potentially reduce the number of referrals being accepted.
11. Finally, it is recommended that the potential to enhance co-production with patients from outpatient stage be considered to reduce the number of patients who are listed and subsequently opt not to be treated.

INTRODUCTION

During 2017, the NHS Wales Delivery Unit (DU) highlighted concern that despite a reduction in the number of patients in Wales waiting in excess of 36 weeks on a referral to treatment (RTT) pathway the number of patients waiting over 52 weeks had been growing. Moreover, it was felt that the impact of these long waits was not well understood. Emerging reports from England have subsequently identified harm to patients arising from protracted waits for treatment.

Consequently, the DU work programme incorporated a plan to undertake a review with two key objectives. Firstly, to assess the impact of long waits for patients in terms of potential harm and adverse outcomes resulting from the extended delay. Secondly, to seek assurance that there are adequate clinical and operational risk management processes in place to safeguard patients and to address the issues underlying extended waits for treatment.

This report summarises the findings of the review for Cardiff and Vale University Health Board (the Health Board) and is supplemented by a summary report setting out the themes identified across Wales and recommendations with wider applicability.

REVIEW METHODOLOGY

The review comprised three main phases: data analysis, site visits and patient feedback.

Data analysis

Data analysis comprised two main elements; examination of waiting lists for planned care alongside national emergency and deaths datasets and review of concerns data.

Waiting list analysis incorporated scrutiny of RTT waiting list data at two census points (September and December 2017) for specialities with waits over 52 weeks at the September census point. Specialities with small numbers of 52-week waits were excluded, taking into account both individual Health Board and all-Wales status. Review of the two snapshots enabled identification of changes in the composition of the list.

The data were examined with reference to emergency activity databases and the Office for National Statistics Deaths Dataset using pseudonymised patient data. This clarified the volumes of long waiting patients with a record of access to unscheduled care via attendances at emergency departments and/or emergency admissions at any Health Board site across Wales from 30th September 2016[1] to 31st December 2017. Further detail on the data analysis is available in appendix 1.

A sample of the long waiting patients was selected for review. This incorporated random selections of patient pathways within the following categories:

1. Pathways with patients who had died.
2. Pathways with patients identified as still waiting as at the end of December 2017.

[1] 30th September 2016 was used as a proxy for the patients' commencement on the RTT pathway to facilitate the review of the total cohort.

3. Pathways identified as being removed from the waiting list as at the end of December, either through treatment or removal other than treatment (ROTT).
4. Categories 1 to 3 were further stratified by patient pathways where an emergency department (ED) attendance or emergency admission could be identified from the national data and those with no record of an emergency activity.

Health Boards were also requested to submit data on numbers of concerns (complaints, incidents and claims) for the period January to December 2017, supplemented with qualitative analysis of themes observed by the Health Board and the impact of learning from concerns on service development.

Site visits: Meetings with Health Board teams

The DU review team met with Health Board colleagues with operational and executive remits for planned care and quality and safety. The discussions provided an understanding of the processes for managing planned care, the safeguards in place to ensure that patients are safe while they await care and to expedite treatment when necessary, and governance mechanisms for providing assurance to the executive team and board. Discussions with directorates were with the specialities with the largest volumes of 52-week breaches at the beginning of the review.

Site Visits: Case notes and patient administration system (PAS) review

The Health Board provided patient case notes for the sample identified from the data analysis and facilitated access to the PAS via designated Health Board colleagues. This review focused on understanding each patient's planned care pathway and whether any emergency activity was recorded for this patient during the period of their wait for assessment and treatment.

At the time of the site visit some patients' notes were unavailable due to imminent appointments, and ongoing care etc. Cases where notes were not available were not reviewed on PAS and had to be excluded from the analysis. A further six cases were excluded from analysis due to inability to identify and follow the patient pathway from the notes supplied[2]. This appeared to be due to further volumes of notes not being available. In total, 54 cases were included in the analysis.

Sample population requested	Sample population reviewed	Sample population excluded from analysis
71	54	17

Patient feedback

Health Boards issued questionnaires on behalf of the DU to a randomly selected sample of patients who had waited 52 weeks or more at the end of September 2017 to seek patient views on their experience of awaiting treatment. Returns were issued to and collated by the DU. A hundred questionnaires were issued to Cardiff and Vale University Health Board patients. 29 questionnaires were returned; amongst these were 13 patients who were

[2] In some instances, the notes supplied did not include the speciality for the pathway of interest. This is presumed to be due to unavailability of notes due to the conditions described above such as being required for imminent care.

resident out of the Health Board area but had been on a waiting list for planned care at the Health Board.

ASSESSING IMPACT AND HARM

In order to provide a structured framework for identifying and classifying harm, the DU reviewed a number of national documents and undertook a wider review of literature relating to long waits for planned care elsewhere in the UK. Appendix 2 sets out the literature review summary and lists the references.

The literature review identified variations in the examples of what may constitute harm and how this should/could be graded. More recent documents that were designed specifically for assessing harm for RTT patients provide a positive supplement to documents intended to have general use as they supply pertinent examples for planned care. The threshold for harm varies between documents; this highlights the challenge presented by the need to make a subjective judgement on harm. Psychological harm was referenced almost universally but was not always supported by harm ratings, potentially due to the difficulty in making judgement of impact of waits for treatment on psychological wellbeing.

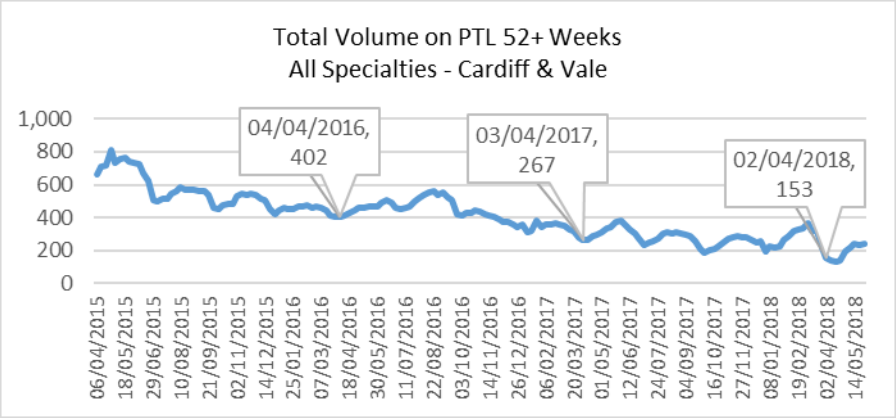
A fundamental finding from the literature review was that Health Boards need to consider multiple tools to achieve a more holistic understanding of harm. Using only a single tool risks limiting the judgement to clinical harm only and omitting the wider perspective of impact of waits on patients including their mental health.

When reviewing individual patients' cases, unless an instance of harm clearly fell into a specific grading, the review team considered the range of potential categorisations prior to finalising the findings set out in this report.

WAITING LIST PROFILE

During the past two financial years, within a context of an increasing total waiting list, the number of long waits (52 weeks or more) for planned care at Cardiff and Vale has been gradually diminishing overall, albeit within a pattern of quarterly growth and reduction reflective of the quarterly cohort management approach.

Figure One: Total volume of 52+ week waits (Source: Weekly PTL reports)



Whilst long waits have been observed in several specialities, there has been a shift in the number of specialities with large volumes of long waiting pathways; during 2017, 52-week breaches were eradicated in Ear Nose and Throat, Paediatric Surgery and Urology, all of which had hitherto had protracted periods with significant numbers. Consequently, from 2017-18, the vast proportion was consistently within two specialities: Orthopaedics and Neurosurgery. Notably, the proportions have shifted, with the number of long waiters for Neurosurgery reducing whilst those for Orthopaedics have increased. This reflects the feedback received from Health Board colleagues during site visits regarding positive outcomes from improvement work undertaken in Neurosurgery on the one hand, whilst specific operational challenges in Trauma and Orthopaedics have compounded demand and capacity imbalance.

During the waiting list review period, Orthopaedics and Neurosurgery consistently accounted for more than 75% of 52-week breaches. The remaining long waits were distributed among a number of specialities including General Surgery and Ophthalmology both of which were also included in the scope of the review; the remaining specialities were excluded, due to small numbers (generally 5 or fewer) within the waiting list review period.

FINDINGS

1. Patient reported impact

The patient questionnaire response highlighted that significant numbers of long-waiting patients are experiencing adverse impact that constitutes low-level harm, with a small number experiencing moderate harm. The reported experience of a small number could potentially be assessed as constituting significant harm.

1.1 Impact on daily life

79% of respondents to the DU's patient survey reported constant or frequent adverse effects on their daily lives, such as pain, reduced physical function, and emotional distress. The strength of feeling of patients was evident in the fact that all patients who reported adverse impact took the time to describe the effects in their response.

"[I was in] constant pain, lacked mobility, [was] unable to drive, couldn't sit for long periods [and was] unable to go out and socialise.

It also impacted greatly on my mental health which is poor generally and became much worse before I was treated."
Cardiff and Vale Patient A, who reported a 17-month wait for treatment

"The quality of life became unbearable."
Cardiff and Vale Patient B who reported an 18-month wait for treatment.

1.2 Impact on social and economic activity

Many reported impact on social activities, while a smaller number (4 of 29) described adverse impact on their employment ranging from missing some working days to being unable to work. Whilst the inability to work results from the condition rather than from an action by the service provider, the inability to provide the treatment will be the limiting factor for patients whose treatment is anticipated to relieve their symptoms and/or improve functioning.

1.3 Impact on mental health

17% of patients told us their mental health was affected by their long wait for treatment. The case review identified only one instance of a patient reporting depression to the service during their wait, giving rise to the concern that patients may be unlikely to disclose any adverse effects on their mental health unless asked, or alternatively, that mechanisms by which such discussions are being held with patients are not routinely recorded in the patients' notes. Consequently, it was not possible to provide assurance that the psychological wellbeing of patients was being robustly addressed.

"My illness has changed me very much. I do not do much as I have constant pain, moody, annoyed at myself, confidence has gone, could go on and on."
Cardiff and Vale Patient C, awaiting Orthopaedic treatment who described their condition as having worsened while waiting.

"My health has deteriorated, my condition has got worse, and I am being treated for depression as a result of still awaiting my operation as I believe the operation will enhance my life."
Cardiff and Vale Patient D, awaiting Orthopaedic treatment.

1.4 Deteriorating health

17% of patients reported that their health/their condition had deteriorated while they were awaiting treatment. One further respondent indicated that a hernia had developed because of their ongoing condition. Some of the harm review structures reviewed graded such deterioration as moderate harm.

2. Data analysis and case note review

2.1 Data review: Characteristics of and changes in waiting list composition

At the September census, there were 170 long waiting patient pathways in the waiting list data[3]. Four specialities were represented, General Surgery, Neurosurgery, Ophthalmology, and Orthopaedics.

The review found no correlation between waits over 52 weeks and incidence of emergency attendances and/or admissions. Of the 170 cases, 58 pathways (34%) had evidence that patients attended and/or were admitted as an emergency between September 2016 and the December 2017, compared with 39% of patients waiting fewer than 52 weeks (for the same specialities).

Between September and December 2017, 58 patients were treated (34%) and a further 41 removed (24%). 70 cases (41%) were still awaiting treatment at 31st December 2017. One long waiting patient died. This patient had been listed for Neurosurgery but the reviewers found no evidence that this patient had been treated prior to their death.

2.2 Case note review

The DU undertook the case note review between 25th and 27th April 2018, 7 months after the September census.

Whilst the majority (73%) had waited between 53 and 69 weeks as at September 2017, 24% of patients had waited between 70 and 99 weeks. Three percent had waited more than 100 weeks, with the longest wait at 131 weeks, which was for Neurosurgery.

At the time of the review, 48% of patients in the sample had been treated, however, 20% of the cohort reviewed was still awaiting treatment and a further 15% had been removed from the waiting list without treatment.

Status at review	Number of patients	Percentage of review cohort
Treated	26	48%
Still waiting	11	20%
Other (removed)	8	15%
Patient decided against treatment	6	11%
Deceased	1	2%
Unclear	2	4%
Total	54	100%

[3] N.B. This is broadly representative of the total profile of waits greater than 52 weeks for the Health Board, but the DU did not request waiting list data for specialities with low numbers of long waits. Hence, the figure differs from the total reported 52-week breach figure reported by the Health Board for September 2017.

Patients were removed from the list for a variety of reasons. Two patients were too unwell to proceed. One patient did not confirm that they wished to proceed with surgery. A further patient was removed with a plan to re-assess in 6 months. In some instances, the rationale for removal was not able to be fully determined.

Whilst the age of patients varied from under 10 years of age to 81 plus, the vast majority of patients were aged between 51 and 80. Patients' age was not found to be a contributory factor in their pathway.

2.3 Impact on patients

Case review evidenced that while some patients had eventual positive outcomes from treatment despite their protracted wait, other patients experienced adverse effects/outcomes.

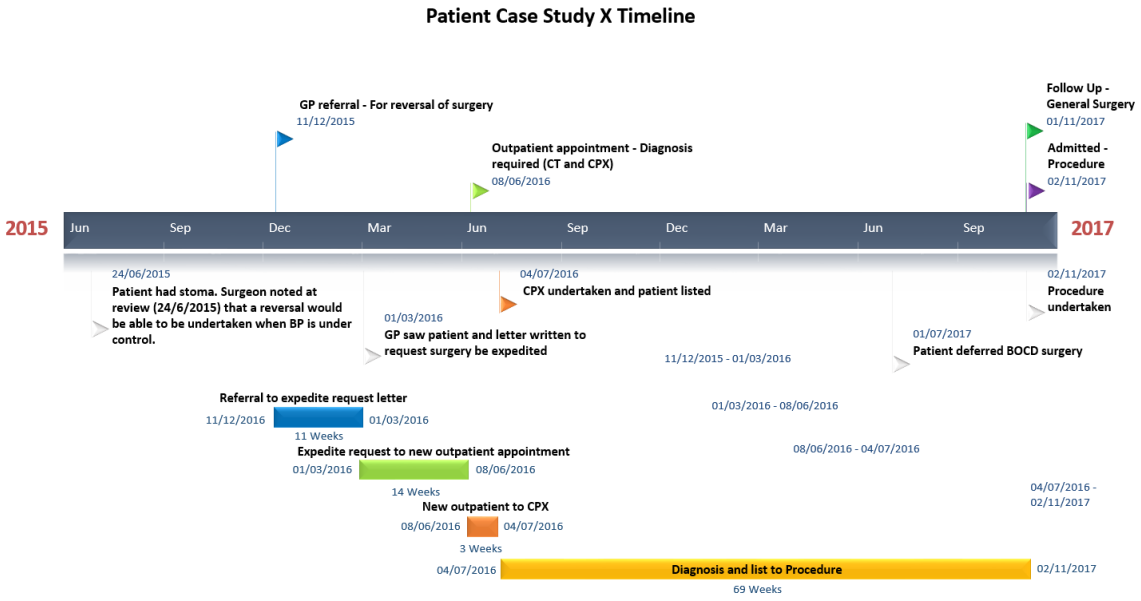
In recognition that the review was limited to the patient notes supplied and the information held in the PAS, the DU applied a cautious assessment of harm; where an instance of harm could be assessed within two categories, the lowest was applied. The DU identified the majority of patients who experienced harm in the low category in the main due to the prolongation of symptoms. However, the ability to assess harm was limited by the apparent lack of explicit framework for recording patients' baseline and any subsequent change in clinical presentation and symptoms. This appeared to be addressed exclusively in clinical correspondence. Some of the examples below may be assessed as moderate harm:

- The patient requiring additional investigations (3 patients) with potential associated cost (for travel and time away from employment) and possibly anxiety;
- Impact on other aspects of the patient's health;
- Depression resulting from the impact of the long wait and prolongation of symptoms (This applied to one patient, whose treatment was expedited once they reported their depression to the Health Board);
- Missed opportunity to have other health procedures undertaken, resulting in prolonged symptoms for two conditions due to the long wait (2 patients).

Patient Case Study X

Patient X was referred to General Surgery in December 2015 for reversal of Hartmann's procedure. The GP wrote to the service in March 2016 to request an expedited appointment due to the impact on the patient's health, noting that Patient X was too nervous to walk because the stoma protrudes and is uncomfortable and this makes it difficult for Patient X to manage their weight. Patient X was listed in July 2016 following outpatient assessment and cardiopulmonary testing and treated 69 weeks after listing. The time from referral to treatment was 98 weeks.

Patient X had also been referred to Trauma and Orthopaedics and had been considered for cubital tunnel decompression. Patient X had opted to defer this intervention pending completion of the reversal procedure resulting in the continuation of these symptoms for more than a year due to their extended wait.



However, incidences of moderate harm were also noted:

- Patients experiencing worsening symptoms;
- Increase in need for medication or treatment.

2.4 Management of co-morbidities and multiple pathways

Of greatest concern to the DU was the evidence of the impact of long waits for patients with co-morbidities, particularly those on multiple RTT pathways. The potential for missed opportunity and adverse impact/outcomes appears to be greater for these patients.

Two patients were removed from pathways without treatment because they were deemed too unwell for the procedure; in one instance, this was identified at surgical pre-assessment, in the other this judgement was made following admission for the procedure. The latter case stood out as a particularly poor patient experience although the review team noted and acknowledged the positive intention in seeking to treat this patient, who had complex health needs.

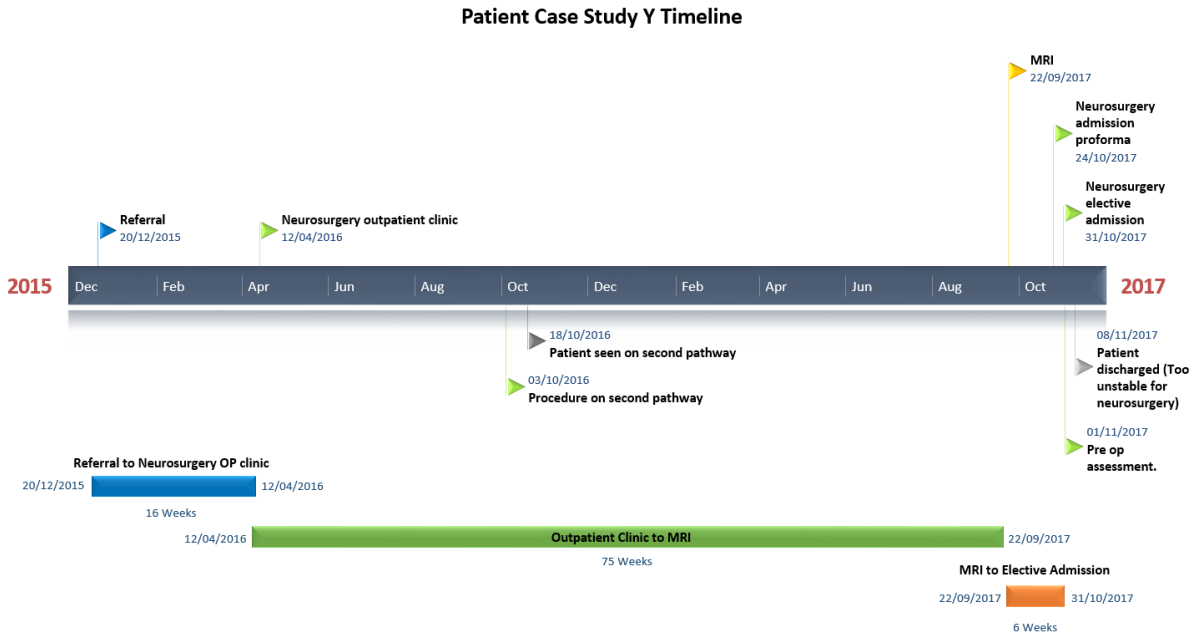
Patient Case Study Y

Patient Y had a complex history and was known to several services. Patient Y was referred to Neurosurgery in December 2015 and accepted as an urgent referral. Patient Y's outpatient appointment was 16 weeks after the referral date. The outcome of this consultation was listing for surgery with a note that this patient required additional support services to be in place for surgery.

Six months later Patient Y had an appointment with the other speciality; treatment was planned. It was unclear from the notes whether Neurosurgery would need to be delayed pending this treatment.

Following a further wait of almost a year and an additional diagnostic procedure, Patient Y was admitted for Neurosurgery in October 2017 (96 weeks after referral). Patient Y underwent a pre-operative assessment following admission. After 8 days in hospital Patient Y was assessed as being too unstable to proceed to surgery and was discharged from hospital and removed from the Neurosurgery waiting list.

It was not possible for the DU to determine categorically whether there was a direct link between the long wait and the patient's deteriorating health resulting in the inability to intervene surgically. However, given the intent to operate when the patient was listed, and the intervening gap of 81 weeks from listing for Neurosurgery to admission (and within this total wait, a gap of 56 weeks from the patient's last procedure in another speciality), there may have been missed opportunity to treat this patient. The timeline for this patient is set out below.



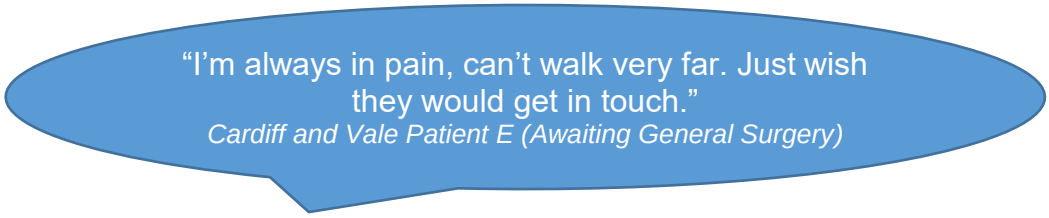
The DU noted opportunity to improve co-ordination for patients with co-morbidities on more than one RTT pathway where advice from other specialities is required and/or guidance in prioritising treatments, as exemplified in case study X on page 11.

Two patients amongst the 54 cases reviewed (3.7%) were on two pathways and opted to delay treatments on one pathway, to their detriment, because of an extended wait for the treatment that they prioritised. The wait for the prioritised treatment was more than a year from the time when the two patients made their decision to defer the second pathway, effectively adding a year to their wait for the subsequent treatment.

There was evidence that the patients had both highlighted their rationale for prioritising the treatments to the health care professional in the speciality for which they opted to defer treatment. However, it was unclear whether these patients had received guidance regarding respective waiting times and whether the services supported these patients to assess the costs and benefits of prioritising each treatment. The effect of such decisions is potentially significant for the patient; one deferred procedure was noted by the clinician to have a 60% chance of improving the patient's pain and an 80% chance of significant benefit if the problem were reparable.

2.5 Typical pathways and patient experience

The DU observed that long-waiting patients are experiencing delay for initial outpatient assessment and/or long waits after listing for treatment, with considerable gaps between appointments/reviews and little or no apparent communication during these periods of delay. This was also reflected in the patient feedback. 31% of survey respondents reported that they had not been contacted during their wait to ascertain whether treatment was still required.



The review found instances of repeat investigations following a period of delay and patterns of multiple cancellations of surgery and associated repeated cycles of pre-assessment, which extended patients' overall wait. One patient's surgery had been cancelled 6 times. Whilst unavailability of beds or staff are often the cause of cancellations, this occurrence is detrimental to patient experience and results in avoidable cost to the Health Board in terms of wasted/repeated appointments in secondary care. The impact of repeated investigations and cancellations on patients was not explicit in the cases reviewed; however, the psychological impact of cancellations may be substantial. Given the lower clinical priority attributed to these patients they may be less likely to be prioritised by the Health Board during times of peak demand. The DU identified one patient who had two planned treatment dates cancelled despite being prioritised as urgent.

2.6 Management of clinical risk

Rather than proactive failsafe mechanisms to manage risk, the DU observed and was informed of reactive systems requiring patients to contact the Health Board if their condition changes while they are awaiting treatment. These include patient feedback direct to the secondary care team, or via primary care expedite referrals, with a subsequent impact on primary care capacity and risk that some patients may not seek assistance when required, or until actual harm has occurred. Significant gaps between appointments or contact from services exacerbate the potential for patients to experience avoidable harm while they wait. Consequently, under the current system, the Health Board cannot be assured that patients are not coming to harm while they await care.

64% of patients in the case review sample had a gap greater than 6 months between appointments. Of these, half had gaps of 12 months or more.

Longest time between appointments/direct contact with patient	**Number of patients**
3-5 months	1
6-11 months	18
12 months or more	17
Unclear/unknown	13
Other	3
Gaps noted due to patient decisions or non-attendance (Did not attend – DNA)	2
Total	**54**

A notable exception is the work described by the Neurosurgery team to review all patients waiting over 52 weeks via telephone consultation and the intention to review all cases proactively once they reach 26 weeks.

2.7 Recommendations

It is recommended that the Health Board:

1. Implements a proactive review of patients at clinically determined points during the pathway, and at 52-weeks as a minimum. Harm review literature from NHS England provides an evidence base for the value of undertaking such reviews to identify whether patients have experienced any harm/adverse impacts. The DU is proposing Wales-wide debate to construct and implement a proactive harm review process.
2. Seeks to install a PAS system alert for patients with more than one RTT pathway and reviews processes to ensure that a discussion is held between the multi-disciplinary teams to manage interdependencies in the patient's care and to support the patient to prioritise treatment.
3. Reviews processes for primary and secondary care collaboration for complex patients on more than one pathway.
4. Reviews its communication and engagement processes for patients on RTT pathways, with a particular focus on ensuring that contacts and appointments with patients facilitate patients' feedback, and patients are made aware of how to contact the Health Board in the event of a change in their condition/symptoms. The national work on patient reported outcome measures and patient reported experience measures provides a framework for some planned care pathways; there is scope for the Health Board to expand its use of this framework.

3. Governance

Health Board colleagues described a corporate focus on reducing long waits, which is supported by the reducing trend for 52-week waiters and the eradication of long waits in a number of specialities during 2017.

3.1 Structures and Processes

Clear performance management and quality and safety structures were described to the DU, with processes for escalation of risks, issues and concerns from directorates through Clinical Boards to the Executive team and Board, however there is scope to improve connectivity between these processes.

Speciality and Clinical Board processes

- Positive working relationships between triumvirates at speciality level were noted. Speciality teams described the lead roles for the performance management and quality and safety management structures and processes.
- However, given that performance and safety meetings are separate entities with different membership, there is a risk that decision making may not be supported by a full understanding of risk and learning from concerns.
- Structures for disseminating learning within clinical boards appeared to be robust, but there is scope to improve the sharing of learning between clinical boards. This

was reflected in discussions with staff. Provision is made in improvement plans to identify a representative to visit other boards' quality and safety meetings.

Corporate processes

- It was evident that corporate level priorities for improvement reflected previous serious incidents (for example, in Ophthalmology), and performance risks, however escalation processes tend to focus on the areas assessed as highest risk and may be missing opportunities for significant improvement identified through near misses and no-harm incidents.
- Whilst serious incidents are reported to corporate leads for both quality and safety and performance, complaints are not routinely reported to performance leads, and the focal point for discussing issues of risk and safety is the corporate Quality and Safety meeting, again creating a distance between discussions on performance and quality and safety.

3.2 Concerns information

The Health Board provided the DU with data on concerns specifically relating to waits/delay for planned care for the 2017 calendar year.

Concern	Number
Complaints	638
Incidents	0
Claims	1 (Ophthalmology)

Complaints data highlights a body of concern from patients about the long waits or delay in receiving planned care with 638 making a complaint to the Health Board in 2017. The Health Board reported that this figure includes both formal and informal concerns, including those where the investigations did not substantiate that there were any delays.

The majority of complaints received were in the Surgery Clinical Board (Ophthalmology/ENT received 254 complaints and Orthopaedics 152), followed by Neurosciences with 58 complaints.

The identification of Ophthalmology as a priority for improvement, founded on an overarching improvement plan covering a number of sub-specialities along with Service Improvement Team support demonstrates a positive response to the high number of complaints and the previously reported serious incidents and associated claim(s).

It was difficult to make reliable comparisons between Health Boards' concerns submissions for a number of reasons including population size, varying numbers of long-waiting patients and different service structures. Nonetheless, it was notable that Cardiff and Vale University Health Board was the only organisation not to report any incidents or near misses to the DU for the reporting period. It was not clear whether this was attributable to an oversight in the data supplied, or whether there were no incidents recorded relating to long waits.

Given the apparent absence of reported incidents and near misses, it appears that overall concerns data understates both the occurrence of issues and the impact of long waits on patients.

3.3 Recommendations

It is recommended that the Health Board

5. Reviews how concerns data (including incidents and near misses) for long waits is recorded and used at quality & safety meetings and how widely this is disseminated;
6. Reviews the use of local risk management systems to ensure that incident and complaint data can be identified for the same episode of care ;
7. Raises awareness amongst staff of the importance of reporting near misses;
8. Reviews the use of concerns data to identify trends and share learning for a range of specialties across the Health Board.

4. Addressing waiting times

4.1 Factors affecting service capacity

Discussion with Health Board colleagues elicited a range of factors considered to adversely affect capacity to treat elective patients. These ranged from the physical environment (e.g. access to theatres) and staffing deficits resulting from turnover or difficulty to recruit to posts in some sub-speciality areas, plus the impact of unscheduled care activity on scheduled care.

While capacity factors affect length of wait there is also evidence that prioritisation decisions have an impact, as evidenced in Neurosurgery where significant improvements have been made to waiting times since the service has strengthened a focus on long waiting patients.

Whilst the reason for delay in accessing outpatient appointments was not discernible from case note review, some of the long waits after listing were clearly attributable to cancellations for surgery due to constraints noted by staff, such as lack of beds.

Processes for triage/prioritisation, and listing for surgery varied between specialities. Speciality teams indicated that for many conditions there were not agreed thresholds for accepting referrals or listing for procedures. Triage/grading of referrals is undertaken by individual consultants in the main, but with multi-disciplinary teams for some cohorts or patients/conditions. Peer review did not appear to be commonplace where triage of referral was undertaken by an individual staff member.

The DU was informed of such a review being instigated following a consultant taking up a post in another organisation. This necessitated the patients being transferred to other members of the team who reviewed the patients. These patient reviews identified that other consultants would have applied different thresholds for listing, and would not have proposed surgical treatment for a number of the patients.

Addressing variation in practice to reduce the number of patients unnecessarily accessing secondary care pathways will reduce the volume of wasted appointments and should consequently improve access times for patients who require services.

4.2 Improvement plans

Speciality teams each described the areas of greatest concern and clearly articulated the actions that had secured existing improvements in waiting times. These ranged from the commissioning of outsourced activity, to investment in new and/or additional permanent roles (for example the development of nurse injectors for Ophthalmology), alongside shorter-term locum posts.

Concerted efforts to change practice in Neurosurgery comprising a number of actions (including patient case review, pooling procedure lists and embedding a focus on treating long waiters alongside managing emergency demand) have borne fruit in facilitating reduction of patients waiting over 52-weeks. Lessons learned potentially have wider applicability for other specialities.

However, despite positive progress, further work is required to achieve sustainable services and fully eradicate long waits. Current and future work to revise pathways is planned for both Ophthalmology and Orthopaedics. For Neurosurgery, theatre and staffing capacity were highlighted as key requirements. The Neurosurgery team also highlighted concern about surgery cancellations caused by lack of beds due to the difficulty repatriating patients back to their resident Welsh hospitals.

4.4 Recommendations

9. Given that 28% of the sample for case review were removed from the list without treatment or opted not to be treated, it is recommended that the criteria for acceptance of referrals and listing for treatment be reviewed for the treatments with a high volume of ROTT, with a particular focus on those that have long waiters.
10. Further review of pre-referral consultation with patients (in primary care) is recommended, to assist with improved management of patient expectation and potentially reduce the number of referrals being accepted.
11. Finally, it is recommended that the potential to enhance the pre-listing consultation be considered to reduce the number of patients who are listed and subsequently opt not to be treated.[4]

CONCLUSIONS

The Health Board is aware of the factors affecting waits for planned care and has made progress in improving waiting times with further action to improve access planned. There remains considerable work to achieve sustainable delivery of timely planned care across all specialities.

Therefore, it is fundamental that the Health Board prioritises review of its practices to safeguard patients while they await planned care. The current system does not proactively

[4] The DU learned of an enhanced consent process using a web-based educational as a supplement to the existing risk-benefit discussions between clinicians and patients which has been trialled by Abertawe Bro Morgannwg University Health Board in partnership with the Royal College of Surgeons of Edinburgh. This is thought to enhance the likelihood that patients who consent to surgery will proceed with accessing their treatment, as they have better understood the risks and benefits.

review patients regularly on their pathway and the review evidenced that some patients are coming to harm while they wait and many are experiencing adverse impacts daily.

Current systems and processes do not support the Health Board to understand the impact of prolonged waits for treatment on patients and address this accordingly; this can be achieved through proactive patient review, supported by improved communication with patients throughout their pathway and enhanced learning from concerns.

NEXT STEPS

A national report highlighting the key findings and themes from the review will be presented to the Welsh Government. Given a number of recurring issues and recommendations across Wales, the DU will recommend that consideration be given to facilitating Wales-wide debate to shape key structures and processes to assess and mitigate risk of harm to patients experiencing long waits for planned care and ultimately, to eradicate long waits. At the request of Health Boards, the DU will meet with Health Board colleagues to discuss the findings of the review further, in support of local implementation of the report's recommendations.

APPENDICES

Appendix 1 – Data review

Summary of analysis of long waiters' emergency attendances and admissions

Number of PATHWAYS	Died *(as recorded in ONS Deaths Dataset as at 16/7/2018)*	Still Waiting - on WL as at e/o Dec 2017, same spec, any length wait. No record of death before 16 July 2018	Treated* (Non emergency admission method Activity in APC, same HB, same spec). No record of death before 16 July 2018	Not on List (ROTT or Other) (Total minus other columns). No record of death before 16 July 2018	**Total**
Attended ED or Emergency admission in Wales, under any specialty during period **20160901 to 20171231***1	1	20	21	16	**58**
No evidence of ED attendance or emergency admissions during this time period*1	-	50	37	25	**112**
Total	**1**	**70**	**58**	**41**	**170**

Summary of review of long waiters in conjunction with ONS Deaths Dataset

Died details (# of PATHWAYS)

Treated* (Non emergency admission method Activity found in APC, same HB, same spec) in review period **20170930 to 20171231**	0
No evidence of treatment under above criteria	1
	1

Appendix 2 – Literature Review

Assessing and Grading Harm to Patients Awaiting Planned Care

Harm assessment structures generally comprise five levels from no harm to severe harm and finally death. The documents reviewed vary in the degree to which they incorporate impacts on the patient beyond clinical impact/harm; however, existing Welsh guidance (Putting Things Right, 2013) makes provision for impact on patients' lives in both the low and moderate harm categories.

The types of harm in these categories include loss of working time, requirement for additional treatment, and the cancellation of appointments in addition to clinical or process issues that result in avoidable injury or impairment of health that require intervention.

More recently, NHS England has been considering how to identify and classify harm for patients who have been awaiting planned treatment on Referral to Treatment (RTT) pathways. The types of harm identified include prolongation and worsening of symptoms. In some documents, the psychological impact of prolonged waits on the patient is more fully recognised and integrated.

Assessing Psychological Harm

Putting Things Right makes provision for the recognition of patients' dissatisfaction in the no harm category, but does not include any examples of assessment of psychological impact of a patient concern related to planned care in the harm rating. There are examples supplied in Appendix Q of payments made to patients, which include recognition of psychological consequences of an incident/event.

Seven Steps to Patient Safety stresses the importance of grading incidents according to harm and that this should include psychological "injuries such as shock, anxiety, depression…" (Page 98).

The difficulty in making a judgement on psychological harm is referenced in NHS England's Clinical Harm Review Handbook, noting that patients' baseline is not assessed at the point of referral.

Harm Ratings

Grade/Harm Rating	Putting Things Right Guidance (2013)	NHS England External Clinical Harm Review Handbook (2016) (Definitions for RTT pathway)	Seven Steps to Patient Safety (2004)	Barking, Havering and Redbridge University Hospitals Clinical Harm Review Programme Document
1/ No harm	a) Concerns which normally involve issues that can be easily / speedily addressed; b) Potential to cause harm but impact resulted in no harm having arisen; c) Outpatient appointment delayed, but no consequences in terms of health; d) Difficulty in car parking; e) Patient fall – no harm or time of work; f) Concerns which have impacted on a positive patient experience.		No harm: • Impact prevented–Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. • Impact not prevented–Any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care.	In the clinician's opinion, the patient has suffered inconvenience only.
2/Low	a) Concerns regarding care and treatment which span a number of different aspects/specialities; b) Increase in length of stay by 1 - 3 days; c) Patient fall - requiring treatment; d) Requiring time off work - 3 days; e) Concern involves a single failure to meet internal standards but with minor implications for patient safety; f) Return for minor treatment, e.g. local anaesthetic or extra investigations.	Prolongation of symptoms	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any	In the clinician's opinion, the patient has suffered inconvenience e.g. prolonged discomfort not leading to need for significantly stronger analgesia or causing psychological harm. In the clinician's opinion the patient has suffered inconvenience or symptoms that, whilst not

Grade/Harm Rating	Putting Things Right Guidance (2013)	NHS England External Clinical Harm Review Handbook (2016) (Definitions for RTT pathway)	Seven Steps to Patient Safety (2004)	Barking, Havering and Redbridge University Hospitals Clinical Harm Review Programme Document
			extra time as an outpatient, or continued treatment over and above the treatment already planned. Nor does it include a return to surgery or re-admission.	sufficient to warrant a 'moderate' conclusion have sufficient impact to warrant a letter of apology and explanation; Example 1 – a child has multiple episodes of tonsillitis requiring antibiotics and resulting in school absences; Example 2 – an adult is awaiting a total knee replacement and during the extended wait suffered continuing pain (although not requiring stronger analgesia) and interruption to activities of daily living because of poor mobility
3/ Moderate	a) Clinical / process issues that have resulted in avoidable, semi permanent injury or impairment of health or damage that require intervention; b) Additional interventions required or treatment /	Increase in symptoms. Increase in medication or treatment.	Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons	In the clinician's opinion, the patient has suffered moderate physical or psychological harm. For example, if there was a delay treating a locally

Grade/Harm Rating	Putting Things Right Guidance (2013)	NHS England External Clinical Harm Review Handbook (2016) (Definitions for RTT pathway)	Seven Steps to Patient Safety (2004)	Barking, Havering and Redbridge University Hospitals Clinical Harm Review Programme Document
	appointments needed to be cancelled; c) Readmission or return to surgery, e.g. general anaesthetic; d) Necessity for transfer to another centre for treatment / care; e) Increase in length of stay by 4 -15 days; f) RIDDOR Reportable Incident; g) Requiring time off work 4 -14 days; h) Concerns that outline more than one failure to meet internal standards; i) Moderate patient safety implications; j) Concerns that involve more than one organisation;		receiving NHS-funded care. Moderate increase in treatment is defined as a return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.	invasive basal cell carcinoma such that a larger cosmetic procedure was required this would be moderate harm unless it causes significant psychological harm in which case it should be classified as severe harm.
4 / Severe	a) Clinical process issues that have resulted in avoidable, permanent harm or impairment of health or damage leading to incapacity or disability; b) Additional interventions required or treatment needed to be cancelled; c) Unexpected readmission or unplanned return to surgery; d) Increase in length of stay by >15 days;	Irreversible progression of disease. Death on the waiting list from index condition.	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care. Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as	

Grade/Harm Rating	Putting Things Right Guidance (2013)	NHS England External Clinical Harm Review Handbook (2016) (Definitions for RTT pathway)	Seven Steps to Patient Safety (2004)	Barking, Havering and Redbridge University Hospitals Clinical Harm Review Programme Document
	e) Necessity for transfer to another centre for treatment / care; f) Requiring time off work >14 days; g) A concern, outlining non-compliance with national standards with significant risk to patient safety; h) RIDDOR Reportable Incident;		permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage.	
5/ Death	a) Concern leading to unexpected death, multiple harm or irreversible health effects; b) Concern outlining gross failure to meet national standards; c) Normally clinical/process issues that have resulted in avoidable, irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well-being; d) Clinical or process issues that have resulted in avoidable loss of life; e) RIDDOR Reportable Incident;		Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care. The death must relate to the incident rather than to the natural course of the patient's illness or underlying condition.	

Overview of focus on planned care and psychological impact/harm

	Putting Things Right Guidance (2013)	NHS England External Clinical Harm Review Handbook (2016) (Definitions for RTT pathway)	Seven Steps to Patient Safety (2004)	Barking, Havering and Redbridge University Hospitals Clinical Harm Review Programme Document
Is harm for RTT patients explicitly featured?	Includes examples of harm that may arise on RTT pathways (e.g. delayed outpatient appointment) despite being a document intended to cover all aspects of patient care.	Yes. Designed to support clinical harm review with suggested definitions of harm for RTT pathways listed.		Yes. Designed to support RTT clinical harm review.
Is psychological impact on patients addressed?	The harm rating references patient dissatisfaction (no harm only. Appendix Q includes examples of payment to patients for incidents where there has been a psychological impact.	References psychological harm but does not including in harm definitions. Makes reference to the difficulty in assessing psychological harm due to a lack of baseline at referral to RTT pathway.	Notes that "Psychological injuries such as shock, anxiety, depression, uncertainty about recovery, fear of future treatment and disruption to work and family life are just some of the possible effects following a patient safety incident." (Page 98)	This is considered in the example provided for the moderate grading and references severe psychological harm.

Documents reviewed

Barking, Havering and Redbridge University Hospitals, (Dr M. Smith, Associate Medical Director), How to Set up and Run a Clinical Harm Review Programme for RTT and Long Waiting Patients

Harm2 Tool from Mayor S, Baines E, Vincent C, Lankshear A, Edwards A, Aylward M, et al. Measuring harm and informing quality improvement in the Welsh NHS: the longitudinal Welsh national adverse events study. Health Serv Deliv Res 2017;5(9)

NHS England, External Clinical Harm Review Handbook (2016)

National Patient Safety, Agency Seven Steps to Patient Safety – The Full Reference Guide (2004)

Putting Things Right Guidance on dealing with concerns about the NHS from 1 April 2011 (Version 3 November 2013)

Appendix 3 – Acknowledgements

The DU would like to extend grateful thanks to colleagues at Cardiff and Vale University Health Board for their full support and participation in undertaking this review. The review team would like to note particular thanks to all colleagues who were interviewed during phase two of the review and to colleagues in Information, Medical Records, Patient Experience and RTT teams for supplying information prior to site visits, access to patient notes and PAS records, and facilitating the patient survey.

Appendix 4 – Terms of Reference

Terms of Reference for a Review of the Impact of Long Waits for Planned Care on Patients

1. Terms of Reference

This document specifies the agreement between the Delivery Unit (DU) and Cardiff and Vale University Health Board (HB) in undertaking a review of the impact of long waits for planned care on patients.

2. Background

The Delivery Unit has identified a concern that despite a reduction in the number of patients in Wales waiting in excess of 36 weeks on a referral to treatment (RTT) pathway the number of patients waiting over 52 weeks has grown.

Across Wales there are currently 22,898 patients on a referral to treatment (RTT) pathway who have waited in excess of 36 weeks[5]. Of these, there are 5363 patients who have waited over 52 weeks for treatment. 1267 of the (52-week) patients' cases are classified as urgent. The majority of urgent waits over 52 weeks are for Orthopaedics (860), General Surgery (173) and Urology (101) and the distribution of patients is in the main in three Health Board areas[6].

3. Rationale/Aims

The rationale for the proposed review is to assess the impact of long waits for patients in terms of potential harm and adverse outcomes resulting from the extended delay.

The output of this work will be a report summarising the findings of the review and recommendations for action to ensure that there are adequate clinical risk management processes in place to safeguard patients and to address the issues underlying extended waits for treatment.

The key outputs incorporated in the report will include:

- Identification of the volumes of long-waiting patients being conveyed to/attending accident and emergency departments;

[5] Data as at week commencing 28/08/2017. Source: Weekly PTL.

[6] Urgent patients waiting over 52 weeks on an RTT pathway at 03/04/2017: Abertawe Bro Morgannwg University Health Board – 390, Betsi Cadwaladr University Health Board – 443, and Hywel Dda University Health Board – 301.

- Identification of the volumes of long-waiting patients admitted as emergency admissions and the resultant impact on beds;
- Identification of the numbers of patients who are not discharged to their usual place of residence following admission;
- Identification of the themes and trends from concerns (incidents, complaints and claims) relating to long-waiting patients ;
- Assessment of the processes by which patients are selected and prioritised for treatment and the clinical risk management processes applied to ensure the safety of long-waiting patients;
- Assessment of the Health Boards' ownership and response to any issues arising from long waiting patients.

4. Review Arrangements

The review will be a joint undertaking of the Delivery Unit's Scheduled Care and Quality and Safety teams reporting to Mr Philip Barry, Assistant Director – Scheduled Care and Mrs Julie Parry, Assistant Director – Quality and Patient Safety. The lead will be Elizabeth Beadle, Performance Improvement Manager.

The Health Board lead will be ……..

5. The Approach

To attain the required level of understanding of the issues being considered the Delivery Unit will utilise a four-stage process.

The review will focus on patients who have waited longer than 52 weeks for commencement of definitive treatment.

5.1 Phase One – Data Review

The first stage of the work will consist of a data review.

I. Data extracts of patients awaiting planned care (RTT) at two points in time will be prepared. These will be assessed and categorised into populations to determine:
    - The number of patients whose treatment has commenced;
    - The number of patients who are still waiting;
    - Patients who have been removed from the waiting list for any other reason.
    - Whether any patients have died in the time between the two dates.

II. Data sets comprising emergency attendances, admissions and discharges will be requested for the 12-month period corresponding to the patients' wait on an RTT pathway. These will be reviewed to determine:
    - The number of Emergency Department (ED) attendances for the patients in the cohort within the twelve-month period during which they have been awaiting treatment;
    - The number of emergency admissions for these patients resulting from ED attendances and the category of admission;

- Discharge destination (to identify whether patients returned to their usual place of residence);
- Whether there are any discernible patterns relating to the emergency attendances/admissions and the priority categorisation for cases (priority/routine).

Statistically significant cohorts of patients will be selected from the sample population and Health Boards will be contacted and informed of the patient identifiers for these patients in order that patient records can be collated for review in phase 2. Health Boards will also be requested to extract details of concerns (incidents, complaints and claims) raised in relation to the duration of the wait for planned care during the time period being considered in the review.

5.2 Phase Two – Site Visits

1. Notes Review

The DU team will review patient notes to undertake detailed analysis of the reasons underlying the ED attendances, emergency admissions and discharge destination to identify whether there is evidence that the patients' long wait for planned care was a contributory factor and if there is evidence that any harm has occurred.

The notes review will also seek to establish how the learning from analysis of incidents resulting in harm is used to inform action to improve clinical risk management processes.

2. Meetings with Health Board Teams

The DU will meet with key individuals involved in the management of patients on RTT pathways. The meetings will cover the processes for;

- Assessing the relative clinical priority of patients;
- Selecting patients for treatment;
- Risk management arrangements for assuring the safety of patients while they await treatment (both clinical and corporate management of risk);
- Obtaining and using patient feedback to inform their clinical risk management processes;
- Investigation and analysis of concerns and implementation of actions identified for improvement.
- Service constraints impacting on ability to assess and treat patients.

5.3 Phase Three – Review of Patient Experience

The final phase of the review will focus on the patients' perspectives on long waiting times to identify whether/ how their wait for treatment has affected them. Health Boards will be requested to contact patients to ascertain whether they would be willing to provide feedback on their experience whilst awaiting treatment. Patients who are willing to participate will be requested to complete a questionnaire/ attend a focus group session.

5.4 Phase Four - Health Board Feedback

Following completion of phases one to three and in advance of issuing a final report summarising the findings of the review, feedback will be provided to each Health Board to assure that the organisation has an opportunity to understand the findings, and to provide further information if appropriate.

6. Process and Timescales of Review (*N.B. Timescales subsequently changed due to data availability.)

Phase/Activity	Date
1. Data Review: • Test phase (national data supplied by NWIS) • Full data analysis (data to be supplied by Health Boards)	September 2017 to November 2017
2. Site visits 2.1 DU to issue notification of visits, request for patient notes and support for patient survey. 2.2 Visits	 November 2017 December 2017 – January 2018
3. Patient experience review	January 2018
Analysis and report completion	January - February 2018
4. Feedback to Health Boards	February 2018

7. Outputs

The DU will produce a report which summarises the findings of the review, highlights areas of both concern and good practice. The report will make recommendations for improvement based on evidence and good practice.

8. Escalation

Identification of significant risk:

If during the review the DU identifies significant risk to staff or patient care, the DU will discuss the specific risks with the Lead Manager designated by the individual HB. It is the responsibility of the Lead Manager to confirm the actions to be taken by the HB to address the identified risk.

Escalation to the Executive Team:

If the DU remains concerned about the level of action taken, this will be escalated to the Executive Lead for the HB and the Welsh Government Lead.

Escalation to an appropriate External Agency

If the DU feels that the HB has not fully addressed the identified significant risk, this will result in escalation to the appropriate external agency.

The DU will be working closely with both Welsh Government and the UHBs and making recommendations for the purpose of further improving and developing the services. On signing this document, both the DU and UHB are agreeing to conduct the review under the above terms of reference.

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UHB Executive Lead	Director, DU
Date: ----------	Date: ----------

Cardiff & Vale University Health Board

Report title: Delivery Unit: Review of the Impact of Long Waits for Planned Care on patients

Ref	Recommendation	Management response	Planned completion date	Responsible officer
R0	The report be presented to the Health Board's Executive Board's quality and patient safety committee for consideration of the findings and recommendations for action.	The report will be presented at the Health Board's Quality and Patient Safety Committee in September 2019.	17/09/19	Deputy Chief Operating Officer
R1	The Health Board implement a proactive review of patients at clinically determined points during the pathway, and at 52 weeks as a minimum.	It has been agreed that this will be led by the each Clinical Board's Director of Nursing, with support from the Directorate Quality Leads. Specific actions agreed with the Clinical Board Directors of Nursing are: • Each Directorate to determine their definition of a long waiting patient, in agreement with clinicians. As a minimum (in line with the recommendation) 52 weeks would be the stop gap for all specialties. • Discussion and agreement with each Directorate Quality Lead on proactive reviews and assurance that this was happening • This would form a standing agenda item of each Clinical Board's QSE meeting on a quarterly basis (on an exception basis only)	In progress. Process to be embedded in all Clinical Boards by 30/09/19.	Clinical Board Directors of Nursing

Ref	Recommendation	Management response	Planned completion date	Responsible Officer
R2	Seeks to install a PAS system alert for patients with more than one RTT pathway and reviews processes to ensure that a discussion is held between the multi-disciplinary teams to manage interdependencies in the patient's care and to support the patient to prioritise treatment	Agreed there is merit in identifying and alerting MDT teams where a patient is on more than one pathway to allow discussion between teams. Having reviewed the options, this is best served via data extraction and an alert from our Business Intelligence System (BIS) rather than Patient Administration System. Phase 1 will therefore to develop this alert process via BIS. Phase 2 will be to agree a process with Clinical Boards once the information is readily available.	Phase 1: 18/10/19 Phase 2: 30/11/19	Phase 1: Deputy Chief Operating Officer / Information Modernisation & Development Manager Phase 2: Deputy Chief Operating Officer / Clinical Board triumvirate
R3	Reviews processes for primary and secondary care collaboration for complex patients on more than one pathway.	See Management response to R2 above. Phase 2 will incorporate discussion and agreement of a process with primary and secondary care.	As R2 above	As R2 above
R4	Reviews its communication and engagement processes for patients on RTT pathways, with a particular focus on ensuring that contacts and appointments with patients facilitate patients' feedback, and patients are made aware of how to contact the Health Board in the event of a change in their condition/symptoms. The national work on patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) provides a framework for some planned care pathways; there may scope for the Health Board to expand its use of this framework	This forms a key element of the Health Board Outpatient Transformation Programme ('Outpatient 2025'). The Health Board has already implemented PROMs and PREMs in a number of specialities, with plans to roll out further. In addition, the Health Board is implementing 'Patient Knows Best', a patient portal. This will support self-management, allow patients to view their care plan and also have direct communication with clinicians. In relation to communication with long waiting patients on a planned care pathway specifically, it is anticipated that this will be incorporated into Directorate processes for monitoring and review of long waits	In progress. Rollout to further specialties by March 2020 As R1 above	Digital Transformation Manager / relevant Directorate Managers As R1 above

Ref	Recommendation	Management response	Planned completion date	Responsible Officer
R5	Reviews how concerns data (including incidents and near misses) for long waits is recorded and used at quality & safety meetings and how widely this is disseminated for planning service improvement.	Agreed to review the collation of data in R6 and agree a plan to disseminate to the Clinical Boards QSE meetings to inform their service improvement plans Patient Safety and Quality team have met with Lightfoot 2-09-19, to discuss how information from Quality and Safety sources e.g Datix, EMAT and National Audit databases can be used to underpin the Lightfoot work programme and strengthen the quality of data that is now being used in an increasingly routine way to underpin improvement projects and Transformation agenda.	By end December 2019	Assistant Director Patient Safety and Quality/Assistant Director Patient Experience
R6	Reviews the use of local risk managements systems to ensure that incident and complaint data can be identified for the same episode of care.	The Once for Wales project aims to have a standardised approach across Wales to the categorisation of concerns to enable better triangulation of data Locally we can develop a dashboard to recognise a complaint event and incident event date as the same for the same contact Explore existing CCS2 categories on datix to identify relevant categories so that data can be more easily drawn from the system. Work with the information Department to set up a system which links patients who are breaching to incidents and complains on Datix. This will	April 2019 for Once for Wales By December 2019 for local dashboard By end December 2019 Review progress end December 2019	Assistant Director Patient Safety and Quality

		enable greater triangulation of available data to identify patients who are coming to harm.		
Ref	**Recommendation**	**Management response**	**Planned completion date**	**Responsible Officer**
R7	Raises awareness amongst staff of the importance of reporting near misses	Staff are expected to report near misses and UHB incident data demonstrates that staff routinely report near misses or cases of minor harm to patients. This is embedded in regular education and training programmes. Importance of reporting near misses will be highlighted in forthcoming Patient Safety and Quality newsletters	Embedded in practice End September 2019	Assistant Director Patient Safety and Quality
R8	Reviews the use of concerns data to identify trends and share learning for a range of specialities across the Health Board.	Reference to R6-Data can be analysed to speciality level and relevant information shared directly	By December 2019	Assistant Director Patient Safety and Quality/Assistant Director Patient Experience
R9	Reviews the criteria for acceptance of referrals and listing for treatments with a high volume of ROTT, with a particular focus on those that have long waiters	Agreed. In the first instance this work will focus on those specialties with long waiters ie. 52 weeks or above and a high ROTT rate.	By December 2019	Assistant Director Performance Delivery / Clinical Board Directors of Operations / Directorate Managers
R10	Noting staff feedback that there are not clearly designated thresholds for accepting referrals for all conditions, further review of expectations for primary care consultations prior to referral for planned care is recommended, to assist with improved management of patient expectation and potentially reduce the number of referrals being accepted.	This work is being taken forward via the Transformation Programme with the implementation of HealthPathways, an internet based repository of clinical pathways and guidance. As at 28/08/19, 53 local pathways of care have been collaboratively developed by primary and secondary care and published. These focus on the management of conditions	Commenced & ongoing.	UHB Healthpathways Lead

		within Primary Care with clear guidelines on referral to specialist services at the appropriate point.		
Ref	**Recommendation**	**Management response**	**Planned completion date**	**Responsible Officer**
R11	The potential to enhance co-production with patients from outpatient stage be considered to reduce the number of patients who are listed and subsequently opt not to be treated	The UHB will review the enhanced consent process, as highlighted by the Delivery Unit, trialled by Swansea Bay UHB – in the first instance to assess its applicability for orthopaedics (the specialty with the longest waits currently)	30/09/19	Assistant Director Performance Delivery

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

MINUTES OF THE MEETING HELD ON 8TH MAY 2019

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Matthew Temby	Clinical Board Director of Operations
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Chris Tetley	(attending on behalf of Media Resources)
Robert Bracchi	Consultant, AWTTC
Rachael Daniel	Health and Safety Adviser
Lisa Griffiths	Quality Manager, Laboratory Medicine
Maria Jones	Senior Nurse, Outpatients
Sarah Wilcox	(Representing Pharmacy)
Suzie Cheesman	Patient Safety Facilitator
Lesley Harris	Head of Radiography UHL
Kathy Morris	Clinical Audit
Emma Cooke	Head of Physiotherapy

Apologies:

Mike Bourne	Clinical Board Director
Alun Morgan	Assistant Director of Therapies and Health Sciences
Bolette Jones	Head of Media Resources
Mathew King	Head of Podiatry
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/170 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 19/171 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 19/172 Approval of the Minutes of the Last Meeting

The minutes of the meeting held on 10th April 2019 were **APPROVED.**

CDTQSE 19/173 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 19/132 EXPERT Programme

Robert Bracchi reported that the SBAR was presented to the AWTTC Senior Management Team. A number of questions were raised and a meeting is being arranged. Feedback will be provided to this Group from the meeting.

CDTQSE 19/135 Celluloid Film

The material being stored at the CRI has been identified. Sion O'Keefe is working with Bolette Jones to relocate the archive to an alternative location

CDTQSE 19/137 Flu Campaign

The incentive prize has not yet been awarded to the Clinical Board. The Clinical Board will consider how the prize money can be utilised. Sue Bailey is keen to benefit staff under the theme of health and wellbeing. She is also considering training in patient safety particularly in relation to human factors. Suggestions were also put forward of providing staff with care training and replacing equipment.

Maria Jones has sent out a call for flu champions for next year's flu campaign and a reminder for training.

CDTQSE 19/152 Professional Concerns

Gareth Edgell will be presenting to the next meeting.

CDTQSE 129/155 TRUS Procedure

Following the last meeting, justification was provided that the pre-labelling of specimen pots was safer for patients and Chair's action was taken to approve the procedure.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/174 Patient Story

Cellular Pathology will be presenting a patient story at the next meeting.

CDTQSE 19/175 Feedback from UHB QSE Committee 19th February 2019

Nicola Foreman presented the Board Assurance Framework noting that there will be more check and challenge with controls in place. There is only one risk on the register for the QSE Committee relating to safety and regulatory compliance and this risk should be reduced within six months.

It was also reported that further work needs to be undertaken in relation to the risk register but there is no movement in terms of the new template.

CDTQSE 19/176 Health and Care Standards

The Clinical Board self-assessments have been submitted.

Corporate leads are bringing evidence together to produce a UHB response.

CDTQSE 19/177 Risk Register

Directorates are required to send their most recent iteration of their risk registers to Helen Jenkins. The Clinical Board risk register will then be updated and presented to the next meeting for review.

Action: Directorates/Helen Jenkins

CDTQSE 19/178 Exception Reports

An incident occurred in Pharmacy involving a baby who received an overdose. The baby was not harmed and the incident was not classified as an SI. An internal RCA is being undertaken.

A concern was received from a patient in Radiology who was given anaesthetic prior to a cortisone injection and sustained a fall when getting off the treatment table. The patient's leg was swollen and bruised and may require surgical intervention. This is being considered for reported as an SI.

Overnight last night there was an issue in blood sciences specimen reception. A significant volume of work received from Primary Care was left overnight which was not made safe and not booked in. A possible late drop off and workforce issues in the team contributed to the issue. All the data is being reviewed and there may be a small cohort of patients that will need to be re-bled. An independent investigation needs to be undertaken.

Matt Temby stated that as part of the investigation the actions of the management team need to be investigated as they were aware that a large number of the team were inexperienced and in training. Sue Bailey is concerned at the increase in issues and errors within Specimen Reception and the Clinical Board Management Team will need to meet with the Specimen Reception management team to discuss the issues and support required.

Action: SMT

The Laboratory Director has asked if NPEX can be implemented as a matter of urgency. NPEX is a system that allows automatic transfer of information across organisations. Matt Temby will check with Mike Bourne for an update as he believes that there is an issue around implementation with NWIS.

Action: Matt Temby

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/179 Initiatives to promote Health and Wellbeing

The Clinical Board is running an initiative for health and wellbeing in the Clinical Board entitled 'Work Health, My Health'. As May is National Walking Month, staff in the Clinical Board are being encouraged to participate in introducing more walking into their day. Matt Temby held a walking meeting yesterday and thanked everyone who participated. He will also be holding a lunchtime walk for staff in the Clinical Board later in the month.

Emma Cooke reported that a project is being run in conjunction with Public Health in Physiotherapy involving Making Every Contact Count and health and wellbeing promotion to patients is being integrated as part of this. The service is considering whether to submit this as a Bevan Exemplar project. Sion O'Keefe advised that Outpatients have undertaken work with other services around Making Every Contact Count and will share the work they have undertaken.

Action: Sion O'Keefe

Rachael Daniel reported that the HSE will be undertaking a health at work audit in the third quarter of the year. She noted that the audit will not involve stress but will focus on MSK, manual handling and RIDDORs and the management of incidents. The Health Board will be commencing planning for this audit and will be liaising with Clinical Boards.

Managers will need to ensure that staff are compliant with Manual Handling and Violence and Aggression training. It was noted that staff have experienced difficulties in accessing the face to face manual handling sessions and Rachael Daniel will feedback this issue.

CDTQSE 19/180 Falls Prevention

Suzie Cheesman reported that simulation training for falls is available.

SAFE CARE

CDT QSE 19/181 Concerns and Compliments Report

A performance dashboard for concerns has been implemented in the Clinical Board. In April 2019, all directorates were reporting a green or amber status and there were no issues to report.

The Clinical Board received 3 concerns this month, which is below the average number of concerns that it receives per month.

There were 0 breaches in response times.

7 compliments were received this month, which is the average number of compliments that the Clinical Board receives per month.

The key theme of the formal concerns received relates to poor attitude of staff. A discussion was held that it is difficult to ascertain if staff were being discourteous or whether the patient was upset with the message that was being conveyed to them, or if the patient had been aggressive or challenging. It was agreed that if a patient is being aggressive to a member of staff, the UHB has a Vexatious Patient Policy in place and the incident should be reported on the Datix system.

It was noted that the Booking Centre has implemented a call recording system and this is useful for training purposes.

CDTQSE 19/182 Ombudsman Reports

Nothing to report.

CDTQSE 19/183 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 19/184 Patient Safety Incidents

The Clinical Board is reporting 3 SIs which are currently being progressed and 1 new SI.

In69239 - the closure form was submitted to Welsh Government in October 2018. The patient safety team are following this up for closure.

In82274 relates to a choking episode of a patient on a ward. This is currently under investigation.

In88890 relates to a patient who had a rare but known complication of a neurovascular procedure and passed away following the procedure. This is currently under investigation.

CDTQSE 19/185 New SI's

The new SI relates to a troponin issue.

There was a problem with new analysers where results of 0 were being reported. The manufacturer could not find the fault. A number of updates to instrument parts were made to prevent the fault and the error could not be recreated. It was decided that a safeguard would be to trap any results of 0 using the middleware software. The manufacturer planned to trap results between 0 and 0,1 and results between 0.1 and 0.9 would be reported as <2 and be released in the usual way. The

manufacturer sent a summary of the planned changes to the department but this contained an error in the computer code. Laboratory staff would not be expected to notice that this coding error. A testing environment of the middleware does not exist and therefore all changes were made in the live environment.

The error in the change to the software resulted in all results >0,1 being reported as <2, therefore all results were being incorrectly reported with a number of false negatives.

Swift action was taken to ensure all patients were made safe. An RCA will be undertaken by an independent Investigating Officer.

CDTQSE 19/186 RCA/Improvement Plans

Nothing to report.

CDTQSE 19/187 WG Closure Forms – Sign Off

There were no closure forms to be received.

CDTQSE 19/188 Regulation 28 Reports

Nothing to report.

CDTQSE 19/189 Patient Safety Alerts

There were no new patient safety alerts to report.

CDTQSE 19/190 Addressing Compliance Issues with Historical Alerts

Sue Bailey has been asked to review the number of IRMER incidents being reported relating to patient ID to demonstrate compliance with Patient Safety Notice PSN 026 – Positive Patient Identification.

CDTQSE 19/191 Medical Device Risks/Equipment and Diagnostic Systems

A serious risk has been raised by the UHB Medical Equipment Group. The UHB purchased new defibrillators in June 2018 to replace 50% of the old XL kit across the UHB. Roll out of the new machines has been slow due to training issues. To ensure safe practice at least 80% of staff within an area must be trained prior to use.

The old XL defibrillators are now problematic as the battery replacement at 18 months is being delayed due to a worldwide lack of availability. The UHB has batteries on order for six months without delivery. There is now a possible situation that the defibrillators in use could potentially fail. The solution is for the new machines to be brought into use as soon as possible. However there is not enough capacity within the resuscitation team to provide the training and also the availability of staff to undertake the training. The company Zoll have agreed to assist with training and Clinical Boards have been asked to encourage staff

availability to receive the training. The resuscitation team have also agreed to increase the level of training they can provide.

It was noted that Zoll has provided training in Radiology. Rebecca Vaughan-Roberts will provide Emma Cooke with the contact details for the company.

Action: Rebecca Vaughan-Roberts

The issue will be placed on the UHB risk register for medical equipment.

CDTQSE 19/192 IP&C/Decontamination Issues

The terms of reference for the IP&C Group were **RECEIVED** and **APPROVED.**

Maria Jones has sent out a further request to IP&C links to understand current level of compliance and training needs against ANTT. It was noted that the Interim Medical Director is supportive of medical staff receiving the training.

Alun Morgan is collating information on line insertion within the Clinical Board. It was noted that work is being undertaken at a UHB level on a strategy for consistent practices and this is being led by Carol Evans. Sue Bailey to advise Alun Morgan to link in with this.

Action: Sue Bailey/Alun Morgan

Compliance against water safety across the Clinical Board is to be monitored by the IP&C Group. Risk assessments are to be undertaken on hydro pool and compliance.

Maria Jones has circulated a call for flu champions for the Clinical Board for next year's flu campaign.

CDTQSE 19/193 Point of Care Testing

Matt Temby reported that the Quality Lead for POCT is on maternity leave. Work is being undertaken on the structure of the team going forward,

CDTQSE 19/194 Key Patient Safety Risks

Safeguarding

Nothing to report.

MCA Act

Dates for consent training have been circulated.

Emma Cooke raised a query on the cut off age for parental consent, particularly for children in special schools. Maria Jones will make enquiries.

Action: Maria Jones

CDTQSE 19/195 Health and Safety Issues

At the Clinical Board Health and Safety meeting, Stuart Egan provided complimentary feedback of the health and safety training for managers and encouraged managers to attend. Dates are available on the intranet. It was noted that the training is targeted at senior management level.

Two RIDDOR incidents have been reported in the Clinical Board. In Cellular Pathology a member of staff dropped a heavy piece of equipment on their foot and the equipment had not been subject to a risk assessment.

A radiology member of staff injured their fingers moving a bariatric patient. It was noted that procedures were being followed correctly.

CDTQSE 19/196 Regulatory Compliance and Accreditation

Sue Bailey provided issues for escalation from the Clinical Board Regulatory Compliance Group. The Clinical Board is concerned with the level of progress that is being made in SMPU and UHL Pharmacy Production Unit in terms of their regulatory compliance. A meeting has been arranged with the Service Director.

An SBAR relating to the management of specimen reception Datix issues is being revised.

There is instability in terms of staffing in Blood Transfusion Laboratory due to staff changes including a new Quality Lead.

Haematology has made good progress in the improvement of its performance metrics.

Sample processing problems have been raised with two types of tests affected HbA1c and Haematinics, which has led to samples not being processed in a timely manner.

All departments in the Clinical Board with the exception of Medical Physics, Podiatry, Outpatients/Patient Administration and Physiotherapy have submitted business continuity plans on the new UHB template. These areas are asked to feedback to Sue Bailey with a timeframe of when these will be produced.

Action: Kathy Ikin/Mathew King/Sion O'Keefe/Emma Cooke

The Clinical Board Regulatory Compliance Group Terms of Reference were **RECEIVED** and **APPROVED.**

UKAS have closed the Cellular Pathology non-conformances and the department has now received full accreditation.

Natural Resources Wales conducted an inspection this week in Radiopharmacy, Nuclear Medicine and Biochemistry. Very good compliance was reported against radioactive waste and open radioactive sources and the departments were able to demonstrate good training and record keeping

CDTQSE 19/197 Policies, Procedures and Guidance

It was noted that the UHB Security Services Policy has been approved.

EFFECTIVE CARE

CDTQSE 19/198 Clinical Audit

Kathy Morris reported that she is due to retire. Any queries relating to clinical audit to be directed to Mick McGeoch. The Clinical Board thanked her for her input into this Group.

Sue Bailey will circulate the UHB clinical audit plan.

CDTQSE 19/199 Research and Development

The next meeting of the Clinical Board R&D Group is to be held tomorrow.

Emma Cooke reported that issues have been raised with therapists being principal investigators. This will be discussed further at tomorrow's meeting.

CDTQSE 19/200 Service Improvement Initiatives

Service improvement work is being undertaken relating to appointments and scheduling in Outpatients, particularly around DNAs and cancellations. Technology is being explored to engage with patients and their outpatient consultations in a bid to move away from paper. The CSI team have set up a project with common principles on the technology available to patients.

The Health Board has also rolled out a system 'Patient Knows Best' based on how to better engage with patients and giving patients easier access to clinicians.

CDTQSE 19/201 NICE Guidance

Nothing to report.

CDTQSE 19/202 Information Governance/Data Quality

The Interim Medical Director is chairing the Medical Records Management Group and the Health Records Operational Group. A discussion was held around the value of these groups and it was agreed that the Medical Records Management Group will cease to function. Escalation from the Health Records Operational Group will be forwarded to the Information Technology and Governance Committee.

DIGNIFIED CARE

CDTQSE 19/203 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 19/204 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

CDTQSE 19/205 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/206 Equality and Diversity

A patient concern was received relating to a historic letter template which made a gender specific reference to a GP. Sue Bailey reminded directorates to check their historical letter templates.

TIMELY CARE

CDTQSE 19/207 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/208 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

At year end the Clinical Board achieved its RTT targets. Paediatrics GA list waits which are a challenge, reported 8 weeks and less. Support from Therapies to the Trauma and Orthopaedics directorate at year end was well-received and they thanked the Therapies Team for their assistance.

INDIVIDUAL CARE

CDTQSE 19/209 National User Experience Framework

Health records has been asked to clarify arrangements for the park and ride on patient letters. Sion O'Keefe will share the wording being used to other departments that issue patient letters.

Action: Sion O'Keefe

It was noted that a Park and Ride Scheme will be implemented for UHL in June.

STAFF AND RESOURCES

CDTQSE 19/210 Staff Awards and Recognition

Nominations have been received and forwarded on for the NHS Wales Awards.

CDTQSE 19/211 Monitoring of Mandatory Training and PADRs

It was noted that this month is Mandatory May month.

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

The following minutes were **RECEIVED:**

Biochemistry Quality Group Minutes 2.4.19
Outpatients/Health Records & Media Resources QSE Minutes 2.4.19
Clinical Board Health and Safety Group Meeting 16.4.19

ANY OTHER BUSINESS

Nothing to report.

DATE AND TIME OF NEXT MEETING

12th June 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 12TH JUNE 2019

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Matthew Temby	Clinical Board Director of Operations
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Bolette Jones	Head of Media Resources
Alison Bax	Professional Head of Radiography UHW
Lesley Harris	Professional Head of Radiography UHL
Rachael Daniel	Health and Safety Adviser
Mathew King	Head of Podiatry
Maria Jones	Senior Nurse, Outpatients
Sarah Wilcox	(Representing Pharmacy)
Claire Constantinou	(Representing Dietetics)

Apologies:

Mike Bourne	Clinical Board Director
Alun Morgan	Assistant Director of Therapies and Health Sciences
Lisa Griffiths	Quality Manager, Laboratory Medicine
Paul Williams	Medical Physics
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Robert Bracchi	Consultant, AWTTC
Suzie Cheesman	Patient Safety Facilitator
Rhodri John	Operational Support Service Manager
Sarah Jones	Quality Lead, Pharmacy
Andrew Wood	Clinical Director, Radiology and Medical Physics/Clinical Engineering Directorate
Kathy Ikin	Directorate Manager, Radiology and Medical Physics/Clinical Engineering Directorate

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/212 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 19/213 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 19/214 Approval of the Minutes of the Last Meeting

The minutes of the meeting held on 8th May 2019 were **APPROVED.**

CDTQSE 19/215 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 19/177 Risk Registers

Updated risk registers have been received from Dietetics, Media Resources and Pharmacy. All other departments to review their risk registers and submit to Helen Jenkins.

Action: All

It was noted that Laboratory Genetics' risks are still held on the Clinical Board risk register and CRAF. The Clinical Board risk register and CRAF therefore needs to be reviewed and updated.

Action: Helen Jenkins

CDTQSE 19/177 NPEX

Matt Temby advised that the NPEX system is now in progress with NWIS.

CDTQSE 19/179 Making Every Contact Count

Sion O'Keefe to share the work Outpatients has undertaken with Emma Cooke.

Action: Sion O'Keefe

CDTQSE 19/192 Line Insertion

A visioning workshop is arranged in July to standardise the approach for line insertion. A lot of interest has been shown in the workshop which is over-subscribed.

CDTQSE 19/194 Cut off Age for Parental Consent

Julia Barrell has advised that this issue is not straight forward. Directorates should follow the Consent Policy and Gillick competency. It is recommended that any staff with a specific query to contact Julia Barrell where advice is required on a specific case concerning competency.

CDTQSE 19/196 Business Continuity Plans

Business Continuity Plans have not been received from Physiotherapy, Medical Records and Medical Physics. It was noted that Medical Physics has been given an extension as an exception.

Action: Emma Cooke, Sion O'Keefe, Kathy Ikin

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/216 Patient Story

Cellular Pathology were scheduled to present a patient story but were not in attendance. Sue Bailey will follow up with the department to reschedule.

Action: Sue Bailey/Scott Gable

CDTQSE 19/217 Feedback from UHB QSE Committee 16th April 2019

The minutes of the UHB QSE Committee 16th April 2019 are not yet available.

CDTQSE 19/218 Health and Care Standards

The Clinical Board self-assessments have been submitted and awaiting corporate sign off.

CDTQSE 19/219 Risk Register

The Dietetics risk register has been reviewed. The highest scoring risk of 20 relating to IV access was challenged by Matt Temby. The department was asked to submit their risk assessment against this risk to help understand their rationale for this scoring.

Action: Claire Constantinou/Judyth Jenkins

CDTQSE 19/220 Exception Reports

Sue Bailey reported that there are a cluster of IRMER incidents that have occurred in Radiology. A number of these relate to issues outside the department with the wrong addressograph. Previously, an alert had been placed on the UHB intranet highlighting the implications of placing the wrong addressographs on request forms. The patient attends Radiology and the identification checks match and as the patients are being referred from the same wards/environment they have similar clinical problems so the identification checks and the justifications all match.

Lisa Griffiths has reported that the number of cases where this occurs in Laboratory Medicine are significant and has suggested whether other Clinical Boards should raise this issue in their Quality and Safety Meetings. Matt Temby stated that a collaborative approach needs to be taken to resolving these issues.

Sue Bailey advised that a group will be meeting to look at themes and trends of IRMER incidents and the contributing factors such as the working environment.

An Executive walk round in Outpatients highlighted issues relating to the estate/environment in the department. Sue Bailey and Mike Bourne have also scheduled a visit to the department to look at the environment and facilities.

An SBAR has been received from Blood Sciences relating to specimen labelling incidents. Over the last year these incidents relating to incorrectly labelled specimens, where practically possible, have been captured on Datix reports. The incidents are of no or low harm and are allocated to the appropriate manager of an area to provide a response but usually there is limited or no investigation undertaken. A significant number of these incidents are outside of the laboratory control and are subsequently closed by the laboratory. The time undertaken to capture the incidents on Datix, subsequent management of the incidents and closure is overwhelming both the reporting team and Datix with the risk that more serious incidents are not being reviewed in a timely manner.

The SBAR recommends that these incidents are captured once a month through a data gathering exercise and sent as a batch to the individual Clinical Boards for review at their QSE meetings and captured on Datix as one incident per Clinical Board. This will be assigned to the relevant manager and a patient list will be attached to each incident. This will also highlight the extent of the issue.

The Patient Safety Team has raised concerns with this approach that without individual Datix incidents they could not look at individual patient details, however the details of the individuals are being captured on the LIMS system. There is no risk as clinicians will receive a report from the LIMS system advising them that the sample has not been processed due to a labelling error.

The Clinical Board Regulatory Compliance Group has agreed this process as a way forward for the no and low risk of harm incidents and submitted the SBAR to this Group for ratification. Any incidents that are not low harm will be processed individually through Datix.

The SBAR was **APPROVED** with a caveat that Sue Bailey will provide assurance to the Patient Safety Team that individual cases will be captured through the LIMS system.

Action: Sue Bailey

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/221 Initiatives to promote Health and Wellbeing

Maria Jones is seeking flu champions for the next winter season.

Sue Bailey has received ideas on how the incentive prize could be utilised to benefit the health and wellbeing of staff but it was noted that the monies have not yet been received.

A discussion was held that due to high demand, there is a lack of availability of Next Bikes on the UHW site.

CDTQSE 19/222 Falls Prevention

Nothing to report.

SAFE CARE

CDT QSE 19/223 Concerns and Compliments Report

The Clinical Board's performance against concerns deteriorated in May 2019. 10 formal concerns were received however 33% of these were resolved informally. There were 2 breaches in response times. 9 compliments were received.

Areas to highlight include Outpatients/Patient Administration directorate which reported 2 formal concerns both of which were responded to informally. However the department is reporting 1 breach in response times relating to a concern received in the previous month. 4 compliments were received.

Radiology reported 4 concerns and 1 breach in response times relating to a concern received in the previous month.

Since 1st April 2019, the Clinical Board has received 14 concerns. The issues raised are diverse and there are currently no specific themes to report.

Matt Temby is concerned that the Clinical Board is reporting breaches. He asked for the Radiology department to identify solutions between staff groups in their teams to ensure there are no breaches. Maria Jones to feedback to Health Records that their outstanding response needs to be actioned.

Sue Bailey was pleased at the number of concerns being managed informally.

CDTQSE 19/224 Ombudsman Reports

Nothing to report.

CDTQSE 19/225 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 19/226 Patient Safety Incidents

The SI Report detailing the open SIs within the Clinical Board was **RECEIVED.**

In69239 was submitted to Welsh Government in October 2018 and is awaiting closure.

In82274 relates to a choking episode of a patient. This is currently under investigation.

In88890 relates to a patient who passed away following a neurovascular intervention. This is currently under investigation.

In90956 relates to Triponin incident due to a software coding error affecting the new analysers. A hardware error has also been reported which is being linked to this incident.

In92069 relates to a paediatric overdose. An investigation is underway.

CDTQSE 19/227 New SI's

There are no new SIs to report.

CDTQSE 19/228 RCA/Improvement Plans

There were no RCAs received.

CDTQSE 19/229 WG Closure Forms – Sign Off

There were no closure forms to sign off.

CDTQSE 19/230 Regulation 28 Reports

Nothing to report.

CDTQSE 19/231 Patient Safety Alerts

No Patient Safety Alerts have been received this month.

CDTQSE 19/232 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 19/233 Medical Device Risks/Equipment and Diagnostic Systems

Tony Powell reported that only 50% of staff in the Health Board are trained on the new defibrillators. Concerns have been raised as the new machines cannot be issued until staff are trained and batteries are failing on the old equipment. Areas affected in this Clinical Board include Physiotherapy Outpatients where only 6 out of 21 staff are compliant. X-ray UHL is 33% compliant. Tony Powell will send Sue Bailey the compliance rates for all the areas that require training in this Clinical Board.

Action: Tony Powell

Directorates commented that information on the training sessions has not been widely circulated. Tony Powell will send the training dates to Helen Jenkins to circulate.

Action: Tony Powell

CDTQSE 19/234 IP&C/Decontamination Issues

Maria Jones reported that ANTT training session is being held tomorrow.

CDTQSE 19/235 Point of Care Testing

Nothing to report

CDTQSE 19/236 Key Patient Safety Risks

Safeguarding

Maria Jones reported that the Safeguarding DLM title has changed to Health Lead Practitioner.

If there is an event where criminality is suspected, departments are requested to call the police and let the Safeguarding team be aware.

Safeguarding sessions are being cancelled due to low numbers. There are a lot of changes being made to the training programme and Maria Jones will circulate the details of these changes.

Action: Maria Jones

MCA Act

Nothing to report.

CDTQSE 19/237 Health and Safety Issues

Rachael Daniel reported that the HSE has closed its queries relating to Hafan Y Coed.

No date has yet been confirmed of the HSE audit of the UHB. The audit will focus on MSK and Violence and Aggression however the HSE has looked at asbestos management issues in another Health Board which is outside of scope. The audit will include visits to A&E and Mental Health other areas that will be inspected are not known.

Competencies on ESR have changed for all staff for violence and aggression Modules B&C only needs to be undertaken for patient facing staff. Managers are required to risk assess staff and advise LED of the staff in their areas where modules B&C are not a required competency in order to get the competencies of individuals changed. Managers also need to risk assess and prioritise the staff that require the Module C break-away techniques. This can be linked to the number of incidents in a department relating to violence and aggression. It was noted that training is to be updated every 2 years.

Rachael Daniel will enquire whether it is possible for cascade trainers to be trained in the techniques.

Action: Rachael Daniel

CDTQSE 19/238 Regulatory Compliance and Accreditation

Sue Bailey reported that improvements in the regulatory compliance metrics were noted at the Regulatory Compliance Group.

Concerns were raised around audit compliance in Stem Cell Processing Unit however this is a recording issue as the audits are being undertaken.

There are estates issues in UHL Pharmacy Production Unit which is impacting on the team's performance.

Matt Temby thanked members of the Regulatory Compliance Group for their response to changes in performance management.

Sue Bailey reported that notification has been received from the MHRA that it will be inspecting Pharmacy UHL and Radiopharmacy UHW in the same week at the end of July.

An Internal Audit of governance arrangements in Pharmacy relating to regulatory compliance was undertaken. The outcome was that reasonable assurance was received.

CDTQSE 19/239 Policies, Procedures and Guidance

Decontamination of Ultrasound Transducers Standard Operating Procedure

The UHB Decontamination Group has previously received the procedure and no amendments were requested.

Sue Bailey requested the document is formatted to a consistent font. There were no amendments required relating to the content therefore the procedure is approved subject to formatting. When the document is formatted it will be submitted to the Ultrasound Governance Group.

Action: Sally Lynch

EFFECTIVE CARE

CDTQSE 19/240 Clinical Audit

The Clinical Board Clinical Audit Plan was circulated. Sue Bailey requested for any further additional audits that need to be included in the plan.

Action: All

CDTQSE 19/241 Research and Development

Nothing to report.

CDTQSE 19/242 Service Improvement Initiatives

The Monthly Innovation meeting with Robyn Davies is being held on Friday. Matt Temby encouraged any members of staff with any ideas to attend. He requested attendance particularly from Clinical Engineering staff as they would be able to provide valuable input.

CDTQSE 19/243 NICE Guidance

Nothing to report.

CDTQSE 19/244 Information Governance/Data Quality

An Information Governance incident occurred involving paediatric images that were archived in a facility off site. The images had been destroyed following a flood in the facility and sent for incineration. The level of risk is being investigated and will also determine if this is reportable to the ICO.

DIGNIFIED CARE

CDTQSE 19/245 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Radiology received an unannounced visit from the CHC. The only criticism raised was that the chairs in the waiting area were all the same height.

CDTQSE 19/246 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Sarah Wilcox reported that the Welsh Pharmaceutical Officer has instructed that all Pharmacy professionals are dementia friendly by the end of 2019. Training is taking place for professionals working in Pharmacy across the UHB and this is being well received by staff. Sue Bailey is a Dementia Champion and noted that there are always professionals attending the sessions who are personally affected with a relative or friend with dementia.

Mathew King reported that Podiatry has sensory loss kit available in the department but are unclear on how to use it. Sue Bailey believes the equipment was provided from Action Hearing Loss but will visit the team as she may be able to help set this up.

Action: Sue Bailey

CDTQSE 19/247 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/248 Equality and Diversity

Sue Bailey attended the After Thought session which provided training on equality and diversity using actors to deliver scenarios of real life examples. She noted that the session was engaging. The key learning was around the need to challenge poor behaviour.

TIMELY CARE

CDTQSE 19/249 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/250 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Radiology waiting lists are being well maintained. Therapies are reporting 0 breaches.

CDTQSE 19/251 Delayed Transfers of Care

The Delayed Transfer of Care Report for May was **RECEIVED.**

It was noted that escalations for MRI are now being submitted directly to the service.

INDIVIDUAL CARE

CDTQSE 19/252 National User Experience Framework

The feedback report for May was **RECEIVED**. It was pleasing to note that 100% of users felt they were greeted with a friendly manner. 96% stated they had enough seating and the waiting area was clean and tidy.

Excellent feedback and comments were received on the care provided by staff.

The majority of concerns raised relate to car parking. It was noted that a Park and Ride Scheme for UHL will be implemented in July. Sion O'Keefe is looking at including information on the park and ride in patient letters.

STAFF AND RESOURCES

CDTQSE 19/253 Staff Awards and Recognition

Nothing to report.

CDTQSE 19/254 Monitoring of Mandatory Training and PADRs

The Workforce and OD Team are undertaking work to improve PADR compliance across the Clinical Board.

The UHB is changing its approach to recruitment and appraisals, moving to values based frameworks.

The Clinical Board is currently reporting reasonable compliance against mandatory training.

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

The following minutes were **RECEIVED:**

Biochemistry Quality Group Minutes May 2019
Clinical Board Regulatory Compliance Group Minutes May 2019

ANY OTHER BUSINESS

Nothing to report.

DATE AND TIME OF NEXT MEETING

10th July 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 JULY 2019

Present:

Matthew Temby (Acting Chair)	Clinical Board Director of Operations
Mike Bourne	Clinical Board Director
Robert Bracchi	Consultant, AWTTC
Scott Gable	Head of Laboratory Services, Cellular Pathology
Mathew King	Head of Podiatry
Lesley Harris	Professional Head of Radiography UHL
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Judyth Jenkins	Head of Dietetics
Bolette Jones	Head of Media Resources
Maria Jones	Senior Nurse, Outpatients
Sarah Jones	Quality Lead, Pharmacy

Apologies:

Sue Bailey	Clinical Board Director of Quality, Safety and Patient Experience
Alun Morgan	Assistant Director of Therapies and Health Sciences
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Lisa Griffiths	Quality Manager, Laboratory Medicine
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Rachael Daniel	Health and Safety Adviser
Suzie Cheesman	Patient Safety Facilitator
Rhodri John	Operational Support Service Manager
Emma Cooke	Head of Physiotherapy

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/255 Welcome and Introductions

Matt Temby welcomed everyone to the meeting.

CDTQSE 19/256 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 19/257 Approval of the Minutes of the Last Meeting

The minutes of the meeting held on 12th June 2019 were **APPROVED.**

CDTQSE 19/258 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 19/177 Risk Registers

The Outpatients risk register has been reviewed and is being finalised.

The Therapies and AWTTC risk registers are under review. A timeframe of when these will be completed to be sent to Helen Jenkins.

Action: Judyth Jenkins/Robert Bracchi

It was noted that the Laboratory Medicine risk register requires significant work as Laboratory Genetics no longer sits in this Clinical Board and their risks will need to be removed from the Laboratory Medicine risk register. Lisa Griffiths to provide an indicative timeframe for when this work will be completed.

Action: Lisa Griffiths

CDTQSE 19/196 Business Continuity Plans

Physiotherapy, Health Records and Ionising Radiation are still outstanding. The Clinical Board is aware that there are complications relating to Ionising Radiation business continuity that need addressing. Maria Jones was asked to follow up on the Health Records plan with Keeley Baker and Judyth Jenkins to follow up on the Physiotherapy plan with Emma Cooke.

Action: Maria Jones/Judyth Jenkins/Keeley Baker/Emma Cooke

CDTQSE 19/217 Cellular Pathology Patient Story

Scott Gable to arrange a date to present a patient story with Helen Jenkins.

Action: Scott Gable

CDTQSE 19/219 Dietetics Risk

The risk assessment relating to the item scoring 20 the dietetic risk register has been reviewed and the score has been updated to 16. Judyth Jenkins to send the revised risk register with the new scoring to Helen Jenkins.

Action: Judyth Jenkins

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/259 Patient Story

Bolette Jones presented on an incident involving a Clinical Photographer at UHL who provides cover in the studio every day and essentially works alone. Leaving work she was approached by a patient visibly upset who requested to use her mobile phone. She overhead that patient say that she was going to attempt to take her life. She had been discharged from Mental Health Poisons Unit as she was considered fit and well however the patient did not want to be discharged and had refused to leave the unit. Security had been called to remove her from the department. The photographer called for assistance from the ward but they advised they could not assist. The photographer had assumed that the ward would send someone and take over the care of the patient. She then contacted security and stayed with the patient until they arrived. The photographer later asked herself if she could have done anything more. Her managers advised her that she had done everything possible and was offered support. The Safeguarding Team also confirmed to her that there was nothing further she could have done, however they advised the team to ensure they are up to date violence and aggression training as the situation could have been very different.

Judyth Jenkins advised that a similar issue occurred to a dietitian who encountered a patient in a distressed state after discharging themselves and was left alone to address the situation as the ward refused to collect the patient and return the patient to the ward.

Matt Temby commented that the question should be asked of where does responsibility lie, particularly when a patient discharges themselves. He acknowledged that patients have the right to self-discharge but he is concerned that the ward areas from where the patients originated are not re-instigating care and management of the patient. He suggested that these stories need to be shared with other Clinical Boards and will ask Sue Bailey to share them with her colleagues in the other Clinical Boards.

Action: Sue Bailey

Matt Temby thanked the members of staff involved in these cases for their intervention and for demonstrating the values of the Health Board.

CDTQSE 19/260 Professional Concerns Presentation

The presentation from Gareth Edgell, Safeguarding Team has been deferred to a future meeting.

CDTQSE 19/261 Podiatry Walk-in Clinics Presentation

Matt Temby welcomed Vanessa Goulding, Highly Specialised Podiatrist to the meeting.

Diabetes is on the increase and has resulted in a significant increase in the number of patients referred to Podiatry. Diabetic foot care accounts for 1% of the NHS

England budget. 25% of all patients with diabetes will have a diabetic foot ulcer in their lifetime. More than 1 in 10 result in amputation. 80% are avoidable.

Patients who present late to a specialist are more likely to have an amputation. Rapid access clinics have been set up but there are patients who delay in coming forward and delays often lead to chronic larger deeper foot ulcers and ultimately are more difficult to treat.

The National Diabetes Footcare Audit (NDFA) enables services to measure their performance against NICE guidelines and peer units and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease. The UHB has participated in this since 2014.

The NDFA Quality Improvement Collaborative looked at improvement projects to develop local quality improvement programmes, develop skills to increase quality of care and share lessons. Cardiff and Vale UHB proposed for a walk in clinic to be set up twice weekly which allows patients access to a healthcare professional with the competent skills to direct care as necessary. The walk-in clinics commenced at the end of November 2018 with a pilot in one locality. Inclusion criteria included acute diabetic foot emergencies and excluded general care podiatry or MSK problems. Active empowerment, patient responsibility and co-production are key parts of the management plan.

In February 2019 the initiative was spread across the whole of Cardiff and Vale. The clinics are promoted on screens in GP waiting rooms and infographic has been produced for patients. Prior to the set up of the walk-in clinics, 65.6% of patients waited longer than 3 days to receive their first expert assessment. 15.6% waited greater than 14 days. More patients are now self- presenting with an increase of 62% being reported. 52% attending had a diabetic foot ulcer. 17% were not appropriate.

The aims of the walk-in clinics are:

- Reduce the interval to the first expert assessment.
- Reduce the severity of ulcers.
- Reduce emergency admissions.
- Reduce amputations and other complications.
- Increase patient activation to access when necessary.
- Upskilling the wider team.
- Improving care pathways.

Lessons learnt from the service improvement include:

- The importance of patient activation, empowerment and personal responsibility.
- There is still work to be undertaken around patient education.
- The need for clinicians to apply criteria consistently.
- Flexibility with clinical space and job plans on walk-in clinic days**.**
- Availability of follow up appointments.
- The need to ensure the service is publicised and that patients are aware when clinics are cancelled at Bank Holidays.

- The service does not currently capture how long patients have had their wound prior to attendance and this would be useful.

The service improvement will be presented in January next year at the NDFA Collaborative showcase event.

Further improvements will be explored around antibiotic prescribing, casting and vascular imaging. There is also the potential for roll out for other foot wounds.

It was noted that an economic analysis of the current pathway in Cardiff and Vale has not been undertaken to demonstrate value for money. Robert Bracchi will ask the Clinical Director for AWTTC if there is any expertise in the directorate to assist in this analysis and to request that he makes contact with Mathew King, Head of Podiatry.

Action: Robert Bracchi

Matt Temby thanked Vanessa Goulding for attending. Mathew King will circulate the presentation slides.

Action: Mathew King

CDTQSE 19/262 Feedback from UHB QSE Committee 23rd April 2019

The minutes of UHB QSE Committee held on 23rd April 2019 were **RECEIVED.**

CDTQSE 19/263 Annual Quality Statement

The UHB Annual Quality Statement document was **RECEIVED.** It was pleasing to note that Therapies were well represented in the document and the Media Resources 'Show me Where' tool was referenced. The Clinical Board will need to consider how the laboratories can be better represented in future documents.

CDTQSE 19/264 Health and Care Standards

The Media Resources Annual Quality, Safety and Patient Experience Report was **RECEIVED.** The paper outlines the directorate's key achievements and performance against the health and care standards.

It was noted that the department is reverting to its former name as the Medical Illustration department to reflect the fact that it is now a sole NHS department providing clinical support and a diverse range of services to the UHB. A new departmental identity is being produced.

CDTQSE 19/265 Risk Register

Nothing further to report.

CDTQSE 19/266 Exception Reports

SBAR Blended Diet for Tube Fed Patients at Cardiff and Vale UHB

There is a growing body of clinical evidence that a blended diet via enteral feeding tubes is better for a child's health and condition and there are an increasing number of requests by parents and carers to administer Blended Diet Tube Feed (BDTF). Current the UHB's position is that BDTF cannot be provided safely in the hospital setting as the tubes are not designed for this.

A multidisciplinary group is looking at the process of using hospital food and blending it and establishing what food can be administered down the tubes without causing a blockage. The dietitian responsible for devising the feeding regime must ensure that a full risk assessment has been undertaken for each individual patient and ensure only hospital food is being utilised.

Judyth Jenkins will feed back to this meeting when a safe process and solution has been agreed.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/267 Initiatives to promote Health and Wellbeing

Lunchtime walks for staff have been implemented in Cellular Pathology.

AWTTC staff are participating in the Cosmeston lake race.

Podiatry staff are to receive resilience training. Also within Podiatry a new format has been introduced using Skype for 1:1 clinical supervision to avoid staff travelling from across sites.

Sian Jones, Assistant Head of Workforce and OD is now a Time to Change Champion and is considering how to approach mental health issues and support for staff. Anxiety and depression is the top sickness reason being reported within this Clinical Board.

CDTQSE 19/268 Falls Prevention

Nothing to report.

SAFE CARE

CDT QSE 19/269 Concerns and Compliments Report

There has been no improvement in the Clinical Board's performance against concerns in June 2019. The Clinical Board reported 5 formal concerns, 3 breaches and 8 compliments. No concerns were resolved informally.

Areas of concern are:

Laboratory Medicine which reported 1 formal concern and 1 breach.

Radiology reported 1 formal concern and 2 breaches however it has received 4 compliments.

Physiotherapy reported an improvement in performance this month with 0 concerns, 0 breaches and 2 compliments.

Media Resources continues to report good performance with 0 concerns, 0 breaches and 2 compliments.

Matt Temby requested that any directorates having difficulties or issues in responding to concerns to notify the Clinical Board.

CDTQSE 19/270 Ombudsman Reports

Matt Temby reported that a report was requested in Laboratory Medicine for expert opinion and a well-constructed response has been provided.

CDTQSE 19/271 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 19/272 Patient Safety Incidents

The SI Report detailing the open SIs within the Clinical Board was **RECEIVED.**

In692939 was submitted to Welsh Government in October 2018 and is awaiting notification of closure.

In82274 relates to a choking episode of a patient and is currently under investigation.

In88890 relates to a patient who passed away following a neurovascular intervention. This is currently under investigation.

In92069 relates to a paediatric overdose and an investigation is underway.

CDTQSE 19/273 New SI's

Matt Temby provided an update on the incidents relating to Troponin and the issues with the new analysers. The Clinical Board is working closely with company to resolve the issues. There could potentially be up to 30 patients that will need to be reviewed.

CDTQSE 19/274 RCA/Improvement Plans

Nothing to report.

CDTQSE 19/275 WG Closure Forms – Sign Off

There were no closure forms to sign off.

CDTQSE 19/276 Regulation 28 Reports

Nothing to report.

CDTQSE 19/277 Patient Safety Alerts

No Patient Safety Alerts have been received this month.

CDTQSE 19/278 Addressing Compliance Issues with Historical Alerts

There are no issues to be addressed.

CDTQSE 19/279 Medical Device Risks/Equipment and Diagnostic Systems

Tony Powell, the Medical Device Safety Officer was not present.

CDTQSE 19/280 IP&C/Decontamination Issues

It was reported that fungal growth was identified in the Radiopharmacy production area. A full clean has been undertaken and corrective action undertaken by Estates. This was an isolated occurrence.

Cleaning for Credits has been implemented in Radiology and Lesley Harris is participating in the walk rounds. Rooms where interventional work is undertaken are being re-categorised to reflect the higher level of cleaning standards required.

CDTQSE 19/281 Point of Care Testing

Mike Bourne and Matt Temby are meeting with the Medical Director to discuss how this will be managed.

CDTQSE 19/282 Key Patient Safety Risks

Safeguarding

The next UHB Safeguarding Group will be held next week.

MCA Act

Nothing to report.

CDTQSE 19/283 Health and Safety Issues

Lesley Harris reported that there has been movement of antenatal into a new location where the environment is excessively warm. Pipes in the room are not lagged and the air conditioning is out of order. Excessive heat will damage the ultrasound probes however the work required by Estates to address this is not being progressed. Matt Temby advised Lesley Harris to write to Gareth Simpson in Estates. He has been assisting the Clinical Board on other estates issues.

Action: Lesley Harris

CDTQSE 19/284 Regulatory Compliance and Accreditation

Matt Temby escalated issues raised at the Clinical Board Regulatory Compliance Group in July.

Action Plans to improve compliance against the metrics were requested and these have been submitted.

The MHRA is inspecting Radiopharmacy UHW week commencing 22nd July. This will be a challenging inspection. The MHRA is also visiting Pharmacy UHL during this same week. Pharmacy UHL is demonstrating that controls are in place.

CDTQSE 19/285 Policies, Procedures and Guidance

Chaperone Policy

The All Wales document is now including breast examinations as part of intimate examinations. This poses a staffing issue in Radiology as chaperones are now required for mammography. Lesley Harris was advised to write to Clare Wade in Surgery Clinical Board as this is a chaperoning issue in the Breast Unit.

Action: Lesley Harris

The policy also raises an issue for Medical Photography as lone working in undertaking breast photography occurs in the studio. The directorate must put measures in place to protect staff and therefore patients coming from a ward will now require a chaperone to accompany them.

The question was raised whether the UHB should provide chaperone training. Lesley Harris to discuss with Lisa Franklin.

Action: Lisa Franklin

EFFECTIVE CARE

CDTQSE 19/286 Clinical Audit

Nothing to report.

CDTQSE 19/287 Research and Development

It was noted that the administrative post to support R&D in Radiology is now out to advert.

CDTQSE 19/288 Service Improvement Initiatives

Nothing to report.

CDTQSE 19/289 NICE Guidance

Nothing to report.

CDTQSE 19/290 Information Governance/Data Quality

James Webb, Information Governance Manager was welcomed to the meeting. GDPR was implemented on 25th May and the Information Governance department aims to support Clinical Boards with this.

The NHS Number is considered personal data. Anonymised data and data relating to the deceased is not subject to GDPR.

Where suppliers are enlisted to process data on behalf of the UHB, a data processing contract is legally required. If processing is likely to result in a high risk, a Data Protection Impact Assessment is also legally required. Departments are advised to engage with the Information Governance department at the start of any project.

There are gaps within information asset registers particularly in relation to recording what personal data is being processed on PCs. A template is available on the Information Governance web page and James Webb offered his assistance in completing this if required.

Subject Access Requests are a legal request and are to be responded to in a 30 day timeframe and are free of charge. They can be requested by any mechanism and need to be actioned promptly however there are exemptions. Directorates to contact the Information Governance department for advice.

Information Governance breaches must be reported on Datix within 24 hours. In most cases notification to the ICO is not required, but where this is the case, notification must be made within 72 hours. Fines for data breaches can be significant.

Freedom of Information Requests have to be responded to in 20 working days. If there are concerns that an exemption applies, directorates to contact the Information Governance department for advice.

DIGNIFIED CARE

CDTQSE 19/291 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Radiology UHW is awaiting feedback from the unannounced CHC inspection.

CDTQSE 19/292 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

CDTQSE 19/293 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/294 Equality and Diversity

Mathew King asked whether there should be bariatric chairs in every waiting area in Podiatry. It was advised that if the department is aware of a patient attending that requires a bariatric chair to ensure there is provision and request support from the Manual Handling team if required.

TIMELY CARE

CDTQSE 19/295 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/296 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

There were 0 breaches reported across all Therapies for June and 17 for Radiology.

CDTQSE 19/297 Delayed Transfers of Care

The Delayed Transfer of Care Report for June 2019 was **RECEIVED.** There are no issues relating to this Clinical Board.

INDIVIDUAL CARE

CDTQSE 19/298 National User Experience Framework

It was reported that very positive comments were received for Outpatients and Radiology in the latest feedback report.

STAFF AND RESOURCES

CDTQSE 19/299 Staff Awards and Recognition

Matt Temby encouraged nominations for the Clinical Board Staff Recognition Scheme as it is important to recognise the good work being undertaken by staff.

CDTQSE 19/300 Monitoring of Mandatory Training and PADRs

A Clinical Board survey is being undertaken around PADRs to try to improve compliance. Staff are encouraged to complete this.

Fire training compliance needs to be improved across the Clinical Board.

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

The following minutes were **RECEIVED:**

Biochemistry Quality Group Minutes June 2019
Clinical Board Regulatory Compliance Group Minutes June 2019

ANY OTHER BUSINESS

Nothing to report.

DATE AND TIME OF NEXT MEETING

14th August 2019 at 2pm in Room 1.13 1st Floor Ty Dewi Sant UHW

MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE
20th June 2019
SEMINAR ROOM, LLANDOUGH HOSPITAL

Present: Jayne Tottle, Director of Nursing Mental Health (Chair)
Annie Procter, Clinical Board Director, Mental Health
Ellen Davies, ACNS, Infection Prevention and Control
Claire Humphries, Safeguarding Nurse Advisor
Neil Jones, Clinical Director Adult MH
Robert Kidd, Consultant Psychologist

Apologies: Jayne Bell, Lead Nurse Adult Mental Health
Carol Evans, Assistant Director of Patient Safety & Quality
Catherine Evans, Patient Safety Facilitator
Mark Doherty, Lead Nurse MHSOP/Neuro
Mark Jones, Directorate Manager Adult Mental Health
Jenny Pinkerton, Occupational Therapist Clinical Lead
Mick McGeoch, Clinical Audit Co-ordinator
Ian Wile, Head of Operations & Delivery Mental Health
Jo Wilson, Directorate Manager MHSOP
Norman Young, Nurse Consultant

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting.

1.2 Apologies for Absence

Apologies for absence were noted.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on 18th April 2019 were accepted as an accurate record.

1.4 ACTION LOG/MATTERS ARISING

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

NICE Guidance

Neil Jones said the a response had been sent for the NICE guidance regarding Bi-Polar but the Peri-natal guidance was outstanding.

Annie Procter said she would ask Mick McGeogh about the process for NICE Guidelines and she would then complete a flow chart showing the process. **Action: Annie Procter**

OCD Treatment Pathway

Rob Kidd said that he would share the draft pathway with Neil Jones.

Rob also said that 'OCD Action' may approach Linda Newton of CAVAMH regarding linking with the Partnership Board.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 UHB Quality, Safety and Experience Committee

The Chair noted the Minutes of the UHB Quality, Safety and Experience Committee meeting dated 16th April 2019:

MENTAL HEALTH SERVICES FOR OLDER PEOPLE -IN-PATIENT CARE IMPROVEMENT PROJECT THROUGH ALOS REDUCTION

Ian Wile and Jayne Tottle 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. 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.

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.

HEALTHCARE INSPECTORATE WALES (HIW) ACTIVITY UPDATE

Visit to Vale Locality Mental Health Team: Feedback was largely positive and there were no immediate assurance issues.

A visit to Mental Health Services at Hafan Y Coed during week commencing 18 March 2019. It was noted that feedback was very positive with no immediate assurance issues.

PATIENT KNOWS BEST

Neil Jones noted the Surgical Clinical Board's patient story that was entitled *'Patient Knows* Best':

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.

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.

2.2 Health and Care Standards

Jayne Tottle will update at next meeting.

2.3 Regulatory compliance and external accreditation

Vicky Cartwright, Royal College of Psychiatrists is presenting CCQI accreditation networks to Senior Team on 13th August 2019.

2.4 Risk Register

Rob Kidd said the issue regarding Global Link and CMHT accommodation was discussed at Senior Team meeting. Jayne Tottle will ensure that CMHT accommodation at Global Link is on the risk register. **Action: Jayne Tottle**

2.5 Directorate QSE Groups

The **ADULT DIRECTORATE QUALITY & SAFETY** Minutes dated 23rd May 2019 were noted:

Vale Locality CMHT

Extra support measures are in place and weekly meetings are held to support the team. Screening and discharging of patients is on-going.

Clozapine

Clozapine patient needing daily FBC over the weekend. It is a rare event but there needs to be a procedure, Vicki Gimson, MH Pharmacist is looking into this.

The **MHSOP/NEUROPSYCHIATRY QUALITY & SAFETY -** Minutes dated 13th May 2019 were noted:

Physical Healthcare for MHSOP patients

Dr Turic expressed that on occasions when the GPs are not available, St Barrucs don't always have access to SHOs or emergency response - 2222 process. It was suggested that the SHO's are made aware of the protocol during their induction.

Improvement Action Plans

A discussion took place regarding the REACT review, they are not defined as a crisis service. The REACT team need to decide if they want to be a high intense treatment team or a crisis team. Further discussions will be held.

The PSYCHOLOGY & COUNSELLING QUALITY & SAFETY – Minutes dated 3rd April 2019 were noted:

Interface issue with PMHSS and CMHTs. Martin Harper, Jane Boyd and Julian Willett are meeting to discuss.

Links CMHT–Portakabins are erected in the car park due to flooding in the building.

Rob Kidd reported a number of staff within Clinical Health were nominated for Staff Recognition Awards. Nominees were **:** Anna Mcculloch (Research and Development); Julie Highfield (Leadership); Catherine O'Leary (Leadership); Richard Cuddihy (Manager of the Year). Additionally, Rookwood Spinal Injuries Rehab Unit with two psychologists Jenny Moses and Susanna Moss (Living Our Values).

RK confirmed that Emily Hill was runner up under category of Education & Development.

June Meeting:

Rob Kidd fed back on the meeting regarding Vale Health & Wellbeing Hub at Barry Hospital.

CAMHS now falls within Cardiff & Vale UHB. There had been a discussion to ensure quality and safety. Invite Psychologists from CAMHS to Psychology & Psychological Therapies Directorate Q&S meeting.

Presentation – PMHSS regarding developing in-house software package to record pre and post group measures.

Outlook Calendar. Query on the length of time of retention of outlook calendar data as staff may need to refer to a diary from a few years ago. Neil Jones will ask Mark Cahalane.

Action: Neil Jones

PHARMACY

No report.

MENTAL HEALTH ACT

No report.

INFECTION, PREVENTION & CONTROL (IP&C)

Ellen Davies carried out joint audits at Meadow and Daffodil Wards in Llanfair Unit and St Barrucs, Barry Hospital in May 2019. All wards did really well.

There will be Visits to Phoenix Community and Park Road to offer any support required.

MHSOP's cleaning credit had improved due to a temporary increase in housekeeping hours. Jo Wilson is in discussions with housekeeping regarding cleaning hours. Jayne Tottle will contact Housekeeping. **Action: Jayne Tottle**

SAFEGUARDING

Claire Humphries said that she was delivering WRAP training sessions (Workshops to Raise Awareness of Prevent) which would be rolled out to Mental Health Services.

PHW Safeguarding Audit

This is on-going.

PARIS

Claire said that there will shortly be a "safeguarding box" on PARIS which can be used to insert information, e.g. if there is a POVA in existence. Claire urged everyone to look at this box before visiting the patient.

Safeguarding Supervision

Claire requested identification of anyone who requires safeguarding supervision or one to one. Jayne Tottle suggested that Claire contact Norman Young, Nurse Consultant, Early Episode Psychosis Service.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

3.1 Initiatives to promote health and wellbeing

Jayne Tottle met with Nic Evans and OT to discuss how to support the initiative of staff accessing support for wellbeing as 'stress' being the highest cause of staff sickness followed by MSK.

SAFE CARE

4.1 SIs

Jayne Tottle said there had been an increase in SI over the last few weeks. Other Health Boards had also seen an increase.

Improvement Plan

SM inquest is being held at the end of June 2019:

- Issue with en-suite shower doors which have been replaced with collapsible doors.
- Review of whether the paper observation sheet may be replaced with an electronic device. The Directorate Manager is considering this.

- Maintenance Contracts or the Salto and ROS system.
  There is now a 24 hour maintenance package in place for the ROS system. Arrangements are in place to re-boot each SALTO system to ensure it is recording the correct date and time.
- Staff have been reminded that they can refer patients to EDAS. There are posters on all wards now to remind staff.
- Development of a Frequent Attendee alert. PARIS should have a line alerting that the patient has been admitted frequently. Jayne Tottle said that the new post of Consultant Nurse for Complex Clinical Risk Management in Mental Health could look at this - Action Jayne Tottle.
- Review CPA1a within 72 hours of transfer from Crisis Ward. System being developed to audit compliance.
- Train in-patient qualified staff on Brief Motivation Enhancement. This is being delivered by Will Adams, Practice Development Nurse.
- Support for patients who have lost contact with their children. Benchmark how other services manage similar cases. Claire Humphries, Safeguarding Nurse Advisor, would advise.
- Staff to be aware that the application of Section 3 may increase a patient's level of hopelessness. This is now covered in WARRN training.

4.2 Patient Safety

No report.

4.3 Key Patient Safety Risks

There had been 3 incidents of pressure damage in MHSOP, which was unusual for that service.

EFFECTIVE CARE

5.1 Crisis Care Concordat

Jayne Tottle referred to the Concordat agreement with the South Wales Police. We are 85-90% compliant.

5.2 Research & Development

Chair informed the Group that Professor Jonathan Bisson was now the R&D Lead for the Clinical Board.

Annie Procter informed the Group that a UHB Research & Development Conference was being held on 15th October 2019 in Cardiff City Stadium.

Rob Kidd informed the Group that the trial of Multi-Modular Motion-assisted Memory Desensitisation and Reconsolidation (3MDR) therapy (treatment for military veterans with treatments resistant PTSD) ends in July 2019.

DIGNIFIED CARE

6.1 Visits

CHC visited Beech, Elm, Oak and Willow Wards in January to March 2019:

- CHC highlighted the practice of patients sleeping out on different wards. The Clinical Board accepted that this was far from ideal and the decision to ask someone to sleep on another ward is only made at times of unplanned admissions or when a patient returns unexpectedly

from home leave. Senior Nursing staff undertake risk assessments to determine which patient to ask to sleep out; it would ordinarily be a patient who is ready for discharge. These decisions are made within the framework of the "Adult In-patient Services Sleeping Out Guidance".

- CHC also highlighted that the condition of the communal gardens could be improved. There is no contract for maintaining the garden but we do use voluntary services such as the Probation Service when available.

- CHC requested assessment of the food menu. Jayne Tottle had met with catering staff and the menu has been revamped. Breakfast options are now healthier.

- The missing television remote controls on Oak Ward have been replaced.

- CHC requested reassess the programme of activities. There is an Activities Team. The Manager will review the activities and make changes where applicable.

CHC made an unannounced visit to East Wards 14 & 16 on 16th June 2019. Verbal feedback is very good.

HIW visited Vale Locality CMHT. The report has not been received to date.

6.2 Signage

Heather Hancock, Deputy Directorate Manager, had made Hafan y Coed Ward signs clearer by putting labels next to each leaf.

TIMELY CARE

7.1 Mental Health and Primary Care

Primary Care Home Liaison Services – independent prescribers now run clinics.

Annie Procter is meeting with Mel Jefferson in September, along with MSHOP, to discuss the pathway for dementia sufferers and end of life palliative care.

7.2 Targets

PMHSS Part 2 target measure has been off target due to vacancies in the team but plans are in place to get back by July.

INDIVIDUAL CARE

8.1 Feedback from Surveys

In May 2019 MHSOP received 100%; Adult Community 80% and Adult In-patients 58%.

8.2 Compliments

Compliments received for:

MHSOP and Neuropsychiatry – Plaudits May 2019.

Sue Miles, Hazel Ward – thank you letter from a student.

Complaints

A complaint had been made to the Ombudsman from a parent about the care and treatment provided to her son. The ombudsman upheld two out of the ten complaints:

- It was clear that the discharge plan was not sufficient as the patient would have been homeless upon discharge from hospital, therefore, it was agreed that the patient would remain in hospital until suitable accommodation was sought. The ombudsman said the confusion around the possible discharge caused distress and frustration for the complainant and was unsettling for the patient.

- The complainant said that the Health Board had taken an unreasonable amount of time to respond to her complaint. The Ombudsman did not consider that the complainant was kept reasonably informed of the delay in responding therefore upheld this complaint and the Health Board should make a payment of £125 for the inconvenience caused by the delay.

STAFF AND RESOURCES

9.1 Disciplinary Trends

No report.

9.2 Staffing Levels

Student streamlining for Cohort 16: 27 Band 5 for Adult MH and 11 for MHSOP.

Nurse Recruitment Event on 22nd June in UHW.

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

10.0 Extra Care Area and Low Stimulus Room Procedure for Hafan y Coed

This procedure sets out the appropriate and safe use of Extra Care Areas and Low Stimulus Rooms within Hafan y Coed.

THE PROCEDURE WAS APPROVED.

10.1 Valproate

The proposed questions for legal advice regarding the non-prescribing of contraception for female patients of child bearing age prescribed valproate were noted.

10.2 MDR and IVDR Regulations

The Medical Equipment Group (MEG) from the Cardiff and Vale University Health Board's response to a letter sent by Rob Orford, Welsh Government, on 28th January 2019 was noted.

10.3 Segregation in MH Wards

The Care Quality Commission's Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability or autism had been circulated.

It was noted that Annie Procter had attended Autism training for Mental Health staff last year.

Rob Kidd suggested contacting Rona Aldridge, Integrated Autism Clinical Lead, for basic skills training. Jayne Tottle to liaise with Darren Shore, Lead Nurse Adult MH regarding contacting Rona about the training. **Action Jayne Tottle**

DATE OF NEXT MEETING

Thursday, 15th August 2019 at 9.30am in The Seminar Room, Hafan y Coed.
(next Clinical Board Q&S Lessons Learned Meeting is on 18th July 2019 in the Seminar Room, Hafan y Coed)

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

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE held at 1.30 pm, 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.	**HE**

	Page 4 Patient Flow: Agenda item 28.3. 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	**All**

	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. 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.	**RA**

	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 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 review 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***	

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

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE GROUP held at 1.30 pm, 17th July, 2019 in Coed y Bwl Meeting Room, Woodland House

Present

Gareth Hayes (GH) (**Chair**)	Clinical Director, Clinical Governance
Anna Mogie (AM)	Lead Nurse, North and West Cardiff
Denise Shanahan (DS)	Nurse Consultant
Gneeta Joshi (GJ)	Community Director, Clinical Governance
Helen Donovan (HD)	Senior Nurse, Vale Locality
Kay Jeynes (KJ) (Vice Chair)	Director of Nursing PCIC
Matthew McCarthy (MM)	Patient Safety Facilitator
Mel Lewis (ML)	Lead Nurse, Palliative Care
Nicky Hughes (NH)	Lead Nurse, S&E Locality
Rachel Armitage (RA) (Minutes)	PCIC Quality and Safety Manager
Rebecca Williams (RW)	Assistant Head of Workforce
Sarah Griffiths (SG)	Head of Primary Care Contractor Services
Vince Saunders (VS)	Infection Prevention and Control Nurse

By invitation

Ann Yates	Director of Continence Service
Julie Loxton	Lead Nurse, Communications Hub
Karen Kitschker	Occupational Therapist, North and West Locality

Apologies

Clare Evans (CE)	Head of Primary Care
Denise Shanahan	Consultant Nurse
Karen May (KM)	Head of Medicines Management
Lisa Dunsford	Director of Operations
Helen Earland (HE)	Senior Nurse PC
Theresa Blackwell (TB)	Business Manager
Rebecca Williams (RW)	Assistant Head Of Workforce (representing Nicola Evans)
Stuart Egan (SE)	Trades Union representative

Preliminaries		**Action**
07/19/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Chair.	
07/19/002	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
07/19/003	**DECLARATIONS OF INTEREST** GH asked for any declarations of interest – none noted.	
The agenda was re-ordered		

07/19/004 (Agenda item 6)	**PREVENTING URINARY TRACT INFECTIONS TRAINING AND INFORMATION SUPPORTING GUIDE FOR STAFF** Ann Yates was welcomed to the meeting and provided a presentation on a resource that has been developed for professionals to guide on the management of urinary tract infections (UTIs) and *E. coli,* document is available - see pages of the CavWeb intranet site and is expected to be uploaded to the Primary Care pages. It was highlighted that the guidance relates mainly to older people and represents a change in practice from use of dipsticks leading to over-use of antibiotics to working from signs and symptoms to inform the management plan. It was noted that Nursing Homes in the Vale of Glamorgan will pilot the assessment form for older people, supported by algorithms on management of catheter blockage. The following was discussed: • The increase in the incidence of *E. coli* in the first two months of the current financial year, noting that it was hoped that the new guidelines will assist in improving that position • Potential cost savings across the health system, noting that these have not yet been measured • It was confirmed that the laboratory service has approved this approach, noting that laboratory representatives had been involved in developing the guidance. It was highlighted that this was one of two pieces of work regarding sample management, the other relating to the transportation of pre-analytical samples. • Advice on the removal of in-dwelling catheters; it was confirmed that the guidance is regularly updated so practitioners should always check the most up to date version for this element. **PATIENT STORY: CONTINENCE SERVICE** AY shared the story of a 42-year old female patient with a spinal injury which had led to bladder and bowel insufficiency who had been referred to the Continence Service for support with intermittent self-catheterisation and peristeen for bowel management. She had been admitted to hospital twice with a suspected myocardial infarction and pneumonia and on both occasions had been fitted with an in-dwelling catheter. The secondary care service had sought and followed advice from the Continence Service and the patient had achieved good results. The outcome themes were that the patient was happy with the service which had provided the right treatment by the right people at the right time. It had also demonstrated that good communication across all sectors of care is vital, and in particular that there are key people in specialist care who can offer a continuous service as patient circumstances change. AM highlighted the important point that anyone who self-catheterises is at risk of harm when they are admitted to hospital.	

	The QSE Group **noted** the guide and the patient story.	
07/19/05 (Agenda item 20.1)	**AUSTRALIAN THERAPY OUTCOME MEASURES (AUS-TOMS) FOR OCCUPATIONAL THERAPY** Karen Kitschker was welcomed to the meeting to provide an update on the use of Aus-Toms, noting that good compliance with inputting into the PARIS system had supported the audit. Evaluation had included both South and East and North and West Locality CRT's to accommodate the cross-cover of both areas by the therapy staff; a separate report had been developed for the Vale of Glamorgan. KK described the parameters of the measures used, highlighting that they are both qualitative and quantitative, evidence based and recognised as reliable. KK summarised the data presented graphically and noted that it is seen as positive that many patients maintain condition as it indicates that they are not deteriorating or being admitted to hospital. It was emphasised that many co-morbidites exist behind the falls data. It was highlighted that the Vale data demonstrates a variation in performance; work is under way to review the consistency of measurement by therapists and the acuity and complexity of the patient cohort. It was noted that therapists focus their work on improving activity levels for the patient; the data demonstrates a good range of improvement. It was noted that the rate of well-being may indicate a lot of maintenance; this can be understood as positive as the patient may have had a good level of activity originally which has not deteriorated. The report also includes a measure of well-being for the carer. There is a limited amount of data on this element and work is required to highlight this as in important outcome; while it may not be possible to improve the patient's situation it may be possible to improve the way that a carer feels supported. KJ highlighted that it was important to share this outcome data with the Executive team, noting that the numbers of people who had maintained represented a celebration of the work done. There was discussion on the need to consider the skill mix, noting that evidence demonstrates that there is quicker patient improvement when higher-level decision-makers are closer to the patient. The QSE Group **noted** the update.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
07/19/006 (Agenda item 4)	**MINUTES OF THE PREVIOUS MEETING HELD ON 14TH MAY, 2019** The minutes of the previous meeting were approved as an accurate record.	
07/19/007 (Agenda item 5)	**PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE GROUP ACTION LOG**	

	The Clinical Board (CB) Quality, Safety and Experience (QSE) Group action log was reviewed. Members noted the content. The following points were discussed: **Update on service model and staffing for the CHAP:** It was confirmed that there is now a full nursing staff establishment; there have been alterations among the GP cohort but the same number of hours are covered. The service model and governance are under review; there is a new quality and safety structure and an operational group will drive through necessary actions. Pilot work is under way regarding whether to combine the Prison and CHAP services. This action can be removed from the action log. **05/18/008 Risk Register – GP OOH IT issues:** Issues remain unresolved and relate to the provider; further update required. **01/19/016 Out of Hours Peer Review – Christmas Transfer of Calls** Action completed. **03/19/008 Risk Register – QS&E 000214 OOH:** update to be provided. **03/19/008 Risk Register - PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainability**: action completed. **05/19/008 Quality Dashboard – Immunisation**: a meeting with HIW has been held but a solution remains to be identified. **05/19/009 Risk Register – Risk Escalation:** agenda item **05/19/009 Risk Register – North and West Locality – Individuals with a Learning Disability:** Action completed and regular updates from the Local Authority will be requested by AM. **05/19/010 Audit - Bi-annual Audit Report - Anticoagulation Monitoring by the Acute Response Team (ART) – July – December 2019**: Action ongoing. KJ to liaise with Tracy Meredith. **05/19/011 – Datix:** Action completed. **05/19/015 - Framework for the Management of Performance Concerns in General Medical Practitioners (GPs) on the Medical Performers List Wales**: Action completed.	**LD/HE** **HE**
07/19/008 (Agenda item 7)	**QUALITY DASHBOARD** KJ reviewed the dashboard. The following points were highlighted. **Serious incidents:** KJ confirmed that the Nurse Lead, Primary Care Development, is exploring issues relating to immunisation incidents; a follow-up meeting with key persons	

	is scheduled noting that other errors appear to have been identified. It was confirmed that formal conditions of practice have been imposed on the appertaining practitioner by the Nursing and Midwifery Council. It was important to note that the practitioner is not a UHB employee but the matter is overseen by the Clinical Board as commissioners. It was noted that numbers of serious incidents relating to pressure ulcers have reduced significantly since the change in reporting arrangements. **Concerns:** it was highlighted that the number of concerns has increased significantly across the entire UHB; there has been revised guidance from Welsh Government (WG) relating to independent contractor concerns. **Vacancies:** It was noted that the vacancy position remains challenging. Influences include the impact of the aging workforce; workforce turnover in HMP Cardiff and the District Nursing cohort is particularly challenging. **Information Governance breaches:** it was noted that there had been 3 incidents in June, all of which had been investigated and appropriate actions implemented. There was discussion on the additional burden relating to the change in rules affecting statutory and mandatory training which will have a negative effect on training rates; the lack of sufficient provision was also highlighted. **Pressure Ulcers:** MM highlighted that a lot of closure forms had been submitted in June. Key themes are patient non-compliance and care agencies not understanding equipment. It was confirmed that three incidents had been identified as avoidable; details will be shared with the Locality Lead Nurses. **Healthcare Acquired Infections**: KJ confirmed that root cause analyses (RCAs) of MSSA are undertaken although no themes have yet been identified. **OOH statistics:** It was noted that the statistics have deteriorated slightly although escalation levels and shift fill rates remain reasonable. The QSE Group **noted** the Quality Dashboard and the agreed indicators.	
07/19/009 (Agenda item 8)	**RISK REGISTER (RR)** KJ confirmed that all Business Unit Risk Register scores had been recently submitted to challenge and adjusted where appropriate. **QSE 020714 CHAP:** NH highlighted the ongoing unpredictable attendance numbers and lack of flexibility within the current sytem. **PCIC160414 Primary Care Estates Developments:** SG confirmed that the LDP remains unchanged although actual	

	growth has been less than anticipated. Discussion is ongoing with stakeholders and two major schemes are under way. The Primary Care Estates group has been running for 18 months to oversee estates developments within an accountability framework. **PCIC 29.01.15 GMS Services/Primary Care Capacity and sustainability:** No critical issues. **PCIC 180516 Domiciliary Care Provision:** Remains challenging and work is under way to resolve the issue. **S&E 051216 HMP Cardiff – prescribing** **S&E 051217 HMP Cardiff – MH Provision** **S&E 100718 HMP Cardiff – Spice Incidents** Work is under way to try to resolve issues. A workforce review is in progress aiming to improve the skill mix and staff sustainability. A bid has been submitted to WG for additional funding. Spice incidents risk grading has been reduced to 12. **CHC110817 Continuing Healthcare Commissioning**: A paper has been submitted to the Executive team. **PC230419 Community Dental Service**: Following transfer of staff to PCIC some processes around complaints administration required updating to the corporate approach. A decontamination audit will be carried out imminently. **PC050619 North and West and Vale Localities** – Dementia Team Around the Individual: some dementia services have transferred into PCIC under TUPE regulations and brought with them some risks and caseloads. Work is under way to resolve the issues. ***Park View closure*:** AM highlighted that Park View clinic has been closed for over 1 year but an alternative site has now been identified in Grand Avenue; this will take a further 3 – 4 months to bring up to operational standard. NH confirmed that DoSH has started offering a service in Caerau Lane surgery and work is under way to find an additional GP site. **<u>Risk Escalation Reports</u>** *S&E Locality escalating concerns – Nursing Homes*: NH confirmed that two homes are currently in escalating concerns relating to documentation and other issues. The UHB wanted to impose restrictions on one home but the Council over-rode that; meetings are scheduled to address these issues. A further three homes are being closely monitored. *Western Boundary Changes:* HD highlighted the risks relating to patient flow in the Royal Glamorgan Hospital and Princess of Wales Hospital. SG confirmed that the LMC has requested action on this matter. KJ agreed to follow this up with the Asst COO. *Mobile Phones:* AM summarised the issues relating to inadequate mobile phone provision, including the associated clinical risk and financial pressures. KJ agreed to seek advice	**KJ** **KJ**

	from the PCIC Senior Finance Director on how to progress this matter. The QSE Group **noted** the Risk Register and risk escalation reports.	
07/19/010 (Agenda item 9)	**AUDIT** KJ highlighted that the UHB Medical Director regularly requests updates on Clinical Board audit plans. It was recommended that future audit activity should be reported through BU QSE meetings with exceptions only submitted to the Clinical Board QSE meeting. The Clinical Board updated Audit Plan was summarised. National Diabetes Care Processes and Targets summary report and planned actions: KJ reported that the diabetes audit had been led by Dr Sarah Davies on a local and national level, to be followed up by liaison with Nursing Homes. KJ has a meeting scheduled with Dr Davies to ensure that all the good work is captured and reflected in reports. Prescribing Medication for Post-Traumatic Stress Disorder- an Audit of Cardiff Health Access Practice using the Cardiff and Vale Traumatic Stress Research Group Pharmacological Prescribing Algorithm: KJ confirmed that the project has been authorised; outcomes will be brought to QSE. NH highlighted that further clarity has been sought on the measurement of Mirtazapine prescribing to ensure clarity of results. Cold Chain Audit: KJ confirmed that the cold chain is regularly audited to provide assurance that GMS are aware of their responsibilities. SG highlighted that a recent HIW inspection issued a breach notice on a Practice consequent on a fridge temperature not being recorded. Internal Audit Plan: The plan was shared for information, noting that Business Continuity would be an audit theme for 2019/20. The QSE Group **noted** the report.	
07/19/011 (Agenda item 10)	**DATIX** Current position – Business Unit (BU) queues: The BU queues were noted. Datix Update Report: MM confirmed that there remains very good performance on the measure of incidents being sent on to managing directorates within 7 days. It was noted that those incidents which remained open for over 30 days mainly relate to pressure damage. KJ confirmed that Datix will be scoped and trialled in a Vale GP Practice as a result of the work undertaken relating to Interface Incidents. MM confirmed that All Wales procurement of an incident reporting system had concluded and selected an upgraded version of Datix as the system going forward.	

	The QSE Group **noted** the updates.	
07/19/012 (Agenda item11)	**PHARMACY UPDATE** KM had provided a report which reflected the very good reduction in anti-microbial prescribing. Formal thanks were extended to the Pharmacy team. The QSE Group **noted** the report.	
07/19/013 (Agenda item 12)	**GMS AND DENTAL SERVICES** Governance update: SG summarised the governance update. GH confirmed that the Clinical Governance team is currently managing two long-term safeguarding cases and has recently taken on an additional two cases, one being a GP and one being a dentist. All cases are being managed according to regulations and agreed procedures. HIW: SG confirmed that an immediate assurance notice had been received this week, relating to which remedial actions were under way. It was noted that the HIW approach demonstrates inconsistencies in assessment and communication with the UHB. The QSE Group **noted** the update.	
07/19/014 (Agenda item 13)	**ANNUAL QUALITY STATEMENT** KJ requested that this publication be noted by the QSE, highlighting that it contains a lot of information relating to PCIC. The QSE Group noted the update.	
07/19/015 (Agenda item 14)	**HCAI INFOGRAPHICS** VS summarised the data shown in the infographics highlighting a recent case of MRSA which was the first identified for 117 days. KJ thanked VS for all his proactive work since being in post. The QSE Group **noted** the infographics**.**	
07/19/016 (Agenda item 15)	**BUSINESS CONTINUITY** RA summarised the Business Continuity update noting in particular the transfer of Bronze Control from CRI to Woodland House and that there was to be a streamlining of the arrangements for cascading knowledge over the coming months. The QSE Group **noted** the update**.**	
07/19/017 (Agenda item 16)	**PATIENT EXPERIENCE** KJ highlighted that there is currently no Personal Assistant to support her or the Head of Primary Care; this is having an	

	impact on concerns tracking; this will be maintained by KJ and RA. Concerns themes performance summary by Business Unit: the report was noted. Audit on patient/carer satisfaction with the domiciliary dental service based at Riverside Health Centre: the QSE welcomed the positive results. The QSE Group **noted** the report.	
07/19/018 (Agenda item 17)	**DEATH IN CUSTODY FINAL REPORTS AND ACTION PLAN** NH highlighted that there had been two reports – one from HIW and one from the Prison Ombudsman – in response to which two action plans have been devised. The main issues identified related to documentation, chronic conditions management and the escort risk. The last conflicts with the clear Prison protocol to handcuff prisoners when escorting them to hospital. An additional point raised by the Ombudsman was the apparently unacceptable delay in the provision of information by Prison health care staff. It had been identified that this related to the use by the Ombudsman of the Prison email system while Health staff use the NHS Wales email system; processes have been updated to resolve this. An imminent workforce review will take account of actions planned regarding chronic conditions management in prisoners. The QSE Group **noted** the report.	
07/19/019 (Agenda item 18)	**BUSINESS UNIT QSE MINUTES** KJ confirmed that all BU minutes had been checked prior to the meeting and feedback had been provided as appropriate.	
07/19/020 (Agenda item 19)	**INFORMATION GOVERNANCE** RA summarised the minutes from the Information Governance (IG) group meeting, highlighting that a cluster IG framework has been developed and that destruction dates have been added to the Information Asset Register to guide teams on how long documents need to be retained. There had been three internal and one externally generated IG incidents reviewed at the meeting; appropriate actions have been put in place as a result. The QSE Group **noted** the update.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
07/09/021 (Agenda item 20)	**RESEARCH AND DEVELOPMENT (R&D)** Aus-Toms - see minute 07/19/05 above. Madeline's Project: KJ confirmed that Lead Nurses are seeking opportunities to carry out research on Point of Care Testing (POCT); these will then be reported to the QSE Group.	

	Glucometer audit results by Locality: it was discussed that some data errors have been identified. KJ confirmed that she will request that the audit be repeated to ensure robust data collection. Coaguchek processes audit: This was presented for noting. The QSE Group **noted** the update.	**KJ**
07/19/022 (Agenda item 21)	**TRANSFORMATION PROJECT UPDATE/OUTCOMES** KJ highlighted the requirement for Lead Nurses to gain assurance around governance and robust use of the Locality QSE process in support of these projects. The QSE Group **noted** the update.	
SAFE CARE		**Action**
07/19/023 (Agenda item 22)	**POINT OF CARE TESTING** Point of Care Testing Group Report from meeting held on 4th March, 2019: The QSE Group **noted** the report. DES anticoagulation: KJ summarised the update provided by the GP Contract and Development Manager. It was confirmed that meetings have been held with the POCT team to develop a robust process. It was noted that some GP Practices had not signed up for external quality assurance although it is a requirement of their contracts. KJ has requested a risk assessment and given instruction that Practices are to be required to sign up immediately. A report is to be provided by the end of this week following which an action plan will be devised to manage any Practices which have not agreed to participate in external quality assurance. The QSE Group **noted** the update.	
07/19/024 (Agenda item 23)	**ASSESSMENT OF TECHNIQUE FOR ADVANCING AND ROTATING PEG TUBES** AM highlighted that this tool has been devised for use by UHB and Nursing Home staff and has generated improvement in all areas. The document was presented to the QSE for approval. The QSE Group **approved** the tool.	
07/19/025 (Agenda item 24)	**BARE BELOW THE ELBOW** KJ highlighted the requirement to ensure that staff abide by the guidance. NH confirmed that the Prison staff have been reminded to wear appropriate uniform in readiness for the upcoming inspection.	
07/19/026 (Agenda item 25)	**MEDICAL EQUIPMENT UPDATE**	

	The next meeting of the Medical Equipment Group is scheduled for 18th July, 2019. The South and East Locality Operational and Administration Manager will attend on behalf of the Medical Device Responsible Officer. The QSE Group **noted** the report.	
EFFECTIVE CARE		**Action**
07/19/027 (Agenda item 26)	**INFECTION CONTROL** ANTT Compliance Data June 2019: KJ confirmed that the data demonstrate an improving position. PCIC Infection Prevention and Control Report: VS confirmed that this report was shared for information. The QSE Group **noted** the updates and links to further information.	
07/19/028 (Agenda item 27)	**HMP CARDIFF – SELECT COMMITTEE ENQUIRY AND FUNDING BID FOR MENTAL HEALTH IMPROVEMENTS** NH confirmed that the bid has been accepted but costs need revision. Work is ongoing prior to resubmission. The QSE Group **noted** the update.	
DIGNIFIED CARE		**Actions**
07/19/029 (Agenda item 28)	**DEMENTIA** Dementia Action Week: KJ confirmed that the Dementia Action Week had raised the profile of dementia and Localities are implementing appropriate work streams. Making Wales the Best Place in the World to Grow Older: this report was shared for information. The QSE Group **noted** the updates.	
07/19/030 (Agenda item 29)	**END OF LIFE CARE** National Audit of Care at the End of Life: ML confirmed that the audit had focused on hospital care more than care at home but that most outcomes were positive. Where there are some gaps in provision or low scores these are similar to the rest of the UK. A second phase audit is focusing on qualitative reviews of bereaved people following death. Use of subcutaneous morphine first line for palliative care patients: ML highlighted that there had been an All Wales review leading to implications for the UHB at its border areas when patients come into UHB care on diamorphine; the UHB has used only morphine for some time. The intention is that all patients will be transferred onto morphine which costs less than half that of diamorphine. This work rests with the All Wales Pharmacy Group to progress.	

	KJ gave formal thanks to ML for all her hard work in advance of her imminent retirement.	
TIMELY CARE		**Action**
07/19/031 (Agenda item 30)	**SAFEGUARDING** National Audit of Care at the End of Life: this report was submitted for information. Protocol for Children seen in Fracture Clinic: KJ highlighted this new pathway which has been newly developed as a result of a highly publicised death of a child. Victims of modern slavery – Competent Authority guidance: this report was submitted for information. Addressing Exploitation work stream: this report was submitted for information. Pressure damage MASH data: this report was submitted for information. The following points were discussed: • The challenge for BUs of the requirement for a whole suite of staff training relating to safeguarding. KJ confirmed that work is under way with the Safeguarding team to arrange cascade training • Specific safeguarding training is under way in HMP Cardiff and a review is under way to determine whether to use the Multi-agency Safeguarding Hub or the Prison's own safeguarding system; an appropriate process will be developed. The QSE Group **noted** the updates.	
07/19/032 (Agenda item 31)	**DELAYED TRANSFERS OF CARE CENSUS** KJ highlighted that the Chief Operating Officer had required this item to be submitted to QSE meetings, making particular note of the impact of delayed transfers of care on patient outcomes. The QSE Group **noted** the report.	
INDIVIDUAL CARE		**Action**
07/19/033 (Agenda item 32)	**PATIENT EXPERIENCE** Patient Experience Group minutes June 2019 – North and West Locality: The QSE Group **noted** the minutes.	
07/19/034 (Agenda item 33)	**WELSH LANGUAGE STANDARDS UPDATE** RA presented this item on behalf of TB for information, noting that the UHB had been issued with a compliance notice in November 2018; the Welsh Language Commissioner will conduct a number of checks to ensure compliance.	

	SG confirmed that the regulations for General Medical Services, General Dental Services, Pharmacy and Optometry have been updated to include a number of Welsh Language requirements, noting that it is the responsibility of the UHB to support this work and provide appertaining information. In addition, WG is in the process of scoping with the UHB its position with regard to the regulations. RA confirmed that HIW has already commented on Welsh Language provision in Practices. The QSE Group **noted** the update.	
STAFF AND RESOURCES		**Action**
07/19/035 (Agenda item 34)	**WORKFORCE UPDATE** RW summarised the sickness position, noting that the Clinical Board achieved 4.97% in June, below the target of 5.0% which represents a good direction of travel. It was confirmed that stress, anxiety and depression are the most common causes of long term absence, some of which relate to employment relations issues. It was highlighted that Managing Attendance training sessions remain available. Regarding PADRs, Values Based appraisal training is available and revised PADR forms are being piloted. The QSE Committee **noted** the update.	
SUB-GROUP REPORTS		**Action**
07/19/035	<u>Primary Care Business Unit Reports</u> <u>GP OOH Business Unit</u> No report received. <u>Vale Locality</u> HD highlighted that there are high levels of sickness. The Locality has developed a working group with Cwm Taf Morgannwg University Health Board to resolve the boundary issues. <u>Cardiff South and East Locality</u> NH highlighted that inspections are under way and that staffing issues exist in the District Nurse and Prison teams. <u>Cardiff North and West Locality</u> No additional issues to report. <u>Pharmacy and Medicines Management</u> The previously reported accreditation issue has been resolved. <u>Palliative care</u> ML highlighted that unlocked syringe drivers containing morphine have been located in some departments. A SBAR report has been submitted to the Clinical Standards Committee for discussion. The Assistant Nurse Director, Patient Safety will progress this issue mindful of the findings of the Report of the Independent Panel into Gosport War Memorial Hospital.	

	Primary Care SG highlighted that the detail of the GMS contract for 2020 is awaited, following which the team will identify what will be required to enable support to Practices. Clinical Governance Group 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**	
07/19/036	**CMO and CPhO UPDATES** CEM/CMO/2019/2 Hospitalisation and deaths linked to consumption of 2,4 dinitrophenol (DNP) CEM/CMO/2019/03 Influenza Season 2018-19 – cessation of use of antivirals now recommended CEM/CPhA/2019/12 Co-amoxiclav 125 mg/31.25 mg/5 mil powder for oral suspension CEM/CPhA/2019/13 Potassium chloride 0.15% w/v and sodium chloride 0.9% w/v solution for infusion – BP 1000 ml; potassium chloride 0.3% w/v and sodium chloride 0.9% w/v solution for infusion 1000 ml; potassium chloride 0.15% w/v and glucose 10% w/v solution for infusion 500 ml CEM/CPhA/2019/14 Pharmachem Ltd Paracetamol 500 mg tablets, 1 x 1000 CEM/CPhA/2019/15 Falsified Medicines Directive Alert Class 2, B &S Healthcare, multiple parallel imported products CEM/CPhO/2019/003 Disruption to supply of Diamorphine 5 mg injection CEM/CPhO/2019/004 Disruption to supply of Microgynon 30 tablets and Ovranette tablets CEM/CPhO/2019/005 Disruption to supply of Epanutin® (phenytoin) 30 mg/5 ml oral suspension 500 ml bottle Chief Pharmaceutical Officer letter: Changes to pre-registration training in Wales affecting pre-registration trainees commencing training in 2020	
07/19/037 (Agenda item 38)	**WELSH HEALTH CIRCULARS** WHC (2019) 020 Changes to the Human Papillomavirus (HPV) immunisation programme from the academic school year starting September 2019 (a - English and b - Welsh) WHC (2019) 018 Augmentative and Alternative Communication (AAC) Pathway (a - English and b - Welsh)	
07/19/038 (Agenda item 41)	**SI CLOSURE FORMS** Please access via link O:\Locality QS&E\Quality and Safety Committee papers\2019\04 July 17th 2019 Password protected	
07/19/039	**NHS ALERTS**	

(Agenda item 42)	• Uplift to Optometrists providing the Wales Eye Care services for 2019-20 • General Ophthalmic Services – NHS sight test fee, NHS optical voucher values, payments for continuing education and training and pre-registration supervisors grant
07/19/040 (Agenda item 44)	**UPDATES FROM OTHER GROUPS** **Safeguarding Steering Group Minutes, 28th March, 2019.** **44.2 Minutes from the UHB Nutrition and Catering Steering Group April 2019**
DATE OF NEXT MEETING	
Tuesday, 10th September, 2019, 1.30 pm – 3.30 pm **Nant Fawr Tri (3), Woodland House** ***FOCUS: Palliative Care***	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 25th 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
Navroz Masani (NM), Clinical Board Director
Lisa Higginson (LH), Senior Nurse, N&T
Sarah Matthews (SM), Senior Nurse, N&T
Gareth Jenkins (GJ), Service Manager, Haematology, Immunology
Bethan Ingram (BI), Senior Nurse, TCT
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Richard Wheeler (RW), Consultant, Cardiology
Colin Gibson (CG), Clinical Engineer, Rehabilitation Engineering, REU/ALAS
Gemma Ellis, Consultant Nurse, Critical Care
Vince Saunders (VS), IP&C Lead
Suzie Cheesman (SC), Patient Safety
Richard Parry (RP), Patient Safety
Claire Main (CM), Lead Nurse, Nephrology & Transplant
Claire Mahoney (CM), Clinical Nurse Specialist, IPC
Steve Gage (SG), CB Pharmacy Lead
Judith Burnett (JB), Interim Senior Nurse, Critical Care
Beverley Oughton (BO), Interim Lead Nurse, Critical Care
Helen Scanlan (HS), Interim Directorate Manager, Nephrology & Transplant
Hywel Roberts (HR), Consultant, Critical Care and Medical QSE Lead
Paul Rogers (PR), Directorate Manager, ALAS
Lisa Higginson (LH), Senior Nurse, N&T
Bethan Ingram (BI), Senior Nurse, TCT

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions	
1.2	Apologies for absence Vinod Ravindran, Sian Williams, Rachel Barry, Keith Wilson, Anne-Marie Morgan, Jennifer Proctor and Mary Harness.	
1.3	To review the Minutes of the previous meeting 5th April 2019 The minutes were agreed as an accurate record, subject to page 4 Item 3.2 CG noted this should read as two separate items, progress with an IT solution **and** with regard to the wheelchair replacement programme. Matters Arising • Skin Prep – HR to feed back as part of the HCAI discussion. • Closure Forms – on agenda. • NatSIPPS – the names of the representatives were sent to Holly Williams, QSE Facilitator. BI will confirm the Haematology rep to CF. CF will set up new meetings. • Closure Summary – done. • VRE – letter of apology was discussed. Agreed to wait until there is a clearer picture. Patients who are in at the moment are receiving letters. • Bronchoscopy – Meeting date outstanding. • Clinical Scientist – discussion ongoing with the Renal Network. • Risk Registers – requested again.	**BI/CF** **CF** **Dirs**

	• TCT – leak has been resolved. • Antimicrobial Lead – still outstanding, to be discussed as part of HCAI.	**Dirs**
PART 2: SAFE CARE		
2.1	• Open Serious Incidents • Open Inquests • Patient Safety Alerts <u>Closure Forms</u> 3 forms were submitted, all around pressure damage, all were unavoidable. RP has been doing a lot of work on this as part of the patient safety team. RP will feedback in due course. All are aware of the change in reporting of pressure damage. Forms will be signed off by Carol Evans.	
2.2	<u>Healthcare Associated Infections</u> CF outlines that Specialist Services did not achieve the reduction targets in 18/19. Vast majority of Staph Aeurus bacteraemias are line related. 52 cases of MSSA this year (32 last year – goal for no more than 1 per month). HR has been doing some work on clinell skin wipes. They are not made in a sterile facility so cannot be used for skin injection. HR would therefore recommend that we don't use them for skin prep. However, the company are looking into developing this so will probably be available in a year or two. Haematology use them for phlebotomy but HR felt that the risk was lower because you are not leaving anything in the skin. GE noted that the Critical Care outreach team have noted poor compliance with lines in ward areas in terms of the bundle, e.g. 3 way taps left in situ, no documentation in notes. Critical Care outreach team are going to be doing some education with the wards. VS noted that he had done a VIPS scoring audit in Specialist Services and things are improving. There are clear policies in place in the UHB but it is clear we are not adhering to these policies as demonstrated by the audits. RW asked what type of lines we are talking about. VS confirmed that PVCs are the top in terms of infections. N&T and Haem are planning to decolonise patients who are coming in for planned line insertions. CC is starting chlorhexidine usage for skin wash. CM stated that they need to be washing the patients hair twice a week to decolonise also. PVC packs are in place and used but Cardiac are continuing weekly audits until they are sure this is embedded in practice. CM updated that with regard to the use of blood culture packs in N&T, they have removed alternative separate supplies from the ward so that staff have to use the blood culture packs, however, there are still issues with putting the sticker in the notes. With regard to hand hygiene compliance, it was noted that there are still issues with phlebotomy. VS has fed this back to phlebotomy managers. VS noted that there are still some issues with turning off taps with hands after washing rather than paper towels. The other common themes picked up through the audits are staff opening/closing curtains around a bed space and missing the opportunity to wash hands. Generally VS feels Bare Below the Elbows is much better. ANTT – we do not know how many medical staff are trained. All areas looking at how practice educators can support this. NM highlighted that the vast majority of PVCs are put in by juniors and this is where we need to focus our efforts. Need to relaunch the STOP campaign or start intentional rounding to remove cannulas once they are not being used. They should not be left in just in case. CC – still having difficulty in identifying cannulas put in at the roadside. Have struggled to get engagement from WAST and A&E. CF asked SC to arrange a meeting.	**Dirs** **CF/SC**

	Antimicrobial stickers – SG noted that there was still poor compliance with this. Pharmacy are unable to support the number of audits they were doing previously. The new drug charts will contain this information. RW highlighted that we need to target the foundation trainees. Eleri Davies used to teach on this course but that has stopped now that Eleri has changed role. Yvonne Hyde has had meetings to see what is covered as part of corporate induction. Antimicrobial lead – we are a large clinical board with disparate needs. The workload and the fact that there is no remuneration with the role is making it unattractive to appoint to. GE feels it needs to be a medic and a nurse. NM asked for this discussion to be taken to each Directorate's Q&S meeting for consideration of what it would take for someone to take on this role and support the Clinical Board in reducing HCAIs. SG suggested that it was also important to have a Directorate lead in place to support the Clinical Board. RCAs – 40% cases are outstanding. There is very little medical involvement in completing the RCAs. RP is going to look at the themes coming out of the RCAs to see if there's anything we are missing. The database may also help to identify things that it would have been helpful to have known as part of the RCA that can be added to the RCA tool in the future. NM discussed the intentional rounding tool he has drafted. All Directorates to review and consider if anything needs to be amended and then roll out. Link nurses – how do we bring them together and what opportunity does this give us to influence practice. CF reminded all medical and nursing staff about their professional code of conduct and their responsibilities. NM has drafted a letter to be disseminated among the Clinical Board.	**Dirs** **Dirs** **NM**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u>	
3.2	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u>	
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u> <u>HCS 2.9</u> CG has circulated the draft. We need to raise awareness about the new regulations for medical devices. This applies to all medical devices used in the delivery of healthcare and covers new things that you would not necessarily consider such as software, laboratory reagents etc. To be an agenda item for a future meeting. <u>Mortality reviews</u> RW feels that each Directorate is doing different things. Requested this is a future agenda item for discussion with medics in attendance. <u>Leak</u> BI raised concern regarding the continued leak affecting 5th floor downwards. 1 cubicle is closed until this is fixed.	**GW/CF** **GW/CF**
PART 5: DATE OF NEXT MEETING		
5.1	Thursday 16th May 2019, 8am, in the Critical Care Resource room, UHW.	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 16th May 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
Claire Mahoney (CM), IP&C Lead
Suzie Cheesman (SC), Patient Safety
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
Craig Spencer (CS), Consultant, Critical Care
Lisa Higginson (LH), Senior Nurse, Nephrology & Transplant
Keith Wilson (KW), Consultant, Haematology
Hattie Cox (HC), Assistant Service Manager, Neurosciences
Tessa Northmore (TN), Senior Nurse, Neurosciences
Rachel Barry (RB), Lead Nurse, Neurosciences
John Martin (JM), Clinical Director, Neurosurgery
Tom Hughes (TH), Clinical Director, Neurology
Craig Spencer (CS), Consultant, Critical Care

Present:
Gemma Williams (GW), Personal Assistant, Specialist Services (Note Taker)
Erica Cooke, Senior Staff Nurse, Critical Care UHL

PART 1: PRELIMINARIES		**Lead**
1.1	Welcome & Introductions The group introduced themselves one by one.	
1.2	Apologies for absence Apologies received from Beverley Oughton, Colin Gibson, Claire Main, Sian Williams, Jennifer Proctor, Judith Burnett, Steve Gage and Anne Marie Morgan.	
1.3	To review the Minutes of the previous meeting 25th April 2019 The minutes were agreed as an accurate record, subject to; page 2 Item 2.1 should say “unavoidable” closure forms. Keith Williams on the apologies should be changed to “Wilson” and the title of Claire Mahoney should be changed to Clinical Nurse Specialist, IP&C. Matters Arising Item 1.3 Minutes • NatSIPPS – the Haematology representative was confirmed as Laura Ricketts.	

	• Bronchoscopy Meeting – date now set. • Risk registers requested again – all Directorates to check that they have sent their updated registers to CF. • Antimicrobial lead – to be discussed as part of Directorate HCAI and QSE meetings. CP on agenda for QSE today in Cardiac. Item 2.2 HCAI • ANTT re numbers of medical staff trained and maintenance of PVC lines. CM was previously asked to update the Clinical Board action plan then each Directorate to develop their own. CF noted that she was assuming all areas are working on this. • SC will arrange the WAST and A&E meeting regarding Critical Care having difficulty in identifying cannulas put in at the roadside. SC noted that they will also discuss the email sent a couple of days ago noting an incident where-by an ambulance which should have taken 15 minutes, took 4 hours. • Intentional rounding tool that Nav Masani has drafted – CP noted that they have started to use it in Cardiac. CP is meeting with Nav as there is disparity regarding what will and what won't work. Presenting work to Directorate today. Item 4.1 Any Urgent Business • HCS 2.9 raised by Colin Gibson – GW to include in as a future agenda item. • Mortality reviews – GW to include as a future agenda item for discussion with medics in attendance.	**Dirs** **Dirs** **SC** **GW** **GW**
1.4	<u>Patient Story – Erica Cooke, Critical Care UHL</u> Erica Cooke introduced herself to the group as the Critical Care team leader in UHL and explained that long term ventilation is one of the main services they provide. The patient experience discussed today is a real success story. Patient DB was a fit and well gentleman, who was a keen fitness fanatic. April 2018 admitted to Princess of Wales Hospital with food poisoning (from a curry takeaway house). Confirmed diagnosis of GBS. Patient was moved to the Critical Care Unit at Princess of Wales however was no longer able to breathe by himself. During his 6 week acute phase he was referred to UHL. On admission very hyper anxious, paralysed, could only blink. Initial issues; new unit, new staff, new routine. The patient was extremely panicked all the time. Lost 4 stone. An MDT approach was taken; weekly review of individual patients, consistent approach, communication - used visual progress tools and continuity of nursing care. The patient regained some movement and there was a change of weaning plan. Changed tracheostomy tube. Regular diazepam was given for his anxiousness. The patient started to become more positive after each goal was reached. Started to be able to stand. Increasing time out in his chair. Started to require less assistance. Swallowing improved. Anxiety decreased. His children started to re-visit. He then encouraged and inspired other LTV patients on the unit. The patient then moved to Rookwood Hospital for further rehabilitation. It was felt that the secret to success was continuity of everything and seeing the same staff maintaining same care. Patient is now home. The group agreed that this was a very positive outcome.	
PART 2: SAFE CARE		
2.1	<u>Serious Incidents (SIs)</u>	

	CF referred to the death of the patient on the Cardiac waiting list. Waiting for answers from the Investigating Officer. CP noted that this should be done by the end of this week so that the closure form can then be progressed. CF referred to the death on Renal. SC is awaiting feedback from the Nephrologist and Claire Main, Lead Nurse, N&T. LH will pick up this up with CM. VRE latest update – MH noted that they would be moving from B4H on the 20th May and would be reducing bed numbers from 27 to 18. They will be using some additional beds on C4 Neuro on a temporary basis, cubicles on the rest of Heulwen once Cardiac move back to C5 and the transplant cubicles on TCT. Work will start on 2nd June on B4H. Looking at sending some bone marrow transplant patients to England (patients will be given the option), in order to try to reduce the transplant numbers. This will however impact on the programme. KW noted that the transfer to England is not an easy process. You can potentially delay the transplant, but that it is about balancing out the risks. This is being done on a patient by patient basis. Fire on C5 last week – the whole ward had to be evacuated. Patients were back into one half of the ward on the same day. It was noted that Steve Curry was extremely complementary about the Clinical Board and the way that staff dealt with the fire and patients. Security on the ward actually put the fire out before the fire brigade got there. Staff however have been affected. The unit will access all support mechanisms available. Work on the ward is going well. 1 patient was admitted to Critical Care as a result. Patient has survived.	**LH**
2.2	<u>Closure Summary for Serious Incidents</u> • In82065 For information.	
2.3	<u>Point of Care Testing (POCT)– background/current issues</u> Rachel Rayment introduced herself to the group, noting that she was the Chair of the POCT testing group. Rachel informed the group that she was looking for some support with regards to POCT so that processes are streamlined and standardised. A significant amount of tests that were carried out in laboratories are being carried out at the patient bedside. There is a significant amount of work going on and the responsibility currently lies with 2 people. Trying to develop a different way of behaving. Organisational and practice changes to improve processes are required. CF noted that POCT has been discussed at the Clinical Board Nursing Board previously but not in this group. Rachel is looking for a medical and nursing lead for POCT for each Clinical Board and then possibly a lead for each Directorate who will feed into the Clinical Board reps. The Clinical Board representatives will be the named delegates to then attend the POCT group. They will need to bring relevant data to the meeting and have an understanding of what is being done in each area in relation to POCT. New device requests is an issue. CF, HR and Nav Masani to meet up and discuss how to take this forward. CF noted that the POCT discussion could go to our next Practice Educator Forum. Claire Main and Jen Proctor are leading on this. GW to add to the agenda for next Nursing Board as well. Rachel to send dates and TOR of the POCT group to GW to circulate, including a list of expectations.	**CF/HR** **CM/JP** **GW** **RR/GW**

2.4	Healthcare Associated Infections CF fed back to the group on April figures: • C. Difficile - 3 new cases • MSSA - 3 new cases (need RCAs for these patients). • E coli - 3 cases • Klebsiella Sp. – 1 case May so far: • C. Difficile – 1 case CF noted that it is imperative that work is ongoing regarding line infections. Last year figures show a significant amount line related. Re-launch STOP campaign. CM to meet with Claire Main, Lead Nurse, N&T, who is leading the HCAI group for the Clinical Board. GW to ask for dates from Claire Main and send them onto CM.	**CM** **GW**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee None given.	
3.2	Long waiting patients JC referred to the DU report embedded in the agenda which was shared in order to give some background information. The report focused on high volume specialities patients on planned waiting lists for treatment. Concern raised around patients waiting long times for planned care – for the vast majority we don't know what harm they might be coming to whilst waiting. JC noted that they have been working hard to try to eliminate any patient waiting more than 52 weeks for planned care and also trying to reduce the maximum wait to 36 weeks. Neurosurgery is nearly there. Plan is to try and sustain as a maximum wait going forward. The report doesn't pick up other patients waiting for an intervention or review in our service. JC asked the group how to best capture this information across the Clinical Board (all groups of waiters who are not planned). What processes should we be putting into place whilst waiting so that these patients don't come to harm. KW noted that there are no national guidelines regarding how long a patient should wait for BMT. Where there is a standard clinical practice Haematology have adopted those. Published data to commissioner. If they exceed the published data they inform the commissioner. Extremely time consuming as no tracking system. JC noted that there are checks and balances in the system in Haematology which is not always the case in other services. Need a sense of highest risk areas. CP referred to Cardiac Surgery. The Case Manager contacts the patient saying who they are, that they are on the waiting list, and the patient is posted a booklet regarding their condition and letter which states "If there are any changes in your condition please contact……." Presented as a network to all patients and not just Cardiff and Vale. Database has been set up for C&V patents which flags any patients that have been admitted to any hospital whilst being on the waiting list. The unit managers review this on a daily basis. Important that the Cardiologists are regularly reviewing patients as well, carrying out regular follow ups. JC can feed this back. HR noted that it would be useful for all GPs to have a number of who to ring if their patient is being admitted to hospital.	

	It was noted that patients on the transplant waiting list are reviewed by the Nephrologist if on dialysis and seen once a month. Regular visits from home dialysis nurse and they are seen on a 3 monthly basis by the Nephrologist. JC referred to Neurology noting long waits to see a Neurologist and commence treatment. There had been some concerns dealt with in the Clinical Board recently with allegations of harm as a consequence. RB will discuss with Tom Hughes and feed back to JC. Neuro have had significant challenges around the workforce. This is a priority area to focus on. Each Directorate to feed back all of their long waiters to JC.	**RB** **Dirs**
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Fire on C5</u> CP thanked everyone for their help/support. <u>Unusual Phone Call in Neurosciences</u> HC noted that she had a phone call from a gentleman saying that his son (who had been in recently for a test), needed to come to C4 for 10am as he had a bleed on the brain. HC investigated but found nothing to this effect. The patient had been in to A&E recently but nothing related to a bleed on the brain or anything related to Neurology. The gentleman then received an email saying please ignore the request to come in for tests as it was a hoax. Emailed IM&T security. HC will upload the incident to Datix. HC to feed back to CF. <u>Critical Care Report</u> HR noted that Critical Care have requested to present at the next meeting on Critical Care report. Matt Wise would like to discuss it with the group. GW to include on next agenda. HR informed the group of an incident whereby a patients diagnosis of a stroke was delayed by a number of hours due to an online radiology reporting error (the stroke had not been detected by the online service). The incident has been logged on Datix.	**HC** **GW**
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u>	
PART 5: DATE OF NEXT MEETING		
5.1	Thursday 6th June 2019, 8am, in **the Council room, UHW.**	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 6th June 2019
Venue: Council Room, UHW

Attendance:
Navroz Masani (NM), Clinical Board Director (Chair)
Jessica Castle (JC), Director of Operations, Specialist Services
Hywel Roberts (HR), Consultant, Critical Care and Medical Lead, Specialist Services QSE
Sarah Matthews (SM), Senior Nurse, N&T
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Sarah Williams (SW), Interim Senior Nurse, Critical Care
Gareth Jenkins (GJ), Service Manager, Haematology
Craig Spencer (CS), Consultant, Critical Care
Lisa Higginson (LH), Senior Nurse, Nephrology & Transplant
Keith Wilson (KW), Consultant, Haematology
Tessa Northmore (TN), Senior Nurse, Neurosciences
Rachel Barry (RB), Lead Nurse, Neurosciences
John Martin (JM), Clinical Director, Neurosurgery
Catherine Wood (CW), General Manager, Critical Care and Major Trauma
Judith Burnett (JB), Senior Nurse, Critical Care
Lisa Simm (LS), Service Manager, Neurosciences
Kevin Nicholls (KN), Service Manager, Cardiothoracics
Colin Gibson (CG), Clinical Engineer, ALAS
Matt Wise (MW), Consultant, Critical Care

Present:
Gemma Williams (GW), Personal Assistant, Specialist Services (Note Taker)
Sartha Rajoo (SR), Finance Management Trainee

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome & Introductions NM welcomed Sartha Rajoo, Finance Management Trainee, to the meeting. SR is spending some time with the Core Team today as part of her 'Cooks Tour'. The group introduced themselves one by one.	
1.2	Apologies for absence Received from; Carys Fox, Beverley Oughton, Suzie Cheesman, Steve Gage Claire Main, Anne-Marie Morgan, Jennifer Proctor, Sian Williams and Mary Harness.	
1.3	To review the Minutes of the previous meeting 16th May 2019 The minutes were agreed as an accurate record, subject to; - Item 3.3 Exception Reports – GW to add in "HR informed the group of an incident whereby a patients diagnosis of a stroke was delayed by a number of hours due to an online radiology reporting error (the stroke had not been detected by the online service). The incident has been logged on Datix."	**GW**

	- Item 1.3 NatSIPPS – the Haematology representative surname needs to be amended to "Ricketts". Matters Arising Item 1.3 - Directorates to re-send any updated Risk registers to GW (Pa.SpecialistServices@wales.nhs.uk). GW to add them to the shared drive. - Antimicrobial lead – NM noted that having no lead was a significant issue. Directorates were asked to nominate any colleagues they felt would be suitable for the role. - The meeting is still outstanding that Suzie Cheesman was trying to arrange with WAST and A&E. HR noted that they were awaiting some information first. GW to follow this up with Suzie when she returns from leave. - Future agenda items – GW confirmed that she will include HCS 2.9 and mortality reviews on the next QSE agenda. Directorates to remind medical colleagues to attend the next meeting in relation to mortality review processes. Item 2.1 - Serious Incidents - death of patient on renal. A meeting took place 2 weeks ago. Suzie Cheesman was awaiting some feedback. Claire Main is following this up. Item 2.3 - POCT – CF, HP and NM will meet up. GW to arrange. POCT to be discussed at the next Practice Educator Forum. CP will follow this up. GW confirmed that she will include as an agenda item in the next Nursing Board meeting. - GW is awaiting the TOR and dates for the POCT Group from Rachel Rayment. GW to circulate once received. Item 2.4 - HCAIs – GW is awaiting HCAI dates from Claire Main. GW will send to Claire Mahoney once received. JC requested feedback from Claire Main at the next meeting in relation to line infections. Item 3.2 - RB will discuss long waiting patients in Neurology with Tom Hughes today in their DMT meeting. - Each Directorate was asked to feedback any long waiters to JC. JC will pick this up with Directorates at the RTT meeting today. Item 3.3 - Hattie Cox was due to feed back to CF on the unusual phone call received in Neurosciences. RB will follow this up with Hattie. Increasingly likely that it was generated from social media. - Critical Care Report is included on the agenda.	**Dirs** **GW** **Dirs** **GW** **Dirs** **CM** **GW** **CP** **GW** **GW** **CM** **RB** **JC**
PART 2: SAFE CARE		
2.1	Open Serious Incidents 6 Open Incidents included in the report in total. - In73577 - N&T incident in progress. - In61929 - Neurosciences – in progress. - In81765 - Cardiology – the RCA has been completed. Now progressing to closure form.	

	- In80228 - Cardiac – Met as a DMT pulling improvement plan together. Progressing to closure form. - In82518 – Critical Care – JB noted that this incident has been ongoing for some time as the patient notes cannot be located. Trying to get someone in medical records to take his on. JB will liaise with Suzie Cheesman. - In87624 – Haematology – All in process. Should be able to close this incident shortly. <u>Open Inquests</u> Directorates to review the list and raise any concerns. No concerns/issues reported in the meeting. <u>Patient Safety Alerts</u> Medicines Safety Briefing – "Insulin: Raising Awareness of Safety Issues." Directorates to be aware. List of steps to avoid risk when prescribing insulin.	**JB** **Dirs** **Dirs**
2.2	<u>Closure Forms for Serious Incidents:</u> - In82518 - In82065 - In82891 - In77207 and Improvement Plan All of the Closure Forms were signed off by the group.	
2.3	<u>Healthcare Associated Infections</u> HCAI Report - For information.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Royal College of Anaesthetics (FICM) Report</u> CS presented the facts of the report to the group entitled "Faculty of Intensive Care Medicine External Review". The report was as a result of an external review requested by Critical Care and commissioned by the Health Board. The main concerns that prompted the review were listed as; - SMR 2SD above mean - Capacity and sustainability of model - Anticipated strain of MTC The team visited in January 2019. The team consisted of experienced and credible individuals from MTCs in England. The report is intended to be widely shared. Responses achievable at 3 main organisational levels; - Clinical Board and Below (minority) - Clinical Board to Exec level - Exec level to Welsh Government level The main recommendations were discussed for each level. It was noted that progress has been made in a number of areas since the review took place in January. Re the recommendations for the Clinical Board and below; HR felt that the report hadn't pin-pointed where all of the problems are. He suggested that the report could make the Datix recommendation more specific. CW noted that working groups have been set up within Critical Care around implementation of the key actions required as a result of the recommendations.	

	Re the Clinical Board to Exec level; NM noted that there was a workshop with Executives last week regarding what the options could be about future UHL models of care and acute services. There has also been two meetings with the Clinical Board and Directorate team to review the report and recommendations. No meetings had been held/organised with Executives yet. CS felt that a notable paragraph was that the report acknowledged that the organisation had been carrying a risk rating of 25 for a considerable amount of time without any significant mitigating actions or resolution. NM stated that he felt it was very important to carry this review out. He has been asked by the Executives to provide our response to each of the recommendations. This will be shared with Executives. It was noted that the Chief Executive is highly engaged with the issues. JB commented that a significant amount of the work does crossover into nursing, noting that they want to look at a nursing external review as well. JB noted that they will pull out any actions needed relating to nursing. JC agreed to share the report with the group. NM will be writing to staff and reinforcing the message that the report findings are not a criticism of the team. NM requested that the Directorate sends this message back to the staff on Critical Care.	**JC**
3.2	<u>M&M Processes in Critical Care</u> Defer to the next meeting.	**GW**
3.3	<u>Operational Policy and Annual Report for the ACHD Service</u> JC referred to the Operational Policy and Annual Report for the ACHD service embedded in the Agenda. The documents have been generated for the ACHD peer review planned for June. As part of that review the Directorate had to update their operational policy and produce an annual report for noting. The Policy and Report have been sent to the South Wales and South West ACHD Network.	
3.4	<u>Feedback from UHB QSE Committee</u> It was noted that the Clinical Board is presenting on the 18th June at the UHB QSE Committee. JC expressed a huge thank you to the Lead and Senior Nurses who had provided a significant amount of information at short notice and had been a huge support.	
3.5	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> None.	
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u> None.	
PART 5: DATE OF NEXT MEETING		
5.1	Thursday 27th June 2019, 8am, in the Critical Care Resource Room, UHW.	

AGENDA
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 16th May 2019 09:00-11:30
Venue: Classroom 2

Present

Rebecca Aylward (Chair,) Director of Nursing, Medicine Clinical Board
Diane Walker, Lead Nurse, Integrated Medicine
Jacquie Westmorland, Senior Nurse, Emergency & Acute Medicine
Ian Dovaston, Practise Development Nurse
Gill Spinola, Senior Nurse, Specialised Medicine
Suzie Cheesman, Patient Safety Facilitator

Apologies

Barbara Davies, Lead Nurse, Specialised Medicine
David Pitchforth, Senior Nurse, Integrated Medicine
Kath Prosser, Quality and Governance Lead, MCB
Derek King, Infection Control Lead

	Documents/Other Info	ACTIONS
A1 A2	Welcome & Introductions Apologies for absence RA welcomed all present but noted the disappointing number of attendees. This was attributed to other meetings within the directorates; RA agreed to contact all members of the committee to prioritise these meetings in their diaries.	RA
1.1	To receive the minutes of the previous meeting **1.5 Workplace Inspection Update** DW asked that the following minute be amended: *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.* It appeared that there was a word missing following *DW agreed that this seems* and asked that it state '*DW agreed.'* DW said she had not agreed to arrange skips for waste collection; RA agreed, saying that a waste amnesty day to include skips be arranged.	RK
1.2	Matters arising **1.1 Feedback from UHB H&S Operational Group** RA noted an action for KP to liaise with Carl Ball to arrange a presentation and agreed to check on KP's progress.	RA

	1.2 Manual Handling and V&A Training Guide ID had looked into figures for V&A training compliance on wards on both sites and found a huge variance from 100% to 0 compliance. DP had also identified an increase in V&A related incidents; RA agreed to ask KP to add this to the risk register as a possible correlation. Following an incident wherein a patient had become unwell in the capsule room that was situated a long distance from the main clinic, GS reported that this room was now due to move to the end of the corridor in Endoscopy. **1.5 Workplace Inspection Update** RA agreed to check on KP's progress with arranging workplace inspections on the wards. **Directorate QSE Meetings** GS confirmed that the Gastro QSE meeting had taken place on 9th April; DW confirmed that Internal Medicine and Clinical Gerontology meetings were due to take place today. DW was not happy with the management of directorate QSE meetings but was reluctant to make any radical changes as there was currently good clinical engagement. RA asked that future meetings are not all held on the same day but GS advised that historically directorates all held their QSE meetings on audit days although it was rare for the MCB meeting to also fall on this day. JW agreed to chase submission of the E&AM QSE minutes for April. **1.6 Exception Reports and Escalation of key H&S issues from Directorates** The Hover jacks had been delivered to UHL but one was broken so temporarily unavailable. ID confirmed that to mitigate any risk associated with its unavailability all staff had been made aware how to move patients safely.	RA RA JW
1.3	<u>Patient Story</u> David Pitchforth was unable to attend to present the patient story.	
1.4	<u>Feedback from UHB QSE Committee</u> **CHC Visits** Prior to the recent HIW visit, RA had presented action plans ensuing from the visits from the CHC. These had been noted by the MCB but a need for the Surgery Clinical Board to assist with improving flow through AU and improving the patient experience in this area had been noted and was still under discussion. **Stroke Rehab Governance** The UHB Committee had asked for a progress report to be presented at the next stroke meeting due to be presented by Fiona Jenkins. DW was in the process of writing this report; RA advised that historically it included information on concerns and from Datix. **Management of Endoscopy Surveillance Patients** It was noted that the volume of these patients had decreased to a level that met Steve Curry's satisfaction but risk management measures were still in place.	
1.5	<u>Directorate QSE minutes – exception reporting</u> <u>Feedback Integrated Medicine QSE</u> Nothing further to note – see updates in 1.2 Matters Arising.	

1.6	Papers for noting MCB Management Board Meeting – 25th April 2019. Noted, with reference to the good work carried out within Medicine over the previous year. MCB Nursing Board Meeting 18th December 2019. Noted.	
2.1	Annual Pressure Ulcer Prevalence Audit Pressure ulcer information booklets were being printed and expected to be distributed throughout the MCB in the coming weeks. It was agreed that communications would announce the circulation of this booklet. At a meeting on 29th April it was noted that Repose companions were now available for trolleys; Wayne Parsons had further information. Prevalence of pressure ulcers across the UHB following the last prevalence survey has reduced to 5.3 which is an improvement from last year. It had been agreed that A7 could ring fence beds for patients requiring liver biopsies.	
2.2	Flu Campaign 2019/20 Deferred for discussion at meeting on 20th June.	KP
2.3	Physical/psychological benefits of singing!! RA circulated information on the benefits of singing in the workplace and asked all present to consider ways in which singing could be integrated into the workplace. It was suggested that a video be made with several members of staff singing one line of the song 'Perfect Day.'	ALL
3.1	Care of the Adolescent in Emergency Medicine Deferred for discussion at meeting on 20th June.	KP
3.2	Patient Safety Alerts Bleeding from a dialysis fistula/patient information card WHC 2019 016 – European Parliamentary Elections 23 May 2019 Medicines Shortage Letter Labetalol Tablet Noted. Please share with teams.	ALL
3.3	New SIs WG closure forms for discussion and shared learning **Integrated Medicine** **In85734 avoidable pressure damage** DW reported on a 93 year old patient with grade 2 pressure damage to their heel on admission that deteriorated to grade 3. Damage was attributed to poor documentation, patient heels not being assessed and risk assessment not being reviewed regularly. It had been recorded that patient was wearing Repose boots with intentional rounding being completed every 2 – 4 hours. DW suggested that the patient's heels	

	were clearly not being checked as they had deteriorated. DW planned to discuss this case with the wound link nurse on the ward involved. It was noted that the Senior Nurse was required to discuss this incident with the patient's family but there was no confirmation that this had been done; DW agreed to follow this up. It was agreed that more formal processes were required to ensure that all required actions were being completed and that patients' families were being contacted.	DW
	In85806 avoidable pressure damage DW reported on a 93 year old patient on Heulwen ward who was admitted with existing grade 2 pressure damage that deteriorated to grade 3. Investigations found that the patient's risk assessment was not accurate, a care plan was in place but had not been completed and there were concerns that the patient's dressings were not being changed or removed to check skin integrity. Intentional rounding was frequent but it was doubted whether all areas were being checked. Staff had been advised as to best practise regarding pressure damage but methods to confirm all actions were complete were not in place. DW agreed to check if a Senior Nurse had spoken to the patient's family.	DW
	In78072 avoidable pressure damage DW reported on a patient on the SRC who had developed pressure damage as a result of a sling being left on a chair being sat on by the patient. It was agreed that this damage was avoidable but it was noted that patients in the SRC were still sitting on slings on chairs. All staff had been advised immediately that slings must be positioned to prevent risk of damage but it was agreed that this should be clarified that slings were removed from chairs completely. It was noted that positioning of slings on chairs had not been included in the new pressure damage information booklet.	
	In82343 avoidable pressure damage DW reported on a patient with multiple comorbidities who sustained unavoidable pressure damage in December 2018. The patient had broken skin that deteriorated during their stay on the ward despite risk assessments, skin bundles and intentional rounding being completed to best practise.	
	Emergency/Acute Medicine **In89353 Injurious injury** JW reported on a patient who feel and fractured their left hip. This patient had been fully assessed by a physiotherapist and was found to be mobile with a Zimmer frame. Prior to falling she had used a call bell but proceeded to get up on her own. It had been found that all measures to prevent this fall were in place; the only criticism was that following the patient's fall they should have been lifted with a Hover jack, which they were not.	
	In87829 avoidable pressure damage JW reported on a 74 year old patient with grade 2 pressure damage on admission to AU; this damage was not documented in AU and pressure areas were not checked on transfer to a ward resulting in damage deteriorating to grade 3. It was agreed that ward staff needed to check patient's skin even if patient believes their skin is not damaged.	
	In81612 Unexpected death JW reported on a patient who attended EU with a headache reporting a history of migraine and substance misuse. All tests were reported clear	

	but lumbar puncture had been indicated. The patient signed out against medical advice and was later found in the toilet cubicle in cardiac arrest and later died. The patient was found to be carrying heroin and his death was attributed to an overdose. A sample was sent to Wedinos, the Welsh Emerging Drugs and Identification of Novel Substances Project, but had been mislaid in transit; it was agreed that a more robust way to transport samples was needed. JW asked that the outstanding documentation of this incident by a newly qualified nurse be noted. This incident had been closed by WAG. **Specialised Medicine** **In90063 Injurious injury** GS reported on a patient who had been found in the toilet after falling while putting on underwear. The patient sustained a fractured NOF requiring surgery. The patient's family had been informed and the post falls procedure undertaken in line with best practise but the neuro observations had not been carried out in the required time due to delays with medical staff. Prior to the fall, lying and standing blood pressure observations had not been carried out; all staff had since been reminded of the importance of these test. PDNs were in the process of coordinating falls simulation training and working with the strategy lead. It was agreed that this fall was unavoidable as the patient had not been deemed at risk of falling. **In89748 Avoidable pressure damage** GS reported on a patient on West 1 who had sustained avoidable category 3 healthcare acquired pressure damage to the spine and had pre-existing category 1 moisture damage to the chin and chest that evolved to category 3 damage. It had been found that the patient's Waterloo score did not reflect their low BMI and the skin bundle had not been completed in time and although the patient had been turned twice in 15 hours they had not been nursed on their side. A Dolphin mattress was eventually put in use but after an unknown length of time it was found to have deflated. There had been limited dietetic input to prevent this damage. Positive findings of the investigation were that intentional rounding was in place, as was a care plan and appropriate photographic records. Different dressings had been trialled on the patient's chin but did not prevent deterioration of damage. At the time of the patient's stay on West 1 they were receiving palliative care and had since died; GS had made contact with the patient's family who had confirmed they were not happy with the patient's treatment and intended to lodge a formal concern. RA noted this raised concerns around governance and a failure to communicate with patient's family, despite an obligation to do so. DW suggested that staff be supported in having such difficult conversations with families. RA queried if a letter was being written to send to patient's families outlining the redress process with regard to future claims on previous cases and an increase in claims for redress. RA agreed to discuss with Carol Evans and noted that the concerns team were now asking further questions, such as how well the patient was healing, in relation to the scale of redress claims. DW noted that nowhere in the patient care plan are staff directed to explain to patients the risk of pressure damage.	RA
3.4	<u>Infection Prevention and Control up date</u> <u>WHO Clean your hands campaign</u> The following figures were noted: C.diff – 2 new cases, making total of 28, above target of 12	

	MRSA – 0 new cases, making total of 5, above target of 0 MSSA – 1 new case, total 24, above target of 12 E.coli – 3 new cases, total 50, target 24 Pseudomonas – 0 new cases, total 2, target 0 Klebsiella – 2 new cases, total 9, target 12 With regard to E.coli, DW asked if patients with catheters were being investigated; RA confirmed that this work was ongoing and was due to be shared and implemented in the MCB. ID had carried out an audit on UHL and found that the All Wales catheter bundle was in use generally with the majority being completed each day. IPC was due to be added as an agenda item to the band 7 forum to give wards an opportunity to take control of IPC. **RCAs** An RCA amnesty had been agreed and those over several months old had been written off but a new requirement to complete RCAs in 3 weeks had been introduced. As of April, JM had kept a list of RCAs with deadlines and would be chasing progress. Ward Managers had been made aware of this timeframe. **Audits** It was agreed that following audits, risks were escalated and not accepted as historic or unsolvable, such as the poor material condition of wards. **Cleaning scores** Recent cleaning scores had been quite poor, particularly in UHW. This had been raised at an Exec Performance Review; Ruth Walker had asked for assurance that Ward Sisters were checking audits with housekeeping staff before sign off. UHL's most recent score was 95% which although not ideal was better than UHW's score of 85%. DW suggested the Ward Sisters needed to be empowered to feel proud of their wards and reclaim accountability and ownership of their ward, an example of which being to refer to the cleaning schedule and check that they there were being completed.	
3.5	<u>Risk of bed malfunction secondary to dust</u> It was noted that the brakes on a bed on West 6 had failed recently due to the significant build-up of dust on the brake mechanism. It was agreed that the cleaning schedule be revisited to check how often beds were being pulled out and cleaned.	
4.1	<u>Assessment Unit HIW Action Plan update</u> JM and JW had reviewed the above action plan together and all actions were up to date, including the order of reclining chairs and a quote for a curtain rail. RA agreed for the updated action plan to be circulated.	RA
5.1	<u>Health and Care Standards</u> RA thanked those who had contributed to the recent review of Health and Care Standards and confirmed that they had been submitted for assessment.	

5.2	Feedback from Ombudsman Report Deferred for discussion at meeting on 20th June.	
6.1	National User Experience Framework Feedback from 2 minutes of your time survey – relevant improvement plans RA was in the process of gathering more information on the Patient Knows Best software.	RA
6.2	DTOCs Noted. DW had recently attended BIS training and found that areas in Specialised Medicine were still sitting under Integrated Medicine. RA confirmed that in future DTOC information was to be amended before being circulated to provide patient anonymity.	KP
6.3	Compliments The following compliments had been received: **East 8** – staff had helped a visitor who had fallen, ward receptionist had driven her to UHW. Compliment also praised care of patient on the ward. Specialised Medicine – **Dermatology** **Emergency Unit** – patient was pleased with time taken to be treated, within two hours, and commented on the 'lovely nurse' who treated them.	
7.1	**Winter pressures - staffing** Heulwen ward had closed on Tuesday 14th May; RA asked that this item be removed from the agenda. Thank you letters were to be written to staff who had helped make the ward a success and lessons to be learned would be shared through this committee.	KP RA
7.2	**Congratulations – Staff recognition awards** RA noted the following achievements at the Staff Recognition Awards: Manager of the year: Linda Edwards, Sam Davies Ward Leadership: Jeff Turner, Clinical Gerontology Patient Experience: runners up, ward A4 People's choice award: Delyth Tompkinson Chairs Award: Linda Edwards, Sam Davies Ward NETS awards: Cath Powell and Rebecca Taylor RA asked that her congratulations to the following be noted: - Lisa Waters for presenting at the CNO Conference - Jennie Palmer and Helen Bennet for presenting work on the Welsh Gender Service at the CNO Conference - Ruth Cann for presenting a poster at the CNO Conference - The 'Choose Life' team, comprising DW, Ruth Cann, JM, RK and herself for winning the 'Best Dressed Bed' award at the recent Cardiff and Vale Charity Bed Push - The 'Rhydlafar Warriors' team for competing in the bed push	

AOB	POCT RA asked all present to submit their nominations for the Nurse of the Year Awards at the following link: Nurse of The Year Award www.rcn.org.uk/wales/get-involved/awards Nurseoftheyearawards@rcn.org.uk	

Date and time of next meeting: 20th June 2019 Classroom 2

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

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 7th May, 08:00-10:30 hours
Council Room, A Bl, UGF,

Present:

Clare Wade	Acting Director of Nursing	ClaW
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
Barbara Jones	Perioperative Care Educational Lead	CM
Cath Bradshaw	PDN, General Surgery	CB
Ceri Chinn	Lead Nurse, Perioperative Care	CC
Andrew Hall	Graduate Management Trainee, Perioperative Care	AH
Rowena Griffiths	Quality & Safety Lead, Dental	RG
Catherine Evans	Patient Safety Lead	CE
Chris Wilson	Clinical Director, Trauma & Orthopaedics	CWilson
In attendance:		
Edwina Shackell	PA, Surgery Clinical Board	ES

PART 1: PRELIMINARIES *(Chair)*		
19/60	**Patient Story – General Surgery, Incident 78294** A patient on Heulwen Ward had deteriorated. Members of the arrest team attended whilst colleagues dealt with a simultaneous call. Resuscitation attempts had been made by ward staff, but the anaesthetist required kit not kept on the ward resuscitation trolley. Suction at the bed had not been correctly connected, but the available portable suction was used once replacement batteries had been utilised, as the originals were not working. A member of staff was despatched to theatres for further items of equipment. Security noted that the break glass on the ward had not been reset following the call and remained on a closure setting. The member of staff returning from theatres had no ID badge with them, resulting in a two minute delay in accessing the ward. Root Cause Analysis (RCA) findings were: 1. Suction. It had not been possible to identify why this had not been correctly connected. Daily checks had since been instigated in that area. 2. As a former children's unit it was deemed possible that the smaller armchair had pushed up against the suction unit, unlike other adult wards. 3. Laryngoscope blades. Batteries were not regularly checked due to a reluctance to disturb the sterile packet. A test blade had since been introduced on the Resuscitation trolley to enable testing of batteries. 4. The eye gel requested by the anaesthetist was not standard on Resuscitation trolleys. 5. Door entry system. This was reviewed with Security and amended so that in an arrest situation the doors will remain unlocked until an incident is over. 6. Debrief of staff had been undertaken. 7. A Coroner's inquest had been postponed; notification of a revised date is awaited.	

	It was noted that all actions arising from the RCA had been undertaken.	
19/61	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
19/62	**Apologies for Absence** Received from Gillian Edwards, Vince Saunders, Adrian Turk, Angela Jones, Oleg Tatarov, Michelle Abel, David Scott-Coombes and Jayne Thain.	
19/63	**Declarations of Interest** Nil	
19/64	**Approval of the minutes of meeting held 12th March 2019** The Minutes were approved.	
19/65	**Matters Arising: To receive Action Log from the above meeting** <u>18/41 25/9/18: Cefuroxime 50g powder for intracameral injection.</u> This had been discussed at the last audit. There had been two recent cases of suspected Ophthalmitis. Mr Williams had recently sent an email for feedback on the change of practice, and had received a positive response. It is likely that the switchover to will be made. Mr Roger McPherson will be asked to place this on the next Ophthalmology Quality and Safety meeting for discussion. Training would be arranged for nurses with the supplier. <u>18/105 3/7/18: Orthopaedic Thromboprophylaxis regimes.</u> Mr Wilson advised that the orthopaedic surgeons are keen to implement the use of aspirin as per the NICE guidelines; however, it is clear that the UHB would not indemnify clinicians for the use of this off licence drug. It was clear that prescription of aspirin needs to become UHB policy to give clinicians confidence in prescribing this. There is currently a conflict between NICE recommendation and the UHB position. Clare W advised that Mr Kumar had been liaising with Legal and Risk regarding liability, and was awaiting a formal response. Both licenced products, Ipixiban and Clexane, are more expensive. Mr Kumar has asked for confirmation from clinicians which will be the standardised drug across the UHB. **Action: Agenda item for next TAAG meeting and Surgery Q&S Group.** <u>19/09 15/1/19: NATSIPPS Report</u>. Agenda item <u>19/35 12/3/19: Terms of Reference</u>. Agenda item <u>19/38 12/3/19: SE Wales Interventional Radiology service</u> Assurance was received that a log of all activity is kept to facilitate recompense. Monitoring of any issues arising in directorates would continue via this Group. **CLOSED**. <u>19/40 12/3/19: Datix queues</u>. Currently 170 unopened which may include Serious Incidents. Managers to check if queues are building. Helpdesk and repeat training are available, or as an exception contact Cath Evans, Patient Safety. **CLOSED.** <u>19/44 12/3/19: Transforming outpatients pharmacy, electronic prescribing</u> Feedback: Mr Chris Williams noted that training was limited, and that the system was not straightforward; a pharmacy colleague had experienced accessing. AJ had not yet received feedback. Mr Chris White, T&O, advised that this was not yet implemented in outpatients. **CLOSED** <u>19/44 12/3/19: UHB Diabetes Guidelines 2017</u>	**CW & ES**

	It was confirmed that Sian Williams was following up as agreed, escalating concerns to Abrie Theron and Caryl Taylor. It was noted that pre-operative optimisation of patients is a significant challenge in the next two years, with the Diabetes guidelines potentially being part of this. **CLOSED** 19/52 12/3/19 Coroners' inquests. All to continue to escalate to the Clinical Board management if colleagues become aware of coroner's cases, to enable staff to be supported. **CLOSED** 19/52 12/3/19. Ombudsman's Draft Report. RB confirmed that consent for elective sections is done 3 weeks in advance and reviewed on the morning of surgery. **CLOSED.** All directorates to review their practice of consent for surgery and add any patients that cannot be consented except on day of surgery. **Assurance to be provided.**	**ALL**
19/66	**Terms of Reference – Approval** **APPROVED**	
PART 2: PATIENT SAFETY AND QUALITY		
19/67	**Director of Nursing Annual Report to UHB QSE Committee 16th April 2019** The Report was well received. Concern was raised regarding 4 Never Events. There had been 52 SIs, the majority being pressure ulcers. IPC performance had improved regarding C.difficile (a 50% reduction), but concerns remained regarding MSSA and MRSA. The improvement work over the last year was presented, together with the focus of the improvement work going forward.	
19/68	**Director of Nursing Q&S Report March 2019** Serious Incidents (SIs) – 6: 2 lost to follow up in Ophthalmology reported in retrospect, when patients reported in January/February 2019 with a reduction in vision. 1retained swab 1 wrong site injection 1 pressure damage 1 injurious fall 3 SIs closed with Welsh Government. Concerns: 51 open at 31/5/19. 50% of formal concerns were responded to in 30 days. The Clinical Board has been challenged by the Executive team to improve performance. Dental: 4 Concerns in March. Internal RCAs – Patient Safety aware. One SI patient lost to follow up open.	
19/69	**Directorate Assurance Reports:** 1. <u>General Surgery & Wound Healing, ENT, Urology & Ophthalmology</u> - Ophthalmology – continuing with RCA analysis on insourcing. Independent expert reports being received. - Urology – issue with service in reach to Rookwood. Local plan in place to resolve this - 2. <u>Perioperative Services</u> - A mandated directive is anticipated to move all implants to single use, single wrapped devices. - Sterile laryngoscope blades and handles. An assessment is being undertaken prior to a final decision. The decision will need to be approved by the UHB. The financial impact will be significant.	

	- Serious Incidents at UHW and UHL were reviewed including a retained swab. The RCA was nearing completion and would then be discussed. - Scope room main theatres work continuing for a further 6 weeks. - Concerns had been raised the unsuitability of the DOSA environment for dignified patient review and admission. Escalated to the Clinical Board. - Hire process UHL Theatres is not being followed by T&O surgeons. Discussions are underway to resolve this with the directorate. - Day Surgery UHL, Black & Grey – progressing, a further10 weeks. - Adult resuscitation manikins had been replaced. 3. <u>Anaesthetics</u> - New Throat Pack Guidelines recently discussed. BJ advised that she had sent Throat Pack Policies to Anaesthetics, which will then be revised and brought to this Group. 4. <u>Trauma & Orthopaedics</u> - *MDA/2019/006(Wales) 14 February 2019. Orthopaedic implant head/Radial head and Uni-Elbow: risk of early loosening*. Requires a review of data of long bone plates since February. An individual had been tasked to undertake this review. - Consent audit discussed at Q&S. Day of Surgery consent will be discussed at the next meeting. - TKA and THA specific consent forms. Mr Wilson had contacted Dr Hughes with regard to agreement to use these forms. The forms are in the same format as the All Wales form, but with pre-printed complications. Helen Luton had liaised with Julia Barrell, Mental Capacity Act Manager, who has confirmed that if the form follows the All Wales format, she is content. **DECISION: The use of these specific consent forms is formally RATIFIED by this Group.** Translation into Welsh would be actioned by HL and liaise with Alun John regarding the mechanism for printing. Action: BJ to share the forms with Anaesthetic practitioners for awareness. - Risk register –nursing vacancies added. 5. Dental - The accredited Sterile Services facility had been audited, 1 major and 2 minors identified. Action plan in place. - One SI – report completed and actions agreed. - Concerns – 1 outstanding 30 days, outside of dental RTT rules, the reason being understood.	
19/70	**Exception reports from Directorates/Working Groups** 1. General Surgery, Vascular , Wound Healing - nil 2. Head & Neck, Dental Maxillo Facial and Ophthalmology - nil 3. Urology - nil 4. Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: o Two incidents Friday 3rd May regarding gastroscopes: o One used inappropriately as a colonoscope, taken out of service and will not be used again. o One used which had passed its sterility use by date. o RB raised a colleague's serious concerns regarding the organisation of the Day of Surgery Admission (DOSA) unit, which they had deemed to be unsafe. An example was cited of a day the previous week when 6 patients had required anaesthetic review. Patient dignity and privacy had been compromised, there being a single examination room. Patients were therefore reviewed inappropriately in the changing room. CC advised that on the Friday of the previous week, there had been 26 electives for surgery	

	requiring admission the day before and so a large number of them were carried over and placed on DOSA, impacting that area. RB explained that it was difficult to identify the whereabouts of patients. It was acknowledged that on this occasion the number of patients had been particularly high. A brief discussion ensued, the key points being: - The number of DOSA patients had increased since the model had been signed off. - Lack of clarity where patients were transferred post-procedure. Was this the responsibility of the anaesthetist or the surgeon? - Lack of communication with anaesthetists with regard to the bed position. - Should anaesthetists continue with lists in the absence of an updated bed position? It was noted that practice in Main Theatres, was to complete the first 2 cases then check with the Recovery manager prior to continuing with the lists. It was acknowledged that this may lead to cancellations. - RB explained that on the day in question, the anaesthetist had not been made aware that patients were waiting in Recovery until the 3rd patient had been operated on. - Of necessity all patients attend at 07.30 to facilitate Anaesthetic review. - DOSA ward staff had not fed back that the area was too busy. - It was acknowledged that the DOSA area was being used to relieve pressures elsewhere. It was anticipated that this would improve post winter pressures. - Monitoring would continue. **Action: Colleagues to complete Datix reports should they have concerns regarding patient care.** MB confirmed that there were currently two Datix reports, 1 from an anaesthetist and 1 from a staff member. 5. Trauma and Orthopaedics - nil	**ALL**
19/71	**Alerts and other Safety Notices** <u>NICE Guidance</u> 1. Surgery CB summary spreadsheet: There were no outstanding responses. <u>Patient Safety Notice</u> 2. PSN045/August 2018: Resources to support safer modification of food and fluid 3. IDDSA Update March 2019 A reissue highlighting changes, labelling, and the standardised approach across Wales. **ASSURANCE was RECEIVED** of compliance with the1st April 2019 deadline. <u>Communications from UHB</u>: 4. April 2019: Safe practice reminder: for all staff who use pulse oximeters (ref PSA 048). **RECEIVED and NOTED**. 5. Guidance Document on Valproate Use in Women and Girls of Childbearing Years, 29th March 2019. **RECEIVED and NOTED**. 6. Proposed questions for legal advice regarding the non-prescribing of contraception of female patients of child bearing age prescribed valproate. **RECEIVED and NOTED.**	
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
19/72	**Key Messages from Board/ Committees/ Groups** 1. UHB Medicines Management Group Notes 7th March 2019 and UHB Medicines Management Group Notes 4th April 2019. **RECEIVED and NOTED.** 2. Clinical Board IP&C Group – draft Minutes of 8th April 2019 **RECEIVED and NOTED**. Reduction of C.difficile showed significant	

	improvement. An IPC Plan to improve MSSA and MRSA infection rates will be submitted to the next UHB IPC Committee. 3. Clinical Board Health & Safety Group. Minutes of meeting 13th February 2019 and draft Minutes of 17th April 2019 **RECEIVED and NOTED.** Of note: o Debate continues regarding fire evacuation, both staff training and equipment. The UHB Health & Safety Committee have been asked for clarification on the UHB approach. Added to the Clinical Board Register. 4. Decontamination Committee Minutes January 2019 & 11th April 2019 minutes. Not yet available. **5.** Safeguarding Steering Group Minutes 28th March 2019. **RECEIVED and NOTED.** 6. Orthopaedic Infection Quality Improvement Group Minutes 3rd December 2018, Agenda 3rd December 2018. **RECEIVED and NOTED**. Work in progress regarding preoperative screening for MSSA. 7. TAAG Group Minutes 4th April 2019. Patient friendly letters regarding coagulation had been drafted. 8. Right First Time: Labelling your Specimen and Request Form matters poster. This had been circulated.	
19/73	**Medical Equipment Group (standing item)** Minutes of meeting 18th April 2019 RECEIVED and NOTED. Of note: 1. The majority of defibrillators were obsolete and have been replaced. However training will not be provided by the supplier. The Resuscitation Service lacks capacity to deliver training. The new machines cannot be released in the absence of staff training. In addition, replacement batteries for the old machines are no longer available, now obsolete and will only work if plugged into the mains. There is therefore a significant patient safety issue. RH was due to meet with Angela Jones, Resuscitation Service regarding training capacity. It was highlighted that although an audit session would provide the ideal platform for training, theatre staff would be excluded, as 8-9 lists continue to run. In addition, ward staff are precluded from attending audit. A drop in session could be suggested on the next two audit days, but a directive would need to be issued that these are mandatory. 2. Regulations regarding use of Ultrasound. All users must be trained on all ultrasound equipment. RH had raised this with the Clinical Director for Anaesthetics, to ensure this is included in 'on the job teaching'. Trainees undertake training which is signed off; however assurance was required that consultants have undertaken competency training. A UHB approach is to be determined in consultation with the Medical Director. 3. Regulations on Medical Equipment Management Policy. Formal groups are reviewing Health Care Standards.	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
19/74	1. <u>Surgery Clinical Board IPC update 20th April 2019</u> The report was briefly reviewed. Of note, the Surgery Clinical Board was awarded the Beat Flu award for the most improved in Wales, achieving compliance of 60.9% for frontline staff. Thanks were extended to all 'Flu Champions. 2. <u>Clinical Board HCAI review to end of March 2019</u>. The data summarised the year 1/4/18 – 31/3/19. 3. <u>IP&C RCA database</u>. C.difficile – common themes could not be identified. 4. <u>Falls Report</u>. 1/4/18 – 31/3/19, total of 12 injurious falls, the majority closed with Welsh Government. A review of falls per Directorate for the same period is presented at Surgery Nursing Board	

	5. Pressure Damage Report – 1/4/18 – 31/3/19, total of 28 Grade 3 or 4 pressure damage, reported to Welsh Government. A review of Pressure Damage per Directorate for the same period is presented at Surgery Nursing Board.	
19/75	**National and UHB Audit Reports**: Clinical Board response to NHFD Audit Report 2017 Mr Chris Wilson explained that this was an ongoing, rigorous audit in England and Wales, mandated by their respective Governments. The audit was based on 6 key performance indicators, used to compare Wales with England, and to compare the UHB to national standards.. The UHB performed well regarding patients with frailty hip fractures, a large patient group, with numbers increasing. Of note the UHB was: - Performing well in performing surgery, over the national average in terms of surgery NICE compliance. - Performing very well in terms of patients receiving a nerve block in A&E - Return to original residence, just over average, due to the lack of a rehabilitation ward, thereby increasing Length of Stay (LOS). - Near average prompt orthopaedic review - Poor performance regarding prompt mobilisation of patient not confused post operatively. Responses to the Audit Report had been prepared by Antony Johansen: 1. 9% of trauma patients were admitted to an appropriate bed cf benchmark 40% within 4 hours. Both medical and surgical patients were in Trauma beds. There was a clear need to ringfence beds on A3L and A6. This requires urgent UHB review. 2. Perioperative care – patients to appropriate theatre, could improve. A solution was proposed, paying attention to the whole trauma stream to improve theatre efficiency, and working to introduce 3 session days for anaesthetists, including a dedicated anaesthetist, 08.00 – 20.00. 3. Perioperative care, 16% receive Consultant anaesthetic care cf benchmark 60%;, the above solution would address this. 4. 'Wish lists': eg a. Post operative care, trauma wards are understaffed for therapies. b. Prompt discharge of patients, would require reappointment of ward based social worker and data clerk, Mr Wilson recommended Mr Johansen's comments. Some responses were short term, some for UHB response with regard to funding, and some were part of a bigger picture regarding staff recruitment. A brief discussion ensued, key points being: - It was anticipated by Clare W that the Lightfoot work would be helpful. This was partially acknowledged by Mr Wilson; however it was felt that interrogation of the data by a 3rd party did not change some issues that were very clear and validated, and the challenges encountered in implementing remedial measures, eg Anaesthetist 3 session days, now agreed. - Social Worker funding. It was explained that this post had historically been partially funded by the UHB. - Cautious optimism was expressed that the outcome of the improved data would be improved measures. - Lightfoot is supported by the Executive Team, resulting in a reinvigorated interest in the frailty pathway. The goal is to reduce LOS, and a better patient outcome. This presents an opportunity to present the case for what the service needs, with	

	a cautious anticipation that this will be funded and implemented. This will be led by the Trauma team - It was emphasised by Mr Wilson that the actions arising from the NHFD response must be addressed, these being the most important and effective measures, before other issues are addressed. Some actions are local, as described above; others required the support of the UHB. - Anaesthetic 3 session days had been under discussion, for the Emergency list as well as Trauma (RH). It remains to be decided whether there would be a 5 day 3 session anaesthetist cover, with cover at weekends. - The first two patients on the list are the most important 'golden patients'. Currently specialist trauma lists take the space. Mr Wilson was thanked for his presentation.	
19/76	**HIW/CHC visits** Nil since last meeting. A visit to the Assessment Unit (AU) had taken place in early April 2019. - Of concern was the care of patients in the AU lounge, a 20 seated chaired area. Many surgical patients are pulled into that area, particularly at evenings and weekends. - The inspector raised concerns about the experience of patients in the lounge,. The Board had been asked to help support with transferring patients out of the AU lounge area in a timely manner which the board support as Surgical patients should be in Surgical Beds o An action plan had been written including recommendations which did need resources, eg anaesthetic lists for trauma patients to avoid long waits. Surgical patients with decisions to admit should be moved into any available surgical beds. o RH advised that there was no anaesthetic delay for trauma list. There was more pathway work to do.	
19/77	**Health Care Standards Audit November 2018**: Directorate Feedback on Audit results 1. Perioperative Care performed well, a significant improvement on previous years. All actions completed, and results shared with staff. 2. T&O. Positive feedback in patient comments. Most domains compare favourably with the previous year. Three wards scored low for sleep and rest, two of which were the elective wards, a noisy environment. This is being reviewed with the corporate nursing team. . 3. General Surgery, Urology, ENT – **Action: Andy Jones to feed back next time.**	**AJ**
19/78	**'Flu vaccination – Clinical Board performance** The Clinical Board achieved 61.7% compliance for front line staff, and were recognised as the most improved team in Wales.	
19/79	**Waiting list follow up assurance >36 weeks:** 6. ENT 7. Ophthalmology 8. Urology 9. General Surgery **Assurance required. AJ**	**AJ**
19/80	**Transfusion Committee** 1. Minutes of meeting 9th January 2019. Notes of meeting 5th April 2019 not yet available. 2. Zero Tolerance Report March 2019 3. Traceability Non-Compliance for March 2019 **The above were RECEIVED and NOTED**	

19/81	**Health Care Standards Self Assessment** Submitted the previous week for the CB. Dental submitted separately	
PART 5: GOVERNANCE		
19/82	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. Open Sis, No Surprises: 13 open. Now only reporting avoidable pressure damage. SI reported for patient with suspected Wet AMD, lost to referral, resulting in loss of sight. 2. Regulation 28 report: nil. 3. Open Inquests: 2 4. Serious Incidents: 1. Closure forms sent to WG since 1st April: 3 (target 5) 2. Closed SIs report – please see Director of Nursing Report at 19/68 above. 5. <u>Complaints, Claims and other Concerns</u> 1. All Open Clinical Negligence Claims 19/2/19 to 24/4/19: 5 2 All Closed Clinical Negligence Claims 19/2/19 to.24/4/19: 2	
19/83	**Vascular MDT Review** RH identified that according to the data, the % Mortality & Morbidity in Vascular was higher than peer units. The data is under review.	
19/84	**Gastroscope Look Back** See Perioperative report above at 19/70.4	
19/85	**Defibrillator Replacement Programme – Urgent update** See Perioperative report at 19/70.4	
19/86	**GDPR:** Displaying GDPR Information in Public Areas – Audit Report Recommendation (letter from Sharon Hopkins 29th March 2019) Privacy Notice Briefing for Managers – June 2018 **RECEIVED and NOTED.** Previously circulated to teams.	
19/87	**Standing Item:** **Point of Care (POC)Testing Group** Meets quarterly, and feeds back to UHB QSE via this group. Focus is on improving governance regarding POC devices, blood glucose and pregnancy testing. Colleagues to raise relevant issues to C Bradshaw who relay to the POC Group. Failure of staff to be trained on a device will result in the removal of the device. Training and assurance – bar codes in blood glucose box have been removed, to ensure named staff only use the device. Going forward: Testing of machines via a spot audit. The majority of errors is administration. Data to be able to be interrogated in order to identify to users using a device incorrectly. INR checking: CAVOC. HL to review and provide feedback to Cath B. HL confirmed not and will look into it. Short Stay – in place. Babs Jones had met with Seetal Sali and is arranging pregnancy testing training. A number of wireless meters are going into different areas. This will be discussed at Nursing Midwifery Board regarding which staff group will use these ie HCSW or registered nurses. .	

19/88	**Patient Surveys:** 1. National Survey Report for Surgery (February 2019) 2. '2 Minutes of your time' (February 2019) **RECEIVED and NOTED**	
19/89	**Research & Development** 1. Research Governance Group (RGG) Next meeting 30th April 2019 2. R&D Leads Meeting Minutes 10 April 2019 It was noted that expressions of interest for the Surgery Clinical Board R&D Lead have been invited.	
19/90	**Medical Device Regulation** 1. Letter from Dr Rob Orford, Welsh Government 28 January 2019 2. Response to WG Medical Devices Regulation (2017) questionnaire February 8th 2019. Raised at Medical Engineering Group, working groups looking at. **NOTED for INFORMATION**	
PART 6: DATES OF NEXT MEETING **Tuesday, 30th July 2019, 08.00 – 10.30, venue tbc.**		
PART 7: URGENT BUSINESS		
19/91	1. NATSIPPS – M Bennion attended. It was confirmed that in terms of completing documentation, because the gap analysis had been completed, every policy should be reviewed every 3 years. Therefore, by the end of a 3 years period, all policies should be in LOCSIPP format, which will suffice. However, there should be working groups for Central Line insertion. The Natsipps T&F Group will continue until UHB wide procedures are in place. **Action: to be added to the next Agenda ES**	**ES**
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
19/92	**Recent Reports & Communications** Nil received.	
19/93	**Directorate Q&S Agendas/Minutes including M&M activity** 1. Trauma & Orthopaedics Directorate Q&S Notes & M&M information 2. Perioperative Care Q&S Minutes 2nd April 2019 3. Anaesthetic Q&S Minutes 12th February 2019	

MINUTES
CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 23rd April 2019, 8.30am, Meeting Room, Clinical Board Offices Lakeside UHW

Preliminaries		
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing Meriel Jenney, Clinical Board Director Paula Davies, Lead Nurse Community Child Health Nia John, Consultant in Community Child Health Alicia Williams, Cancer Services Manager Beverley Thomas, Asst Directorate Manager Community Child Health Raj Krishnan, ACD Acute Child Health Cheryl Evans, Directorate Manager, Obstetrics & Gynaecology Eirlys Ferris, Senior Midwife, Obstetrics & Gynaecology Laura Hutchinson, Risk Manager, Obstetrics & Gynaecology Matthew McCarthy, Patient Safety Team Nigel Davies, Clinical Director Obstetrics & Gynaecology **In Attendance** Kirsty Hook, Board Secretary Katie Simpson, CAMHS Project Manager (Item 2.6 only) Rose Whittle, Directorate Manager Community Child Health (Item 2.6 only) Lisa Waters, Senior Nurse Emergency Unit (Item 2.1 only)	
1.2	**Apologies for absence** Louise Young, Michelle Abel, Rachel Burton, Mary Glover, Angela Jones	
1.3	**To receive the Minutes of the previous meeting 26th March 2019** The minutes of the meeting held on 26th March were agreed to be an accurate record.	
1.4	**To note and update the action log of the meeting of 26th March 2019** Updates on all actions were provided and the action log updated accordingly. The action with regards to the representation at the UHB Water Safety Group will be followed up outside of the meeting and representation confirmed to IP&C.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Adolescent CAS card and pathway** Lisa Waters was welcomed to the meeting to provide an update on the work that is being undertaken within the Emergency Unit with regards to 16/17yr olds being seen in adult areas. The background to the work was provided and it was noted that there was a high number of patients that fitted the safeguarding criteria and would require potential follow up. The introduction of the safeguarding reviews were implemented with engagement from UHB healthcare teams including safeguarding and CAMHS. Documentation has been produced to support any review actions which will be implemented onto clinical portal. Feedback is then provided through the safeguarding review meetings on the actions that have been undertaken ensuring that the loop is closed for all patients. A new casualty card has been launched for all	

	adolescent patients and a specific adolescent flowchart produced to support robust safeguarding measures. Education of the new processes has been implemented in order to remind all staff of their responsibilities in relation to safeguarding. There has also been participation with the Cardiff & Vale Youth Board in order to make further improvements in the Unit going forward. Discussion ensued with regards to potential patients coming through directly to Gynaecology services and raising awareness and reflections that may require a similar process to be followed. It was agreed that this would be reviewed to ensure that there are appropriate and robust processes in place.	**O&G DMT**
2.2	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **O&G Report** • Fitness sessions for staff in place and fitness mats have been received from charitable bids • Smoking tannoy installed at the entrance of Maternity. • Stillbirth Review Audit data has been shared at Directorate Q&S and Obstetric Audit and it was agreed that this would be shared at a future Clinical Board QS&PE Meeting for information. • X3 ongoing RCA's in Obstetrics, with x1 joint RCA with Neonatal and x1 ongoing RCA in Gynaecology • The next MDT session is planned for May 2019. • T2 plans are continuing and an interim operational lead has been appointed. • X1 pressure sore reported, further information has been requested and update has been requested from Medical Photography • X1 baby fall reported, no harm has been sustained. • X1 medication error reported, with regards to incorrect dose of Heparin administered IVI no harm was noted. • 10 antenatal CTG machines with Dawes Redman capability have been received and training is taking place. These should be implemented by May 2019. • X3 midwives trained in hypnobirthing. Further discussions taking place with the community teams to discuss enhanced parent education to incorporate yoga & hypnobirthing. Currently scoping the possibility of aqua natal classes. 1 midwife currently provides aqua natal classes, identifying suitable course for further training. • No breaches reported for RTT in month • Plans continue regarding the relocation of the new antenatal clinic in UHL. The move will take place this weekend. • Recent case involving a patient with a hearing impairment– plans put into place to enable 24/7 access via text service. Discussion ensued with regards to looking at understanding this further and what can be undertaken next time to ensure robust mechanisms are in place in order to support the needs of further patients. It was agreed that in order to learn further from this patient's experience, a request would be made as to whether she would undertake a patient story to provide feedback and any lessons that can be learnt. • Staffing – there are a number of medical gaps within the service which are being progressed. Discussion ensued with regards to the induction of the locum consultants coming into the department, queries were raised as to who will be responsible for ensuring that this is completed. It was agreed that the plan would be brought to the next meeting for noting. **Acute Child Health** • X4 ongoing RCA's being undertaken • There has been a reduction in mandatory training compliance and it was noted that mandatory May has been reiterated and all have been requested to ensure that mandatory training is completed.	**LB**

	• MRSA screening compliance continues to improve. All ward sisters to reinforce with staff the need to complete screens. • The "Druggles" implemented within Neonatal has been very positive and work is underway in order to implement across a number of other areas. • 'Let Children know you're Listening'. New safeguarding poster to help adults who work with children to respond supportively in the moment a child chooses to disclose shared with staff. • Cascade training with clinical engineering being offered to staff. • There has been a 10% increase in the number of commercial R&D studies being hosted by CYARU. • Information governance breach has been reported and is being investigated. Feedback has been provided through the staff forum in order to raise awareness and responsibility. • Patient Information Boards now insitu and templates given to ward sisters to populate boards. • Leaflets for parents/guardians describing the radiological investigations involved in safeguarding available. Discussion has taken place with regards to the guidelines and feedback will be provided to the safeguarding team. • Ongoing work taking place on Children's Rights with the Community Child Health Team on the children's charter and youth board. • Recruitment continues across a number of areas for medical posts and nursing. Discussion ensued with regards to access to complex surgery and requirements for senior support to be provided. Discussions are taking place with WHSSC with regards to how this risk will be managed going forward and the challenges this may have for the RTT waits **Community Child Health** • X2 ongoing RCA's. One with regards to a community acquired pressure ulcer which has been completed and an action plan will now need to be completed. The other is in relation to a Child Death in the community. • X1 data breach was noted, car broken into. The investigation has been closed and disciplinary processes are now being followed. • Complex issues with regards to subject access requests for records, many of which are as a result of a safeguarding referral. It was noted that a process will need to be agreed going forward as to how to manage this. • Well Child Bid application has been agreed which will allow the implementation of a Well Child Patient Trainer pilot which fits with the strategic plan to support more children at home or closer to home as early as possible. • Group has been set up and a pathway has been produced with regards to health needs and safeguarding concerns of children that are not attending school. It was agreed that a presentation would be provided on the work undertaken at a future meeting. • Increase in concerns over the last month, noticeably from CAMHS service. • Recruitment continues across CCNS and student streaming. There are a number vacancies coming up within the senior nursing team within Community Child Health. • Ysgol y Deri are anticipating having an additional 250 children and it was noted that this will be difficult to support an additional off site facility from a special schools nursing perspective. It was noted that reviews will need to be undertaken as to how this can be managed as there is no additional resource available to manage this growth in population. It was agreed that further discussions were needed outside of this meeting with regards to the risks associated with this service. It was agreed that an SBAR would be brought to the next meeting. • Succession planning continues for retirement of consultant posts. A locum has been appointed to cover audiology sessions. • A number of patients have been identified that require a follow up appointment for neuro development. Work is ongoing in order to ensure that patients are reviewed as necessary. This is a significant piece of work and it was agreed that reviews will need to be undertaken across all areas within the Clinical Board in order to understand the impact and plans to take	**PD** **PD**

	forward this piece of work in other areas also ensuring robust and appropriate management of follow ups.	
2.3	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** No specific items to note.	
2.4	**Long Waiting Patients Update** **Community Child Health** 21.2% for Primary Mental Health, 6 patients waiting over 67 days. Work is being progressed in order improve this position. There is currently no additional capacity to manage. S&LT is currently at 12 weeks OT is currently at 10 weeks and Physio 10 weeks Neurodevelopment is currently at 35 weeks Community Paeds 26 weeks. Immunisations currently at 95% and work continues with Public Health to increase uptake further.	
2.5	**Business Continuity Update** Work continues across all Directorates and with a number of plans almost at completion.	
2.6	**CAMHS Repatriation Update** Specialist CAMHS repatriated on 1st April 2019. It was noted that a number of vacancies have been inherited which is currently impacting on staffing issues. Recruitment is continuing and it was noted that work is being undertaken with Communications in order to review options to attract to roles. Performance is low and it was noted that significant work is required with regards to robust clinical pathways. Work is being taken forward with regards to the structure of the team and how this can be changed in order to ensure that the team is more cohesive. Discussion ensued with regards to taking forward an external review and it was agreed that this needs to be progressed as soon as possible. HR advice is required as to what changes can be made, whilst in keeping with the TUPE law and process. Discussion ensued with regards to the progression of the CAMHS Clinical Governance Lead, where it was noted that this is currently awaiting job matching in order to progress the post.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients & Staff** • International Day of the Midwife taking place on 10th May 2019 • Psychology Sessions for staff and managers being taken forward for all • C&W Clinical Board Celebration & Staff Recognition Event – Monday 3rd June 2019	
SAFE CARE		
4.1	**Update on Serious Incidents** No new SI's have been reported since the last meeting. Currently there are 10 open incidents within the clinical board and are in process. Trigger list has been implemented within Neonatal and this has been very positive for incident Q's. It was noted that understanding is required with regards to the need to provide assurance as to the open incident Q's and that appropriate actions are taking place.	
4.2	**Closure Forms for noting / Sign Off** **In80789**	

	Noted for information. This has been closed by Welsh Government and all actions have been addressed.	
4.3	**Infection Prevention Control Update** Noted for information. It was noted that Michelle Abel will be leaving the Clinical Board and will be replaced by Jennifer Lewis. Improvements have been made for VIP documentation. It was noted that there has been an increase in year, noting that the management of all incidents is robust. No MRSA has been reported over 600 Days. CSSI infection rates have seen a marked decrease in year.	
4.4	**Safeguarding** No items to note for this meeting.	
4.5	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** **Fistulae/graft bleeds - information for staff (PSN047)** The alert was noted for information and confirmed that this had been shared widely across all areas. There were no exceptions to note.	
4.7	**SBAR Healthy Child Wales Programme** The SBAR was noted for information and outlines the issues experienced due to staff shortages which has impacted on delays in data input and accrual of statistics. A number of recommendations are being implemented in order to look to improve processes across health visiting service which is in line with the work being piloted as part of the All Wales plan. Further updates will be provided as required as this work progresses.	
4.8	**SBAR Specialist Continence Service** The SBAR was noted for information. The Childrens Hospital of Wales provides a tertiary Consultant led paediatric surgical urology Service, and is the only service provision covering South, West and East Wales. The clinical nurse specialist for this service is not tertiary funded and therefore not funded to provide care for patients outside Cardiff and Vale UHB. A letter is being sent to all Health Boards in order to ensure that there are appropriate nursing leads in place as these patients should be managed within local health boards.	
DIGNIFIED CARE		
5.1	**Latest Cleaning Scores Report** The latest cleaning scores report was noted for information. There were no specific exceptions to note for this meeting. The group were requested to ensure that there is attendance at the audits in order to ensure that the scores are an accurate reflection of the audits that are undertaken.	
TIMELY CARE		
6.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** No specific items to note for this meeting. It was however noted that there is a need to ensure that all VTE assessments are completed and documented accordingly.	
INDIVIDUAL CARE		
7.1	**Patient Feedback Video** The patient feedback video was shared with the group for information. It was noted that the feedback included was very positive. Discussions are taking place in relation to some of the	

	concerns raised and an action plan is being produced. A further update will be provided as necessary where this work progresses.	
7.2	**Update on latest 2 minutes of your Time feedback** No further updates to report for this meeting. Feedback continues to be collated and actioned accordingly.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
	No items to note.	
ANY OTHER BUSINESS		
	Charitable Bids Committee Any bids will need to be submitted by Friday 26th April 2019. **RCA – Patient JB** The RCA was noted for information. The case relates to an unexpected neonatal trauma: baby JB suffered a small displaced skull fracture at the level of the lambdoid suture and a left cervical spine (C1-2) facet dislocation. The latter of which is exceedingly rare. The lessons learnt and recommendations were noted and it was acknowledged that the care provided and practices followed from both Obstetrics and Neonatal services were appropriate. Discussion ensued and it was agreed that an amendment to the recommendations to include explore standardised documentation for consent should be included and clarity to be sought with regards to resuscitation training. It was agreed that following this amendment, this report can now be shared with the family, with appropriate medical representation. The lessons learnt and recommendations will also be shared as part of the Directorate Q&S governance processes. **LAC Children placed in ABMU** Further to discussions at previous meeting with regards to issues relating to delays in health assessments being undertaken, it was noted that this has been reviewed and correspondence has been received from ABMU confirming that the health assessments will be completed for all LAC children going forward.	**ALL**

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 28th May, Classroom 1, Main Hospital Building, A Block UGF, UHW (IP&C FOCUS)**

<u>2019 Meeting Dates</u> (4th Tuesday of the Month, between 8.30 – 10.30am unless otherwise stated)

Tuesday 25th June, Room 1.13, 1st Floor, Ty Dewi Sant, UHW (H&S FOCUS)
Tuesday 23rd July, Room 1.14, 1st Floor, Ty Dewi Sant, UHW
Tuesday 27th August, Venue TBC
Tuesday 24th September, Venue TBC (H&S FOCUS)
Tuesday 22nd October, Venue TBC
Tuesday 26th November, Venue TBC (IP&C FOCUS)
Tuesday 17th December, Venue TBC (H&S FOCUS)