Bundle Quality, Safety and Experience Committee 17 December 2019

Agenda attachments

00 - Agenda Dec 2019 - v3.docx

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 17 September 2019 and 15 October 2019
Susan Elsmore
- 1.4 - QSE Public Mins 17.09.19 NF Final.docx
- 1.4.1 - QSE Mins 15.10.19 v2 - AF.NF Final.docx

1.5 Action Log - 17 September 2019 and 15 October 2019
Susan Elsmore
- 1.5 Action Log Sep 2019.docx

1.6 Chair's Action taken since last meeting
Susan Elsmore

1.7 Clinical Board Assurance Report: Clinical Diagnostics and Therapeutics Clinical Board
Aled Roberts
- 1.7 - CD&T Board Assurance Report.pdf

2 PATIENT STORY

3 ITEMS FOR REVIEW AND ASSURANCE

3.1 Healthcare Standards Self-Assessment Plan and Progress Update
Carol Evans
- 3.1 -Health and Care standards Dec 2019_v 4 FINAL.docx
- 3.1.1 - Appendix 1 - ISN 2019 003 - Resuscitation trolley checks.pdf
- 3.1.2 - Appendix 2 H&CS_Dec_2019 v3 FINAL.docx

3.2 Point of Care Testing
Stuart Walker
- 3.2 - QSE POCT SBAR 171219 (002) Final.docx

3.3 Update on Stroke Rehabilitation and Model Workforce
Verbal - Fiona Jenkins

3.4 Local Clinical Audit Plan Update
Stuart Walker
- 3.4 - Clinical Audit Plan Update -18.12.18.docx
- 3.4.1 - Local Clinial Audit appendix 1.xlsx

3.5 Cancer Peer Review
Stuart Walker
- 3.6 - Peer Review report for QSE Dec 19.docx

3.6 Internal Inspections
Ruth Walker
- 3.6 - Internal Inspections QSE.docx

3.7 Patient Notification Exercises in Cardiff and Vale of Glamorgan Populations: Hepatitis C Virus Infection Re-engagement Project
- 3.7 - Hepatitis C Patient Re-engagement QSE Paper V1 20.11.19.docx
- 3.7.1 - Fact Sheet final.docx

4 ITEMS FOR APPROVAL / RATIFICATION

4.1 Policies:

4.1.1 Consent to Examination or Treatment Policy

Stuart Walker

4.1.1 - SBAR Consent to treatment 1119.docx

4.1.1b - Consent Policy final 201119 v2.docx

4.1.1c - EHIA Consent Policy final 1119.docx

4.1.2 Management of Throat Pack Policy and Procedure

Stuart Walker

4.1.2 - Management of a Throat Pack Report.docx

4.1.2b - Management of a throat pack policy and procedure.docx

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4.1.3 Update of Healthy Eating Standards for Hospital Restaurant and Retail Outlets

Fiona Kinghorn

4.1.3 - UHB Restaurant Retail Food Standards V1 FK.DOCX

4.1.3b - Refreshed Hospital Restaurant Food Standards Dec 2.docx

5 ITEMS FOR NOTING

5.1 NICE Guidance Update

Stuart Walker

5.1 - NICE QSE December 2019 v1.docx

5.2 Health Inspectorate Wales Activity Overview

Carol Evans

5.2 - HIW Activity update December 2019 -QSE v2.docx

5.2.1 - Appendix 1 - ISN 2019 003 - Resuscitation trolley checks.pdf

5.2.2 - Appendix 2 - 19065 - OCS - Stroke Rehabilitation Centre at UHL - Improvement Plan 30_...docx

5.3 Health Inspectorate Wales Primary Care Contractors

Carol Evans

5.3 - HIW SBAR -November 2019 v2.docx

5.3.1 - HIW Nov 2019 Appendix 1 GMS.docx

5.3.2 - HIW Nov 2019 Appendix 2 GDS v2.docx

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

Carol Evans

5.4.1 Children and Women Clinical Board

Steve Curry

5.4.1 - Children Women QSPE Minutes 28.05.19.docx

5.4.1a - Children Women QSPE Minutes 25.06.19.docx

5.4.1b - CW QSPE Minutes 24.09.19.docx

5.4.2 Clinical Diagnostics and Therapeutics Clinical Board

Steve Curry

5.4.2 - CD&T - Minutes 14.8.19.docx

5.4.2a - CD&T - Minutes 11.9.19.docx

5.4.2b - CD&T Minutes 9.10.19.docx

5.4.3 Medicine Clinical Board

Steve Curry

5.4.3 - Medicine Clinical Board QSE Minutes 20.06.19.doc

5.4.3a - MCB QSE Minutes 18.07.19.doc

5.4.3b - MCB QSE Minutes 19.09.19.doc

5.4.3c - MCB QSE Minutes 23.10.19.doc

5.4.4 Mental Health Clinical Board

Steve Curry

5.4.4 - MH 18 July 2019 Minutes.doc

5.4.5	Primary, Community and Intermediate Care Clinical Board *Steve Curry* 5.4.5 - PCIC Group mins July 2019 KJ.docx 5.4.5b - PCIC mins Nov 2019.docx	
5.4.6	Specialist Services Clinical Board *Steve Curry* 5.4.6 - Specialist Services Minutes QSE 27.06.19.docx 5.4.6a - Specialist Services Minutes QSE 18 07 19 vn 2.docx	
5.4.7	Surgery Clinical Board *Steve Curry* 5.4.7 - Surgery Q&S Minutes 2019 07 30.docx 5.4.7a - Surgery CB Mins 10.09.19.docx	
6	ITEMS TO BRING TO THE ATTENTION OF THE BOARD / OTHER COMMITTEES *Susan Elsmore*	
7	Review of the Meeting *Susan Elsmore*	
8	Date and Time of Next Committee Meeting: *18 February 2020 at 9.00am* *Coed y Bwl, Ground Floor, Woodland House, Heath*	

Quality, Safety & Experience Committee

Tuesday, 17 December 2019 at 9.00am

Coed y Bwl, Woodland House

AGENDA

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 17 September 2019 and 15 October 2019	Susan Elsmore
1.5	Action Log from 17 September 2019 and 15 October 2019	Susan Elsmore
1.6	Chairs Action taken since last meeting	Susan Elsmore
1.7	Clinical Board Assurance Report: Clinical Diagnostics and Therapeutics Clinical Board	Mike Bourne / Matthew Temby
2.	**Patient Story:**	
3.	**Items for Review & Assurance**	
3.1	Health Care Standards Self-Assessment Plan & Progress Update	Carol Evans
3.2	Point of Care Testing	Stuart Walker
3.3	Update on Stroke Rehabilitation and Model Workforce	Fiona Jenkins Verbal
3.4	Local Clinical Audit Plan Update	Stuart Walker
3.5	Cancer Peer Review	Stuart Walker
3.6	Internal Inspections	Ruth Walker
3.7	Patient Notification Exercises in Cardiff and Vale of Glamorgan Populations: Hepatitis C Virus Infection Re-Engagement Project	Fiona Kinghorn
4.	**Items for Approval / Ratification**	
4.1	**Policies:** 1. Consent to Examination or Treatment Policy 2. Management of Throat Pack Policy and Procedure 3. Update of Healthy Eating Standards for Hospital Restaurant and Retail Outlets	 Stuart Walker Stuart Walker Fiona Kinghorn
5.	**Items for Noting & Information**	
5.1	NICE Guidance Update	Stuart Walker
5.2	Health Inspectorate Wales Activity Overview	Carol Evans
5.3	Health Inspectorate Wales Primary Care Contractors	Carol Evans
5.4	Minutes from Clinical Board Quality Safety and Experience Sub Committees – Exceptional Items to be raised by the Assistant Director, Patient Safety and Quality	Carol Evans
5.4.1	Children and Women – 28.05.19, 25.06.19 and 24.09.19	Steve Curry
5.4.2	Clinical Diagnostics and Therapeutics – 14.8.19, 11.09.19 and 9.10.19	
5.4.3	Medicine – 20.06.19, 18.07.19, 19.09.19 and 23.10.19	
5.4.4	Mental Health – 18.7.19	

5.4.5 5.4.6 5.4.7	Primary, Community and Intermediate Care – 17.07.19 and 12.11.19 Specialist Services – 27.06.19 and 18.07.19 Surgery – 30.07.19 and 10.09.19	
6.	**Items to bring to the attention of the Board/Committee**	Susan Elsmore
7.	**Review of the Meeting**	Susan Elsmore
8.	**Date and time of next Meeting:** 18 February 2020 at 9.00am, Coed y Bwl, Ground Floor, Woodland House, Heath	Susan Elsmore

UNCONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 17 SEPTEMBER 2019 COED Y BWL, WOODLAND HOUSE, HEATH, CARDIFF CF14 4TT

Present:		
Susan Elsmore	SE	Committee Chair and Independent Member – Local Government
Gary Baxter	GB	Independent Member - University
Michael Imperato	MI	Independent Member – Legal
Dawn Ward	DW	Independent Member – Trade Union
In attendance:		
Steve Curry	SC	Chief Operating Officer
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Suzanne Hardacre	SH	Head of Midwifery and Gynaecology Nursing
Cath Heath	CH	Nurse Director, Children and Women
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
Meriel Jennings	MJ	Clinical Board Director, Children and Women
Christopher Lewis	CL	Deputy Director of Finance
Paul Rogers	PR	Directorate Manager for the Artificial Limb and Appliances Service (ALAS)
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
Glynis Mulford	GM	Secretariat
Observers:		
Mandy Rayani		Hywel Dda University Health Board
Joanne Wilson		Hywel Dda University Health Board
Apologies:		
Robert Chadwick	RC	Executive Director of Finance
Steve Allen	SA	Community Health Council

QSE 19/09/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting including colleagues from the Children and Women's Clinical Board. A special welcome was also extended to Joanne Wilson, Director of Corporate Governance and Mandy Rayani, Executive Nurse Director from Hywel Dda University Health Board who observed the meeting.	**ACTION**
QSE 19/09/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
QSE 19/09/003	**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: ▪ Fiona Jenkins, Executive Director of Therapies and Health Science declared a conflict of interest in respect of item 2.1 Diabetic Retinopathy as she Chaired the National Eye Health Delivery Group. The declaration was formally noted.	
QSE 19/09/004	**MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON 18 JUNE 2019** The Committee reviewed the Minutes of the meeting held on 18 June 2019. **The Committee Resolved - that:** a) the minutes of the meeting held on 18 June 2019 be approved as a true and accurate record.	
QSE 19/09/005	**COMMITTEE ACTION LOG** The Committee reviewed the Action Log and noted the following updates: **QSE 19/06/007 – Patient Story – ALAS:** It was confirmed that the new pressure damage assessment tool had been implemented and was well received. Linda Jenkins was leading on the documentation and would be meeting with team for training on the use of new tool. **COMPLETE.** **QSE 19/06/014 – Car Parking Update Report:** The Park and Ride introduced on the UHL site over the summer months had been successful. **QSE 19/06/17 - Stroke Rehabilitation Model and Workforce:** The paper on the agenda demonstrated the progress which had been made to date. Members were informed that HIW had arrived on the SRC Unit on an unannounced visit (17.09.19) and would be reviewing the service over two days. **QSE 18/155 - Bone Marrow Transplant Unit:** The work to refurbish the unit was in progress and near completion. This would be clarified by the Executive Director of Planning at the December meeting. **The Committee Resolved – that**: a) the action log and the verbal updates be noted.	AH
QSE 19/09/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** The Committee Chair confirmed that there had not been any Chair's Action taken since the Committee meeting held in June 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 18 June 2019 where the Safeguarding Report was discussed.	

QSE 19/09/007	**PATIENT STORY – MY JOURNEY – COMPLEX MATERNITY CARE AND THE MULTI PROFESSIONAL TEAM WHO CARED FOR ME** The Chair invited the Clinical Board Director, Nurse Director and the Head of Midwifery for Children and Women's Services Board to present their story. The Story of Bethan and Mark's journey was read out to the Committee. The story demonstrated how up to 40 members of the Multi-Disciplinary Team (MDT) enabled a timely and effective approach into the care of how a low risk patient could suddenly become very ill. The following was highlighted with Bethan's treatment: Bethan was a low risk midwife led pregnancy until 32 weeks gestation when she suddenly became very unwell. After being reviewed by team she was a diagnosed with appendicitis. She had an MRI scan and consequently was diagnosed with a ruptured left kidney. The decision was made to deliver the baby by emergency caesarean. An epidural spinal combination was given to Bethan to remain awake and experience the birth of their first baby. She then underwent a procedure to place stents in both kidneys. The diagnosis was renal obstruction and hydronephrosis secondary to rabbit uterus which was extremely rare. Bethan received seven days of intravenous antibiotics and was cared for by the multidisciplinary team who were able to provide continuous care ensuring she had a positive experience after a worrying event. Arrangements were being made to meet for a debrief with the multi professional team where discussions around the incident and planning for the next pregnancy would take place. The key points in learning for the team were that women who were low risk may become very ill quite quickly. Skilled multi professional teams working and training together provided safe, effective and timely care even in most high risk and complicated circumstances. It showed that continuity of care by the right people in the right place could be achieved. The team also ensured that the couple were placed at the centre of care during their journey. A thank you and complimentary letter was received from Mark and Bethan which was read out citing the genuine care they received and thanking all individuals involved. The Chair stated the patient story was very moving and drew attention to the MDT's exceptional communication where it worked well. The Head of Midwifery expressed the importance of teams and how those involved had touched the family and the continuity of care and compassion was clearly expressed in the letter. On behalf of the Committee the Chair asked to send thanks and congratulate the team for their work. **The Committee resolved that:** **a)** The Patient Story be noted.

QSE 19/09/008	**CHILDREN AND WOMEN'S CLINICAL BOARD ASSURANCE REPORT** The Director of Nursing for Children and Women's Service Clinical Board provided an overview of the Assurance Report, which detailed the arrangements, progress and outcomes in relation to the Quality, Safety and Patient Experience agenda over the past 12 months. The following comments were made: Over the past year specialist CAMHS and cancer services had transitioned to the Children and Women Clinical Board. A summary of the aims of the quality, safety and patient experience was provided. **Staying Healthy:** The Safer Pregnancy Campaign was considered to be well embedded in the Clinical Board and promoted a healthy lifestyle for pregnant women where positive outcomes were seen. Detailed developments for 2019 were pointed out, this included the ChatHealth app for young people and children which would be developed further. Highlighted was concern over compliance rates of the 8, 12 and 16 week contacts required by the Healthy Child Wales Programme and in spring last year this was below the Wales average. A deep dive was undertaken and measures had been put in place to address the issue and the Committee could be reassured that compliance had improved quarterly since capturing the data. **Safe care:** There had been a considerable reduction of still birth rates since 2016. **Infection prevention and control:** Improvements had been made regarding health care acquired infections in comparison to last year and there had been no incidents of MRSA for almost two years. There were robust investigations of all incidents and these would be presented to the QSE Sub Committee. There had been further developments in paediatric surgery where the number of consultant paediatric surgeon posts had increased to seven. The services had been streamlined into specialties and the trainee rota had been fully recruited to. **Dignified care:** The launch of the Young Person Charter was at every bed space and in all outpatient clinics. There was further progress in delivering awareness sessions in conjunction with representatives from Unicef. Developments were underway for children admitted with mental health. **Individual care:** A significant amount of compliments continued to be received and management of concerns remained a key priority of the Clinical Board. Virtual reality was currently being trialled to support women's experience when given birth. As part of discussions the following was asked:	

	Regarding paediatric surgery work undertaken over the past two years what was the greatest learning in regard to the all incidents? The Clinical Board Director responded that the key was to understand the issues and treat people with respect, to work in 'real time' and not to postpone any actions but to listen and deal with concerns as quickly as possible. Also to recognise that there were complexities which may take time to work through. In regards to governance arrangements being changed it was stated that people had been reminded of their responsibility to report, to scrutinise and to be open and transparent. Training sessions had been put in place for all members of staff. Robust systems were in place to feed into QSE Sub Committee and issues had been escalated where appropriate. In response to the work undertaken by staff raising concerns, it was stated a pulse survey had been initiated and focus groups had been set up with staff side representatives and human resource colleagues. Attendance was increasing and night time visits had been undertaken. All of the information would be collated and an improvement plan developed. Work with staff continued as there was a need for solutions to come from staff themselves. A Neonatal Board would be set up and five themes had been identified. In addition, a Task and Finish Group would also be set up. It was highlighted that all staff members in the new unit were positive. Independent Member – Legal asked whether we were on track complying with the 8, 12 and 16 week contact for young people and children. It was stated that from a recent review the team considered they were back on track. The department did not have administration staff to input information and this information was not on the database. The review of the skill mix and the profile of some of the work with the health visiting team was currently underway. It was confirmed that the Young Person's Charter was enshrined fully. This would start with the C&W Clinical Board and subsequently be rolled out to embed throughout the Health Board. Work was being undertaken on this in the Emergency Unit. An update was requested for a future meeting detailing the steps taken.	C&WCB
	In regard to the repatriation of the CAMHS service, it was stated there was a plan in place and this would be presented at the next Board meeting. The specialist CAMHS external report was being reviewed which contained a good summary with actions from the Management Team. The CAMHS plan was very clear and by end of the month all long waiters would have been addressed with a new system in place. It was envisaged for additional staff to be in post by November. Independent Member – Trade Union asked whether there were any comparisons to be made over the past two years regarding incident reporting from staff? The Committee was assured there was a healthy reporting culture with an increase in the number of incidents being reported and a trigger list had also been developed. Weekly meetings were undertaken regarding Datix incidents to see whether further	SC

investigation was required and if necessary incidents were escalated.

In summary the Chair commented this was a comprehensive report and addressed taking responsibilities seriously it also highlighted that the culture of quality improvement had been embedded in the Clinical Board.

The Committee resolved that:

- The progress made by the Clinical Board to date be noted.
- The content of this report and the assurance given by the Specialist Services Clinical Board be approved.

QSE 19/09/009

YOUTH THEMATIC REVIEW

The Children and Women's Clinical Board Director presented the above all Wales Thematic Review stating not all of the actions were pertinent to Cardiff and Vale Health Board. It was recognised that children with mental health needs admitted to Noahs Ark Children's Hospital and cared for within the wards would be re-provided with a safe place to stay. The following comments were made:

In regards to the CAMH service the Medical Director asked what their three big concerns were from the external review? In response, it was stated the main concern was the structure and relationships across the teams and in future it would be important to work through and recognise the need for mutual respect. There were gaps around staffing and the service had evolved in ways of working that were considered to be ineffective and there would need to be assurance that the ways of working were fit for purpose. To review the skill mix and redress the culture would be the biggest challenge. This would need to be done without taking away individual confidence and self-assurance. There was a need to ensure staff were up to standard across specialist CAMHS and that they understood the framework. In addition it was essential to work on the single point of access. On a positive note they had successfully recruited into the Governance and Senior Nurse posts and had filled a number of outstanding vacancies.

The Committee resolved that:

a) The position outlined within the report in Appendix 1 be noted and the concerns raised be noted.

QSE 19/09/010

CWM TAF UHB MATERNITY – CARDIFF AND VALE LESSONS LEARNT

The Director of Nursing for Children and Women's Clinical Board stated the report and assurance framework had been reviewed and changes had been made since that time. The rag rated chart demonstrated that there was one red area left with the actions in place. The following comments were made:

Four consultants had been appointed in regard to the on-call service. Appropriate challenges from the midwifery team regarding a consultant presence on the labour wards had been received. Time had been spent obtaining agreement to change the job plan of consultants to include provision of evening cover . They were also contracted to be present on

weekends. The Clinical Board had been made aware of the lack of regular ward rounds on the ante natal unit and this would be audited to see that these ward rounds were taking place in a routine manner.

In terms of the ambers turning to green, the Executive Nurse Director confirmed that HIW would undertake an independent review shortly which would address the issues. HIW were aware of the local pressures to secure expected shifts within the services. Conversations were ongoing on a regional planning basis.

Independent Member – University, in reference to lean midwifery management and leadership, asked whether this was a quantitative issue i.e. not enough midwives in senior positions or a qualitative issue about how people approached leadership. In response it was stated that it was a combination of both and for a service of this size it would be expected for someone senior to be in a clinical governance role in order to have oversight of the assurances, in particular with changes in flow that would shortly be undertaken. There were two consultant midwives in place and from a strategic point of view strengthening the governance umbrella would be welcomed. An appointment to the deputy had been filled and conversations were underway with the Clinical Board about 'backfill ' to provide more resilience in the team.

In response to seeing a number of women coming from Cwm Taf to the UHB it was stated that the drift started in October 2018. When the Royal College of Gynaecologists published their report, requests for transfers increased significantly and triggered pressure on the Cardiff and Vale service in particular the difficulties with women unable to be seen in a timely manner. There had been discussions with Cwm Taf colleagues and this had settled down. The challenge remained as to what would happen come October 2019.

There was wider discussion on the robustness of the maternity services. The challenge for the service was around indecision, the lack of communication and the issue around the single point of access. The paediatric and maternity picture was similar and the lack of regional planning to some of the issues was the greatest challenge. The Health Board had been proactive around the over recruitment of midwives for future flow but the presumption of flow from other Health Boards had not been clarified. There was a structure in place but this was not based on the findings and the matter had been escalated from the CEO to the Director General of the NHS.

The Committee resolved that:

a) The current position of the UHB against the recommendations in the report be considered.
b) Progress had been made on the areas of non and partial compliance and the impact, in terms of patient flow to Cardiff and the Vale UHB and how this was being mitigated was agreed.

QSE 19/09/011

GOSPORT REVIEW

The Assistant Director of Quality and Safety introduced the report, and

stated there were three areas to provide assurance on, relating to anticipatory prescribing and what we had in place across the organisation, what we were doing in terms of mortality rates and trends in death certification. A high level of assurance could not be provided as there was still work to be undertaken on all three areas. The following comments were made:

Anticipatory Prescribing: An All Wales Framework was in place with an end of life care pathway. There was a national audit report on anticipatory prescribing practices and this confirmed the need to take forward an e-medicines code in anticipatory prescribing. In addition, there was a need to strengthen Cardiff and Vale local audit arrangements, provide more robust audits and look at how we monitor our commissioning services.

Mortality rates: It was recognised there was more to do in routine monitoring and reporting of mortality rates. Although regular reports were brought to the QSE Committee, early flags needed to be placed on the system.

Death certification: This would be addressed with the implementation of the Medical Examiner (ME) system. This had been agreed with the information team and revised with EMAT. Coding software would be introduced in death certification to analyse trends and themes.

The Medical Director provided an update on the Medical Examiner role and advised there would be an obligation to report all deaths within our Hospitals by April 2020 and all deaths within our Health Board by April 2021. There would be an office on both sites with an on-call service at weekends. The stage 1, 2 and 3 reviews and requirements were explained. The three outputs would be:

1. Back to the medical examiner;
2. Back to the service providing the care for the individual and
3. To the central governance unit to ensure thematic learning would be driven from this. If there was any high level of concern this would be put into the SI process.

The Medical Examiner Officer role had been appointed to; the position of the Medical Examiner post had not been filled as yet but a number of people had been trained on line.

The Executive Nurse Director stated the findings were more complex and from the Gosport Inquiry not all of the issues were known. It would therefore be helpful to understand the timeframes as the recommendations were being taken forward. It was considered helpful to provide an update at the next Committee meeting. CE

The Committee resolved that:

a) The contents of the report were considered and
b) Further action was required and had been identified for improvement.
c) Outside of the national audit to undertake a local audit of end of life cases analysing opiate use and whether it conformed to

national guidance.

QSE 19/09/012

OMBUDSMAN ANNUAL LETTER AND REPORT

The Assistant Director of Patient Experience confirmed the report was positive in relation to the number of complaints received from the Health Board. The number of investigations had reduced this year while more cases were upheld in whole or in part but fewer cases had been investigated. There were 10 public interest reports across Wales last year. Two of those reports were issued against our Health Board which had been reported to the Committee. One had been closed and awaited a closure letter on the second case. Clinical information provided from experts for the Ombudsman had been successfully challenged by the Health Board and had not been upheld.

The team was commended for the management of complaints through the system.

The Committee resolved that:

a) the findings of the Ombudsman's Annual Letter 2018/2019 be noted

QSE 19/09/13

PUTTING THINGS RIGHT ANNUAL REPORT

The Assistant Director of Patient Experience provided an overview of the report regarding the complaints system. The report demonstrated that although the concerns team was small it showed the work they did could make the process efficient. The Clinical Boards were engaged by having weekly tracking meetings to talk through their concerns. This had made a difference with sustained performance and did not compromise on quality.

In regards to car parking, feedback had been sent to Parking Eye and the parking office. Recently there had been favourable comments around Park and Ride and people found it much improved on the UHW site. Llandough was becoming an issue but this was around signage and the inability to contact anyone by phone.

The Committee was provided with the current claims position. Members were informed that the Health Board paid out claims under one £1m, if it exceeded this figure it went forward to Board. In the past these were very few but it was highlighted that in the future there would be a greater number of detailed claims going forward to our Board. The Executive Director of Nursing stated recently that a number of incidents had been reported retrospectively that had not been identified previously.

In regard to engaging the public with the Health Board, it was commented that Clinical Boards and Directorates needed to send compliments they received upwards. The new smiley face machines positioned around the hospital enabled users to leave compliments.

Members were advised that the General Medical Practice Indemnity came into effect on 1 April 2019 and the Health Board would be named as a defendant in a case. Training with Primary Care and GP services had been undertaken. More information would be known once the

practices started to engage with the Health Board around their concerns and claims. The Health Board would make the decision in relation to the complaints going forward. From a governance perspective this would provide more clarity to the Health Board of the undertakings in general practices. To provide assurance it was stated the Welsh Legal and Risk Pool service managed these claims. Concerns were raised that the number of concerns could escalate in 2-3 years' time. The Deputy Director of Finance advised that this was a national initiative and the National Assembly was behind the resource implications and should be deemed resource neutral.

The Committee resolved that:

a) the content of the Annual Putting Things Right report be noted

QSE 19/09/014

POLICIES AND PROCEDURES FOR APPROVAL

An overview of the policies and procedures were provided to the Committee for approval, these were the:

1. Parental Infusion Pumps Policy
2. Research Governance
3. Framework for the Management of Performance Concerns in General Medical Practitioners (GPs) on the Medical Performers List Wales

The Committee resolved that:

a) The policies and procedures be approved

QSE 19/09/015

DIABETIC RETINOPATHY – PATIENT RECALL

The Executive Nurse Director provided an overview of the report stating this was the final paper regarding the processes and systems that had been put in place. The following comments were made:

Welsh Government had asked the Health Board to host the Diabetic Retinopathy Service until 2015 when it was moved across to Public Health Wales. It was identified that there was no robust fail safe in place across the pathway. A considerable amount of work was undertaken and 2,848 patients had been identified as waiting longer than one year for an appointment and there was considerable concern that these patients may come into harm. Having gone through the process there was a cohort of 336 patients that needed to be seen immediately. Once seen a Root Cause Analysis was undertaken. 124 cases were referred back to their Local Health Boards. Of those 124, four patients were of concern and suffered mild / moderate harm. These went through the redress process. One patient was still in the redress process, two cases had settled and one patient declined any financial settlement.

The learning from this incident had been applied to other screening services.

The Chief Operating Officer joined the meeting at 10.45am

In response to lessons being learnt it was stated they had received one new incident of a patient that came to harm because they were delayed

	on the waiting list for eye care. At the last QSE Committee meeting there had been a detailed plan presented by the Chief Operating Officer (COO) on the issues of people waiting on the system. There was a need to enable plans previously presented be embedded into the service before any further updates. It was highlighted that one of the key messages and lessons learnt was the risk to people who did not attend screening. This would be shared with other Health Boards. **The Committee resolved that:** b) The level of work undertaken be noted.	
QSE 19/09/016	**CENTRALISATION OF ENDOSCOPY DECONTAMINATION** The Executive Director of Therapies and Health Sciences provided a verbal update advising all decontamination in the Health Board would be centralised to ensure they were clean and safe. There had been discussions with ME and a piece of work was being undertaken to develop an options appriasal. A meeting would be held with the group and shared services; the Committee would be kept informed as the work progressed. **The Committee resolved that:** a) The verbal update on the Centralisation of Endoscopy Decontamination be noted.	FJ
QSE 19/09/017	**UPDATE ON STROKE REHABILITATION MODEL AND WORKFORCE** The Director of Therapies and Health Science introduced the report on the Stroke Rehabilitation Centre (SRC). It was confirmed that: The rehab model and the current position was being reviewed. The Committee were advised that there would be ongoing service improvements looking at patient pathways. A Hyperacute Stroke Unit was being considered in the revised service model and would look at future demands for SRC which was likely to change by taking patients in an acute state. Out of 44 falls only one Serious Incident had been reported to WG with improvements being made on pressure damage reporting. There was good work on patient flow with reduced Length of Stay. In recent months the Deputy Head of Occupational Therapy had been reviewing the workforce model with the Senior Nurse and Lead Nurse. The Committee was assured that there was considerable work being undertaken to finalise the workforce plans to provide a model that was sustainable. The Executive Nurse Director explained to the Committee the concerns which had been raised by staff on the unit when she visited with the Chair. Patient Experience work was undertaken which reinforced the need for improvement. Very good assurance had been provided that progress was being made and the quality issues had improved considerably. The key was to have a workforce model that was different and it was this approach which was being progressed. When this model was completed a verbal update would be required at the December Committee.	FJ

Independent Member – Legal asked although Length of Stay (LOS) had reduced was there a target to be achieved? The Executive Director of Therapies and Health Sciences replied that the SRC stratified their patients using an assessment tool which provided a range of services needed for that client. To ensure patients were in the appropriate place for the appropriate length of time they did not have a target to be achieved because of the different mix and range of patients. Benchmarking data was provided through a SNAP audit and would also benchmark against other organisations.

The Committee Resolved that:
Immediate actions for SRC to be implemented included:

a) Revision of Multi-disciplinary documentation to enhance current processes and improve cross-professional and patient communication.
b) Discussions with the Integrated Discharge Service and Primary Care about further support to the SRC rehabilitation model.
c) Agreement for the Nursing and Therapy Leadership model to support the change in consultant model and to sustain the Quality Improvement Agenda.

QSE 19/09/018

NATIONAL AUDIT UPATE

The Executive Medical Director provided an update on the National Audit and confirmed the following:

The audit showed results over the past six months and how it aligned with the broader work of the national audit and how the organisations were working towards being compliant with all the national requirements. There were some audits which showed positive outcomes. It was acknowledged that there were some areas where improvements were needed.

It was highlighted that outside the list, a pre alert relating to the hip fracture database, had shown concerns and was currently working through the data to take forward.

The Chair commented on the National Audit of Dementia stating the report highlighted 42% of people over 70 with an unplanned admission had dementia. In response it was stated that it encompassed a whole range of cognitive impairment and many of the cases were unrelated to admission but it was acknowledged that this was a big issue. The Executive Nurse Director explained that when patients were admitted to hospital they become more confused and cognitively impaired and this was challenging for the nursing team in terms of managing the patient. The Enhanced Framework was embedded in Medicine Clinical Board and was being rolled out into Surgery and Specialist Clinical Boards. The real key was to avoid patients coming into a hospital setting and there was a need to get that message across to clinical teams.

In regards to presenting a more detailed report, the Hip Fracture data was being worked through and would be escalated through the governance process. Also highlighted was the National Lung Cancer audit which was one of the main drivers for the Thoracic work and

Cancer Services.

The Committee Resolved that:

a) the assurance provided by participation in the National Audits and the headline results and associated quality improvement actions in place be noted and;
b) a detailed assurance report would be presented at a future meeting on the audits presented.

QSE 19/09/19

HEALTH INSPECTORATE WALES ACTIVITY UPDATE

The Assistant Director of Quality and Patient Safety provided an overview of HIW activity since April. The following comments were made:

It was expected for HIW to undertake an unannounced visit to the Maternity Services. Therefore a self-assessment had been completed. A self-assessment was also carried out for Specialist Services and the necessary evidence had been submitted. A further unannounced visit was anticipated in that area.

Unannounced visits had been undertaken in the Assessment Unit and Emergency Unit at the end of March and there had been some immediate assurance issues. Time had been taken to work through these with HIW. The main area of focus in the Assessment Unit was the lounge area and concerns had been raised relating to the quality, safety and patient experience. The Chief Operating Officer and Executive Nurse Director had a productive meeting with HIW and it had been acknowledged that some of the improvements which needed to be put in place would be medium to long term.

There were issues in terms of surgical flow and the improvement work centred on this area. Development of a Trauma Ambulatory Care Unit had been completed to address the flow in the lounge area and the extension of the Surgical Assessment Unit would be opened in November. The Clinical Board met on a weekly basis to monitor the plan.

The outcome of the unannounced visit to Mental Health services provided a positive report. There was a full action plan in place to address maintenance of the gardens. The Deputy Chief Executive attended the May 2019 Board meeting and provided a report on the performance throughout the year.

The Chair asked whether assurance had been received from a patient perspective. In response it was stated that over the past few month's smiley face machines had been placed in the area to capture feedback on a daily basis and as a result of this an increase in patients stating they had received a positive experience had been seen. The trend was improving and had picked up on themes around handover times. Volunteers were also providing feedback and the team were undertaking some bespoke patient experience activity.

Independent Member – Trade Union asked how did the work fit in with

	the Workforce Strategy on culture and behaviour and if this needed to be a priority for the staffing group on the Emergency and Assessment Units. It was stated that at an operational level there was good work between Human Resources and Emergency Unit colleagues. Recognition of behaviour being perceived in a particular way was necessary in order to change behaviour and further work was needed on this area. In regards to raising concerns at GP practices the Committee was informed that information was constantly being refreshed in GP surgeries and worked jointly with the Community Health Council (CHC) on this matter. The CHC had introduced a texting system which was working well. People were encouraged to raise issues promptly for an early resolution. **The Committee Resolved that:** a) The level of HIW activity across a broad range of services be noted. b) The appropriate processes were in place to address and monitor the recommendations.
QSE 19/09/020	**HEALTH INSPECTORATE WALES PRIMARY CARE CONTRACTOR ACTIVITY** The Assistant Director of Quality and Patient Safety provided an update of HIW activity relating to Primary Care contracts relating to general medical services and dental services and explained the HIW process. The following comments were made: Since last years' report there had been five General Medical Inspectorate visits and two surgeries had been issued with immediate assurance letters. Both practices had implemented the systems and processes required to deal with the issues and these were being routinely monitored. More activity had been identified in General Dental Services with immediate assurance issues relating to storage of health care waste in a couple of practices HIW had visited. The Health Board had recently been advised of similar findings in other practices and was looking at this more robustly. The Primary Care Clinical Board was communicating with Primary Care colleagues on this. **The Committee Resolved that:** a) The ongoing monitoring and performance management systems and outcomes for Primary Care Dentists and GMS contractors be noted.
QSE 19/09/021	**CARER MEASURES** The Assistant Director of Patient Experience presented a report on the Annual Carers Report for 2018/19 and the following comments were made: A meeting with Cardiff and the Vale Local Authorities was being arranged to discuss and agree how to support carers. the Report provided an overview of the objectives the Health Board must deliver.

Also being reviewed was supporting carers in general practices and discharge from hospital planning. A pilot would be undertaken on the Llandough site and further discussions would be held with the Local Authorities and in particular with the Head of Integrated Care and the Discharge Team.

The work and schemes undertaken was maturing and there were champions within GP practices for recognising carers. Young carers in schools were inspiring and this was being acclaimed in schools and it was confirmed that the Sam Davies Ward in Barry Hospital had received a silver accreditation award recently.

The next phase of work was to focus on the recognition and number of carers in the Cardiff and Vale workforce. A survey would be distributed within the next few weeks. It was further stated that there was evidence that those in caring roles, as a profession, were often carers at home and there was a need to look at how they could be supported further.

Independent Member – Trade Union asked about the integrated approach and CRTs and the drive towards personalised planning that was not captured in the report. It was stated that the report focused on what had been undertaken with transitional funding and the comments made would be reviewed.

Independent Member – Legal asked how a carer gained access to carer support workers. It was explained carers had an assessment at the first point of contact which would put them in touch with the support and services they need.

The Committee Resolved that:

a) The ongoing work which was taking place be noted.

QSE 19/09/22

DELIVERY UNIT REPORT: IMPACT OF LONG WAITS

The Chief Operating Officer provided a report against the Delivery Unit Review regarding an increased number of patients across Wales waiting greater than 52 weeks. It was confirmed that:

The review comprised a three stage approach. Cardiff and Vale was aware of the position which was improving but more work was needed.

There were a number of recommendations which had been made and it was confirmed that these were routinely monitored by the Strategy and Delivery Committee. Action plans had been developed and the report set out actions to improve the position. The main action being pursued was not to have long waits for planned care. The Health Board was fixed on the strategy of removing long waits across all specialties. This was the year of compliance and the aim was to eliminate, not only over 52 week waits, but also over 36 week waits by the end of the financial year.

It was explained that they had moved from a volume problem to a target issue. In 2015/16 there was just under 1000 waiting more than a year.

At the end of last year it was 150 and this figure now currently sat at 120. One hundred of these cases were in orthopaedics with complex surgery. A clinical risk based approach had been taken to clear areas where there was likely to be greater clinical risk. Orthopaedics had been dealt with later because it was deemed more complex and the clinical risk was not as great as in other areas.

In response to the plan for IT and patients in the system it was stated that in all of the correspondence there was advice for patients to visit their GP if they continued to experience problems. There were also processes in place for GPs to expedite referrals. But the end point was to reach the target of 26 weeks. The pathways were explained and the Committee was advised that many were receiving treatment. There was a wider IT plan to use digital platforms to engage and empower users such as Patient Knows Best and PROMs.

The Committee Resolved that:

a) The findings and recommendations of the Delivery Unit's review of the impact of long waits for Planned Care on patients be noted
b) The action plan developed in response to the recommendations be noted.

QSE 19/09/023

ITEMS RECEIVED FROM CLINICAL BOARDS QUALITY SAFETY AND EXPERIENCE COMMITTEE

The Assistant Director of Quality and Safety stated she had observed there was a lack of medical engagement in the Clinical Board QSE Sub Committees. A meeting would be arranged to address the issues.

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

QSE 19/09/024

ITEMS TO BRING TO THE ATTENTION OF THE BOARD / OTHER COMMITTEES

- The Ombudsman Letter.
- The report for Putting Things Right.
- The HIW Report in which the Assessment Unit received considerable attention.
- The Carers Annual Report.

REVIEW OF MEETING

- The Chair would meet with the Lead Executive and Director of

	Corporate Governance in relation to some of the papers. • A lot had been covered in a short space of time. • Independent Member – University would like to discuss some of the items with the Medical Director.	
QSE 19/09/025	**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 take place on 15 October 2019 at 9.00am, Medical Education Skills Suite, A2-B2 link corridor, UHW	

UNCONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 15 OCTOBER 2019 MEDICAL SKILLS SUITE, A2 – B2 LINK CORRIDOR, UHW,

Present:

Susan Elsmore	SE	Committee Chair and Independent Member – Local Government
Gary Baxter	GB	Independent Member - University
Akmal Hanuk	AH	Independent Member - Community
Michael Imperato	MI	Independent Member – Legal
Dawn Ward	DW	Independent Member – Trade Union

In attendance:

Caroline Bird	CB	Deputy Chief Operating Officer
Dr John Dunn	JD	Consultant Anaesthetist, Programme Director and Simulation Lead
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	JJ	Executive Director of Therapies and Health Science
Louise Kennedy	LK	Ward Manager A5
Annie Procter	AP	Clinical Board Director, Mental Health
Hywel Pullen	HP	Assistant Director of Finance
Jayne Tottle	JT	Director of Nursing, Mental Health
Dr Cellan Thomas	CT	Maxillofacial Consultant
Geoff Turner	GT	Consultant Gastroenterologist
Paul Twose	PT	Physiotherapist
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
Ian Wile	IW	Director of Operations, Mental Health
Glynis Mulford	GM	Secretary

Observers:

Matthew McCarthy		Patient and Safety Facilitator

Apologies:

Robert Chadwick	RC	Executive Director of Finance
Steve Curry	SC	Chief Operating Officer
Abigail Harris	AH	Executive Director of Strategic Planning
Fiona Kinghorn	FK	Executive Director of Public Health

QSE 19/10/001	**WELCOME AND INTRODUCTIONS** The Committee Chair welcomed everyone to the annual special meeting.	**ACTION**
QSE 19/10/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	

QSE 19/10/003	**DECLARATIONS OF INTEREST** There were no interests to declare.	
QSE 19/10/004	**CHAIRS ACTION TAKEN SINCE LAST MEETING** No Chair's action had been taken since the last meeting.	
QSE 19/10/005	**HOT TOPICS** The Assistant Director of Patient Safety and Quality (ADPSQ) informed the Members that a paper would be presented on the ophthalmology issues in December and that she had instructed experts to review 13 cases the team were concerned with. Health Inspectorate Wales (HIW) had carried out two unannounced visits. One visit took place at the Stroke Rehabilitation Centre, where one assurance issue was raised around regularly checking the resuscitation equipment. It was acknowledged that this was an area of concern and work had been undertaken on this matter. The second visit took place at Rookwood Hospital on wards 4 and 5 and a positive outcome had been received in the care of patients. The ADPSQ had a meeting with HIW who informed her that a summit would be held with all the key external stakeholders including Welsh Government. This was important for the organisation in terms of our escalation status.	
QSE 19/10/006	**SERIOUS INCIDENTS AND NEVER EVENT PAPER OCTOBER 2018-19** The Executive Director of Nursing provided an introduction to the report. The purpose of the report was to look at whether the organisation was learning from quality, safety and patient experience Serious Incidents (SIs). It was important to note that the Health Board did have a culture of reporting incidents. Work had been undertaken by the Patient Safety team to motivate people to report incidents and to ensure that those in leadership positions were able to respond appropriately. Reporting incidents focused mainly on ensuring that there was an understanding as to what had occurred, that the organisation was open and transparent and was a learning organisation. The following comments were made: Over the past year 297 SIs had been reported to Welsh Government. No comparison could be made as there was no comparable data from other Health Boards. Five of the SIs were Never Events (NEs). The number of SIs had gradually increased but there had not been an increase in Never Events. It was identified that these events were reported differently in England to Wales. There was learning from the Dental service with the number of NEs. A 'WHO' checklist had been developed within the service and some changes had been implemented and further recommendations had been made. It was acknowledged that there could be an increase in NEs when changes were made.	

	The Executive Medical Director stated that failure to reduce the number of NEs was a national phenomenon and he did not view this as a failure. The same number of NEs had occurred as in previous years. It was suggested that the report could be seen as a success, with a key component being the reporting culture. Therefore there was a need to take a balanced view in comparison to the number of SIs. The Executive Nurse Director highlighted that the NEs were not repeat events. There was a need to see how things were categorised and that a SI was also serious for the patient. Independent Member - Trade Union asked if the data could be explained on Never Events. It was stated that on page 9 the data covered the whole of Wales and on page 7 it covered four years of data in the Health Board. It was further explained that, when the word 'open' was used it meant that the process was still happening and it usually took 6 months to complete a Root Cause Analysis. It was also highlighted that sometimes cases may be open for longer as they may not have been concluded or predominately, because the investigation had not been completed. In the particular reporting period there had been overlaps of time periods and there had been five NEs in the past 12 months but the Executive Nurse Director was comfortable that actions put in place had been addressed. The Chair asked if we could take assurance that we knew what was going on in our system. The Executive Nurse Director explained that we could not look at one SI in isolation to see if we had a robust quality and safety process in our Health Board. There was a need to look at a number of things such as incident reporting, SI reporting, complaints and compliments, claims, patient experience feedback, internal inspections, clinical audit, inspections, outlier data and mortality data. Individual topics were presented to the Committee but also, behind the scenes, this was being triangulated. The challenge nationally was the RTT position and the financial position which had very robust data supporting the information provided. Some of the information was in the dashboards and this was escalated upwards. Fundamentally the organisation is dependent upon staff being open and transparent about their reporting. It was reasonable to look at improving sources of information and use this as a start point to understand what was happening within system. It was highlighted that in an evidence based survey, the single measure used to ensure we were running a safe service was the staff engagement score. The Executive Nurse Director stated there was a need to ensure we had sufficient people in the Patient Safety Team to review the reports to ensure there was robustness and challenge. Independent Member Trade Union, commented that the staff culture needed to be addressed as the surveys were going in the wrong direction. The Executive Nurse Director informed that staff were reporting incidents but they did not feel they received the level of feedback they should. This was being addressed in the Patient and Safety Team who were reinforcing the importance of this. Independent Member – Community, said he was assured in terms of	

	understanding the reporting structure and the multifaceted factors undertaken to gather and analyse the data was helpful. It was encouraging to hear what staff and patients were saying. In regards to looking at categories of incidents he felt reassured that he had a greater understanding of unexpected deaths and severe harm. The Chair stated that the report centred on the culture and also highlighted there was no complacency. Comments were made on the language used regarding assumptions in the paper and that this should be considered for future reports. **The Committee resolved that:** a) appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern	
QSE 19/10/007	**TRACHEOSTOMY SIMULATION** When introducing the simulation the Executive Nurse Director stated that Tracheostomy had been an issue with more patients having procedures. In the past care for people in a hospital setting was unsatisfactory and the team would share with Members the improvements the team had put in place. Dr John Dunn, Consultant Anaesthetist, Programme Director and Simulation Lead, gave a presentation and introduced the team, Louise Kennedy, Ward Manager on A5 North; Gail Prosser, Practice Educator A5 North; Paul Twose, Physiotherapist and Dr Cellan Thomas, Maxillofacial Consultant. Dr Dunn then provided a presentation for people who were not familiar with simulation and explained how it was used to train the multidisciplinary team. The following comments were made: It was explained that simulation was used to put training, which had been taught theoretically, into action in the simulation suite. Simulation was a safe learning environment with clear learning objectives and could be used to simulate isolated tasks or more complex clinical situations, which could be practised repetitively. Ownership was encouraged and also that champion were identified in each Directorate. When teaching simulation, various competencies were looked at such as; communication, situational awareness, leadership, role clarity and coordination. Medical errors occurred during simulation for a range of reasons, including: medication errors, poor communication and dysfunctional teams. Patients were safer and received higher quality care when providers worked as a highly effective team. Multidisciplinary simulation ensured patient safety and Continual Professional Development for consultants and allied professionals. This created a happy work environment and demonstrated benefits to patients and services. Prior to the simulation, Dr Cellan Thomas explained the scenario that	

	would have been undertaken and the type of patient that would be treated. He explained that when doing complex surgery in the head and neck region certain procedures required a tracheostomy and when this was blocked it was not a good experience for either the patient or staff as it became very stressful. By attempting to replicate and practice stress, a positive outcome at the end was more likely to be successful. In the past when a patient had a blocked trachea the arrest team would be called in but would not know anything about the patient. The nursing staff tended to step back although they would know much more about the patient. Therefore, it was important to train the whole team which involved the arrest call team, the nursing staff, physiotherapists, outreach team and anaesthetist. In summary, it was stated that there was a need to provide medical staff with confidence in performing procedures and to de-brief the team following a procedure. It was emphasised that unless this was practiced medical staff would not understand the real thing and this was a key component of the training programme. **The Committee resolved that:** a) That the presentation and simulation be noted.	
QSE 19/10/008	**ANALYSIS OF TRENDS AND THEMES IN DEATHS OF PATIENTS WITH MENTAL ILLNESS** The Executive Nurse Director stated that there was a growing concern at Board meetings regarding the numbers of unexpected deaths of patients known to mental health services. The conclusions would be fed back to the other members of the Board. Dr Annie Procter, Consultant Clinical Board Director for Mental Health, Ian Wile, Director of Operations, Mental Health and Jayne Tottle, Nurse Director, Mental Health provided an overview of the trends and themes identified from Serious Incidents (SIs) and what actions had been taken to address the risks and shortfalls. The presentation also looked at the growth of the Mental Health Services which provided context to the amount of work the service undertook throughout the year. The diversity of Mental Health Services and a comprehensive overview was presented to the Committee. The following comments were made: Suicide prevention had a good evidence base. The tools available would help with suicide prevention but could not identify when a patient would take their own life. Less than 5% of the service focused on service users in hospital as most were seen in the community. The National Confidential Inquiry into Self-Harm (NCISH) published an annual report which the Health Board audited itself against. The Health Board was set in the middle on suicide rates per 1000 compared to the rest of Wales. This year the NCISH focused on 10 ways to improve safety. The review started with safer wards. Wards within new builds were built to a higher specification and discussions had been undertaken nationally when there had been incidents on the Hafan y Coed wards. For instance, doors which had ligature points, had been removed and funding	

	was secured to replace these with collapsed swing doors. There was early follow up with patients being seen five days post discharge. This would be reviewed to see whether this could be reduced to three days. This could be piloted following the remodelling of the outreach service. The Framework for Dual Diagnosis had been set up recently. This process was used for patients who had self-harmed or tried to commit suicide and came out of NICE guidance which had suggested 3-12 sessions. The Health Board committed to 3 sessions which allowed difficult conversations to take place in a frank and safe way. Thematic reviews were undertaken each year and the next one would be undertaken in December. The theme would focus on zero tolerance for suicide. It was acknowledged that although there would be suicides there was a need to aspire to prevent as many suicides as possible. It was highlighted that over 70% of suicides had not used our services. It was acknowledged that the Mental Health Team had not been efficient with identifying risk in patients with psychoses. Regarding the Community Mental Health Team and community changes; mathematical feedback had been received from the Delivery Unit who provided encouraging figures. The service had wasted people's time 60% less than before the changes had been made and the effect on some principles had started to show some benefits. The Third Sector was commissioned last year to undertake some patient feedback and provide improved data. Care Aims training had been undertaken in the Vale and would be rolled out across the rest of the locality. There had been one patient suicide this year. This had not gone to inquest as yet. There had been 12 community deaths. The circumstances for nine suicides had been hanging and five had not as yet gone to inquest. Two patients had left suicide notes. There had been no obvious theme that connected any of the suicides other than the method. Improvement plans were always in draft as more information could be collated from the Coroner's Inquest. There had been nine deaths that were ongoing and had not gone to inquest. Nothing had been found to suggest the incidents were suicide attempts. There was a need to balance risk taking and wanting people to recover and rehabilitate. It was deemed that patients' should take responsibility against the risks of suicide and self-harm. The principle of mental health was not to be restrictive and to provide people with the option of freedom to choose. The Chair asked Members for comments and questions: The Executive Nurse Director stated that the presentation helped to explain the complexity of the service provided and the way in which the services were managed by introducing different processes and services on a changing demand. Members were able to understand that some of the behaviours presented in mental health were not increasing risk but behaviours to seek attention which did not always change into a risk. The ability of teams to have systems and processes in place with skills and	

	knowledge to assess patients was crucial. It was important to empower patients in making the right choices but to support them when they made the wrong decisions. This helped the Committee to understand and provide assurance to the Board that we were not concerned with the service. There was a need to understand this when we had gone through our internal processes and the Coroner had provided a conclusion. No clear themes had emerged and based on the national data available we were not an outlier but took what had been advised as being best practice and implemented this. The Clinical Board Director of Mental Health stated there was a need to evidence our support for staff and service users, and train them correctly. The service users were an integral part of the conversation. The Executive Director of Therapies and Health Sciences said there was a need to balance risk and provide people with independence and she was assured that the service covered all the elements required. The strategic changes made around the service provided low level intervention upfront and linked the strategy to reduce the risk. Independent Member – Legal asked, what was the best way to display the Board-level data as it could potentially be alarming when seen in isolation from the presentation. In response the Executive Nurse Director stated that at the next Board meeting the presentation would need to be reinforced by the size, depth and the complexity and how many people used or were involved in our mental health service and to reinforce some of the messages. Independent Member – Trade Union, stated she had reassurance from the discussion but needed to take back to other Independent Members who looked at the level of tolerance as zero and was not sure this was aligned correctly. *The Executive Director of Therapies and Health Science left the meeting at 11.38am* The Executive Medical Director quoted the National Confidential Inquiry into Suicide and Homicide and made the following comments: 1. The Celtic nations had a historic higher suicide rate than England. This was felt to be environmental in nature. 2. Out of the Health Boards, Cardiff had the second highest rate in Wales with factors influencing the suicide rate clearly different between the Health Boards. 3. If Cardiff and Vale were compared with the English counties it would have the second highest rate in the data presented. If Cardiff and Vale was the best English county, it would have half the suicide rate in the data presented. This was not just about mental health services, all of these things highlighted something more inherent was underlying these rates. There was a need to ask as a Health Board whether we were prepared to review what we were we doing and address the bigger issues related to	

	socioeconomic causes of ill health. The Executive Nurse Director stated it was important to understand the difference as it was not imported in the bigger picture. The bigger picture for our duty for health to try and prevent people from committing suicide. The presentation stated patients who committed suicide who were involved in our Mental Health services, the picture was slightly better that it would be elsewhere in Wales but in relation to our population this was a Public Health issue. The Executive Medical Director commented when SIs were reported to the Board what was often reported related to the population. Board members received SI around recurrent events which raised concerns and there was a need to be clear of the population component in relation to our Mental Health Service. The Director of Operations for Mental Health highlighted that referrals could escalate to 100k a year because of the contact with primary care services. If the primary care workers and third sector was equipped to have some of the difficult conversations with people and recognised risk factors, there was the potential to get information out of the core of the population of Cardiff. This could contribute to the Public Health debate. The Chair emphasised that the issue was not just about health but included health inequalities, housing and poverty. This was a public sector response which was much broader than health. It was suggested that what was learnt from the session, was that individuals who used our services were part of the population which we serve. The statistical data informed we had a suicide rate that was higher than expected. Many of the people included within the data had not yet used our Mental Health Services. The data suggested that as a community we had to do more with our local authority colleagues to have a debate and to consider a summit regarding the suicide rates in our population. The Clinical Board Director agreed that a much broader conversation would be welcomed and Members acknowledged that more could be done in partnership for the population. *The Clinical Board Director Mental Health, Director of Operations Mental Health and the Director of Nursing Mental Health left the meeting 11.49am* In summary, the Chair stated that the Committee had analysed trends and looked at deeper levels of assurance where hope and a way forward was described. She acknowledged that the service was very complex with interdependencies and how, at times, we may try to simplify the issues. Also highlighted was the prospect of working in partnership across the public sector. **The Committee resolved that:** a) The position taken by the Clinical Board be supported and the presentation be noted	

QSE 19/10/009	**MANAGEMENT OF ENDOSCOPY SURVEILLANCE PATIENTS** Dr Jeff Turner, Consultant Gastroenterologist provided a presentation on the above. The following comments were made: Gastrointestinal (GI) Endoscopy is used when patients are symptomatic or have diagnosed conditions and is part of the national outcome screening programme. The surveillance is important for the organisation in terms of the SI's we experienced. Surveys were undertaken of patients with increased risk of cancer but part of the problem experienced was that historically, surveillance waiting times had not previously been reported to Welsh Government. 24 SIs were experienced over a period of 4 years due to the surveillance backlog and this was a Wales wide issue. A presentation was made on the basis of the work undertaken and focused on how improvements had been achieved within the Health Board on a national level. As part of this a robust action plan had been developed. As there were issues around surveillance, a clerical and clinical validation of around 1000 cases was undertaken, as a result of which, a risk stratification spreadsheet was developed. This meant that the highest risk patients were being reviewed and treated first. The endoscopy rate was identified as high risk in patients over 80. Surveillance clinics had been developed and patients had been invited for face to face discussions around the risks and benefits of surveillance. When patients had an informed conversation it was realised they did not want to undertake the risk. An insource provider was used to clear the backlog but decided to exclude very high risk patients from the cohort. To support the insource company, robust governance structures were in place with a consultant presence every weekend and we were able to review live, all of the people that had received an endoscopy. In September 2018 there were 990 patients with no appointment dates. In comparison to October of this year, the numbers had significantly reduced to a minority of 49 patients without appointment dates. The SIs experienced were as a result of people who had become symptomatic on the waiting list but, with efficiency work in-house and the insource contract, the numbers had reduced quickly. The current situation was that the backlog had been cleared apart from patients who had postponed procedures. Surveillance procedures had been included into their core capacity where patients prospectively were booked in, in advance of their procedure date. Historically there had been challenges about meeting diagnostic waiting time. Currently, due to increased demand significant challenges were being faced. This was again across Wales. Insourcing was still being undertaken but this had reduced after a big efficiency piece of work had been undertaken. The insource company would now be used once a month to meet the waiting time targets and it was confirmed that there had	

	been no further SIs. Members were assured that there was an open and honest reporting culture seen within the Directorate which proactively managed any risk to patients. There was a robust plan to address risk and good team working was highlighted. The Chair invited comments and questions: Independent Member – Legal asked, what does insource mean? It was explained that an external private provider (A gastroenterologist) was brought into the unit with a team to deliver the work. Independent Member – Trade Union asked how did we get to the position in the first place and what plans were in place to ensure this did not happen again? In response, it was stated that, in terms of surveillance, this had changed and the UHB now reported these cases to WG along with diagnostics and cancer waits and the UHB was looking across all areas of the endoscopy service. It was acknowledged that there were very significant challenges and it was predicted that a 6% increase year on year would be seen in the symptomatic referral rates. Part of the national endoscopy programme would look at a longer term sustainable strategy due to the pressure envisaged on the service. The Executive Medical Director commended the team for the turnaround and good clinical leadership, stating there were a number of strategic changes to review which would help provide solutions across the long term demand capacity work. He was also asked to explain what the role of the Joint Advisory Group Accreditation (JAG) was and why it was it important. It was explained that JAG was a national accreditation process and looked at all specifications of the service and exemplified good patient care, experience and environment. JAG had visited the UHB in 2012 where all of the standards were met apart from timeliness. The UHB were looking how to achieve JAG Accreditation and confirmed waiting times were significantly better but this needed to be sustained. An external JAG assessor would visit the unit shortly and provide informal guidance on areas for improvements and provide support in achieving JAG Accreditation. Regular directorate meetings were in place and an action plan would be devised. The Executive Director of Therapies and Health Science commented that the presentation showed good governance when we needed extra capacity, in that patients remain ours and in our facility, and this was to be commended. In regards to endoscopy decontamination, there was a need to plan for the future. It was stated that locally there was scope in Llandough for expansion as it provided bowel cancer screening and other advanced endoscopy. On a regional aspect, as part of the national programme, this was largely in terms of training as there may be challenges as this looked at a core group of patients. It was further considered that whilst insourcing does cost to have an external provider, it provides better governance by having oversight of the patients that come into the system and by having the reports on our local reporting systems. The Executive Nurse Director acknowledged that Dr Geoff Turner had	

	undertaken a number of RCAs to get to the root of the problem and made the necessary changes. He did however acknowledge that sometimes it takes time to understand the issue. The comments on insourcing and outsourcing were relevant and a paper would be brought to a future QSE Committee around this. It was explained that there were no nurse endoscopists initially, but complimented this skill as the capability and numbers were growing and he was using them in an appropriate way. Independent Member – Community asked how we were overcoming the perception of the risk of going through this procedure, and were we going into the community for screening to reduce incidents? In terms of perception, more people were being treated 'direct to test' which endeavoured to strengthen information gathering and developed an endoscopy platform on the internet. The team had also implemented text message reminders. The point of contact for the patient was with administrators in primary care, but there were nurses to provide information and redirect to clinic for face to face conversations. There was a continuation of the intention to expand nurse endoscopists and work was underway to improve their knowledge in endoscopy. In terms of bowel screening, demand would increase five fold over the next five years; this will assist in identifying polyps and cancers at an early stage. Funding had been secured for a pilot on fit testing in a symptomatic group of patients. This could be broadened and would help stratify people's risk in the community. As part of this work, GP training would be undertaken and national initiatives had been looked at. The Chair stated that she would write a personal letter of commendation and thanks from the Committee. She further asked if there was any learning to share across the Health Board. In response, it was stated that the supportive processes put in at the weekend provided great assistance and therefore had their own internal governance structures whereby reports could be reviewed and if things could be improved there was the potential to have dialogue. In summary, the Executive Medical Director stated that the key issues discussed helped to focus on any service that was struggling, for them to be open and transparent, to look at everything and to be frank. The key role in clinical leadership was in developing future planning and demand capacity, and for the clinical governance team to identify areas that need to be addressed. This was an exemplar of using our governance processes. **The Committee resolved that:** b) The current position and ongoing work in relation to the management of patients overdue their endoscopy surveillance procedure be noted	
QSE 19/10/010	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** • The committee would be comfortable to provide assurance to the Board they had reviewed themes and trends emerging from serious	

	incidents. • Assurance was provided around tracheostomy and endoscopy. Assurance was also provided in relation to the clinical team and its ability to identify significant areas of concern and make the changes necessary to address those areas. • The serious incidents were debated at length and there was a summit to support the multiagency team in place across our partnership arena. There is progress that we need to make on our population suicide position, as currently we were seeing themes and trends from a health perspective that we had concerns about.	
QSE 19/10/011	**DATE AND TIME OF NEXT MEETING** Thursday, 17 December 2019 at 9.00am Coed y Bwl Room, Ground Floor, Woodland House, Heath, Cardiff	

ACTION LOG

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

SEPTEMBER 2019 MEETING

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
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	**COMPLETED.** Verbal Update for September meeting.
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	**COMPLETED.** On agenda for September meeting. *(Item No: 1.14)* See action (QSE 18/135) To be brought to August Board Development 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	**COMPLETED.** 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 19/06/14	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	**COMPLETED.** Very proactive social media campaign has been launched for the start of the P&R to UHL.
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	**COMPLETED.** On agenda for September meeting. *(Agenda item: 3.2).*
QSE 19/06/20	Cwm Taf UHB	Improvement plan progress update to be	17.09.19	R Walker	**COMPLETED.** On agenda for

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
	Maternity – Cardiff and Vale Lessons Learnt	brought to next meeting emphasising non and partial compliance. As meeting was not quorate, the resolutions would be ratified by the Board	 25.07.19	 S Elsmore	September meeting. *(Agenda item: 1.11).* 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	**COMPLETED.** On agenda for September meeting. *(Agenda item: 1.12).*
QSE 19/04/020	Endoscopy Decontamination – Patient Notification Exercise	To bring a paper to a future meeting once the new procedures have been embedded A paper regarding centralisation to be brought to September meeting.	17.09.19 17.09.19	S Walker F Jenkins	**COMPLETED.** Verbal update for September meeting. On agenda for September meeting. *(Agenda item: 3.1).*
QSE 18/135	Ombudsman Annual letter	Present update	17.09.19	R Walker	**COMPLETED.** On agenda for September meeting. *(Agenda Item: 1.13).* Awaiting QSE & Board decision.
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	**COMPLETED.** Within Chair's report to the Board on 25.07.19.
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	**COMPLETED.** 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 underway.
QSE 19/06/008	Specialist Clinical Board Assurance Report	As meeting not quorate to be ratified by Board in July	17.12.19	S Elsmore	**COMPLETED.**
QSE 19/09/008	Children and Women's Clinical Board Assurance	A paper would be presented to the next Board meeting on the CAMH Service action plan and redesign.	26.09.19	S Curry	**COMPLETED.**

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
	Report				
Actions In Progress					
QSE 19/09/008	Children and Women's Clinical Board Assurance Report	An update was requested for a future meeting detailing the steps taken with the Children's Charter	17.12.19	C Heath	On agenda for December meeting
QSE 19/09/011	Gosport Review	To provide timeframes from the recommendations of the Gosport Review	17.12.19	C Evans	To be completed within 12 months.
QSE 19/09/016	Centralisation of Endoscopy Decontamination	To keep the Committee update of progress		F Jenkins	
QSE 19/09/017	Update on Stroke Rehabilitation and Model and Workforce	A verbal update to be presented at next Committee meeting.	17.12.19	F Jenkins	On agenda for December 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.	17.12.19	S Curry	On agenda for December meeting *(agenda item 3.6)*
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 19/06/011	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 as and when they occur	17.12.19	F Kinghorn	Patient Notification Exercise on agenda for December meeting *(agenda item 3.8)*
QSE 19/06/13	Ophthalmology Report	A short update report including benchmarking data to be brought to Committee	17.12.19	R Walker	A verbal update to be provided for December meeting.
QSE 19/06/20	Cwm Taf UHB Maternity – Cardiff and Vale Lessons Learnt	To provide an overview of the impact in terms of patient flow to Cardiff and Vale UHB and how this is being mitigated	17.12.19	S Curry	Verbal update for September.
QSE 19/02/008	PCIC Clinical Board Assurance Report	To provide an update on issues concerning the mobile units in the Ely Hub and Splott Clinic.		A Harris	Matters arising for December meeting

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 18/155	CD&T Minutes	Update on refurbishment works on the Bone Marrow Transplant Unit	17.12.19	A Harris	Update to be provided at December meeting
Actions referred to committees of the Board					

Report Title:	**CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD QUALITY, SAFETY AND PATIENT EXPERIENCE REPORT**								
Meeting:	**Quality, Safety and Experience Committee**						**Meeting Date:**	**December 2019**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	Executive Nurse Director								
Report Author (Title):	Clinical Board Director for Quality, Safety and Patient Experience, CD&T								

SITUATION

The work outlined within this paper reflects the activity taking place to improve quality, safety and patient experience within the Clinical Diagnostics and Therapeutics Clinical Board leading to improved quality and care outcomes for patients.

REPORT

BACKGROUND

The Clinical Diagnostics and Therapeutics Clinical Board provides a wide range of diagnostic and therapeutic procedures on a local, regional and UK wide basis. Collectively these services underpin, and are core components of, almost every aspect of clinical activity undertaken within the UHB.

The Clinical Board consists of 7 directorates:

1. Laboratory Medicine
2. All Wales Therapeutics and Toxicology
3. Radiology, Medical Physics and Clinical Engineering
4. Medical Illustration
5. Outpatients/Patient administration
6. Therapies
7. Pharmacy and Medicines Management

The Clinical Board vision is to ensure the quality and prudent use of Diagnostics and Therapeutics across the Health Board by:

1. Ensuring that we become better suppliers of services to other Clinical Boards by developing our supplier strategy.
2. Ensuring that all users have equal access to our service, and are treated with fairness, dignity and respect.

3. Working in partnership with other Clinical Boards, Public Health and external partner organisations to improve health outcomes.
4. Ensuring that the 'voice of the customer' is heard and informs the planning, commissioning and delivery of services.
5. Behaving in accordance with the values and behaviours of the organisation
6. Ensuring that staff working within the Clinical Diagnostic and Therapeutics Clinical Board, are provided with opportunity to achieve their full potential.

The key achievements for the Clinical Board in 2018/19 have been:

- Improved quality metrics across the Clinical Board
- Consistent delivery of improved waiting time positions for both radiology and therapies
- Support to other Clinical services in the delivery of improvements to RTT waiting times
- Consistent and high quality support through improved recruitment and retention

Underpinning the overall Clinical Board strategy has been improvements to the quality system in 2018/2019. There have been key improvements to quality within the clinical board demonstrated by the improved performance metrics and the maintenance of ISO accreditation in laboratory services.

This year continues to be challenging with regards to Regulatory Compliance. Services in the Clinical Diagnostics and Therapeutics (CD&T) Clinical Board are amongst the most highly regulated in the UHB with regulatory bodies auditing these services on a rolling programme of inspection along with ad-hoc visits from a number of agencies. The experience in Cardiff and Vale over the last 2 years, supported by feedback from regulators, is that there is an ongoing shift to raise the bar of the expectations of quality management systems.

The increased expectations from regulatory bodies manifests itself in the following ways:

1. The management of the Quality Management System (QMS) in regulated services needs to demonstrate more timely action, sustainability and not be in conflict with the delivery of service. The QMS has developed into a risk based approach where risk management should be the intelligence for change management. This has led to increases in validation requirements for change.
2. Demonstrable governance routes, clear routes for both communication and escalation which includes active listening, visible support, accountability and action.
3. Clear and concise reporting with the continuous development of the performance metrics.
4. The requirement to demonstrate shared learning and continuous improvement.
5. In the last two years, particularly in aseptic production environments, the challenge around improvements to production processes and increased monitoring for microbiological trending has increased.

The Clinical Board Quality, Safety and Patient Experience (QSPE) governance framework provides assurance that it is delivering its diverse portfolio of services in a safe and sustainable manner. The Clinical Board's QSPE priorities for 2019/20 include:

- A strong safety culture embedded at every level of the Clinical Board and Directorates
- Supporting the health and well-being of staff
- Regulatory compliance and accreditation
- Continued self-assessment against the Health and Care Standards with improvement planning against any indicator requiring action
- Regular review of risk management processes and action plans to provide assurance that mitigating actions and risk reduction strategies have been implemented.
- Serious and Adverse Incident Management and Concerns Management
- Embedding the Patient Experience Framework across the Clinical Board, ensuring patients are always treated with compassion, dignity and respect
- On-going support for continuing service improvement
- Ensuring safe working conditions and environments
- Timely access to services based on clinical need

ASSESSMENT

Governance, leadership and accountability

Strengthening the Quality, Safety and Patient Experience (QSPE) position is a key priority for the Clinical Board. The Clinical Board Director leads the QSPE agenda and operational responsibility is devolved to the Clinical Board Director of QSPE. QSPE meetings are held monthly and the Terms of Reference are reviewed annually. The QSPE meeting agenda has been shaped to align with the Health and Care Standards for Wales and this is replicated at Directorate QSPE meetings.

The Clinical Board acknowledged the need to strengthen the governance arrangements with regards to regulatory compliance. It has established the 'Regulatory Compliance Group' with the specific aim of ensuring that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality and safe healthcare and to assist the Clinical Board, and the Executive Board, in discharging its functions and meeting its responsibilities with regard to regulated services within the scope of CD&T Clinical Board.

The Clinical Board risk register is a live document which is maintained and updated monthly. The highest risk issues currently on the risk register are summarised for the Corporate Risk Register as:

Risk	Consequence	Likelihood	Total
Non-compliance with regulatory and accreditation requirements leading to - impact on service delivery and patient safety (potential for cease and desist of service - reputational risk - financial risk e.g. loss of income, fine for breach of statutory duty - inability to maintain suitable systems, practices and facilities to ensure on-going compliance - increasing requirements from regulators which cannot be met - mismatch in capacity/demand on QMS which leads to failure to deliver activities - patient/staff harm as a result of poor safety governance, e.g. ultrasound, MR safety, decontamination, POCT - Health and Safety at Work incidents - patient concerns, claims and redress - failure to comply with GDPR and Information Governance	5	4	20
Workforce - mismatch between staff capacity and demand for safe delivery of service - sickness absence, increasing work related stress, MSK sickness - presenteeism - fragile out-of-hours services (e.g. paediatric Radiology, Laboratory Medicine) - difficulties in recruiting, retaining, training and maintaining competence of staff - lack of staff engagement - barriers from professional boundaries in developing services/skill mix	4	4	16
Non-delivery of a balanced year end finance position due to - increasing cost - increasing demand - failure to meet CRP targets - locum use due to recruitment timelines for winter - outsourcing due to capacity shortfall (e.g. Radiology, pathology) - impact on income from external customers, e.g. Radiopharmacy, SMPU	4	5	20

Operational Effectiveness/Performance - failure to deliver against national standards and guidance leading to risk of patient harm and variation in practice e.g. Diabetes and Stroke - commissioning models do not support the development of CD&T's supporting clinical services e.g. tertiary radiology services, lab support to WHSSC commissioned services, pathology support for Dermatology - difficulty in matching existing capacity to demand compromising the delivery of safe services and achieving quality indicators such as RTT and cancer performance - delay in reporting times (Radiology, Pathology) which impacts on service delivery/delays to diagnosis	4	4	16
Infrastructure - the fabric of some estate is suboptimal to delivery of modern, safe and sustainable healthcare, e.g. Radiopharmacy, Mortuary, Physio UHL - inadequate provision of capital and non-capital equipment impact from aging hardware and software, slow delivery of key IT systems, on-going stability issues (WCCIS, LIMS, Telepath) - no electronic requesting in Radiology (inability to address patient identification issues) - lack of Radiology results notification and acknowledgement system - poor uptake of lab medicine electronic test requesting by other Clinical Boards (leads to mislabelling of samples, poor test requesting, slower processes in the lab) - new equipment not meeting service user specification (e.g. Biochemistry analysers) - lack of access to the medical record including physical and digital storage	5	4	20

The Clinical Board continues to work with services to review risks held on the register to ensure continued appropriate action and mitigation against all held risks.

Health and Care Standards

The Clinical Board QSPE sub-committee agenda is framed around the Health and Care Standards. Below are examples of work being delivered against the standards through this framework.

Staying Healthy (Theme 1)

Health Promotion, Protection and Improvement

The uptake of the Influenza vaccination is a key priority for the Clinical Board. The uptake rate for frontline staff for the season 2018/19 was 70.4%. This was slightly lower than the previous year. Considerable work has been undertaken in developing the role of peer vaccinators and an evaluation of the outcome of this work will be undertaken at the end of the vaccination season.

The Clinical Board is working collaboratively with Public Health Wales to deliver a package designed to encourage increased activity, healthy eating and mindfulness in the work place.

We know that with busy work days and our commitments at home it can be difficult to prioritise our own health and wellbeing. However, small lifestyle changes which we can fit into our days both at work and at home can add up to a big positive difference.
We launched a new workplace initiative Work Health, My Health in May which aims to give advice and information on simple ways to make these small changes around being more active, eating and drinking healthily and improving our wellbeing.

WORK HEALTH
My Health

Staff can access resources at http://www.cardiffandvaleuhb.wales.nhs.uk/work-health-my-health/

Safe Care (Theme 2)
Regulatory Compliance and Accreditation
The Clinical Board services are well regulated and subject to regular inspection against legislation, regulation and standards. In 2018/19 the following regulations inspections took place:

13th December 2018, the MHRA inspected the Blood Transfusion Laboratory for compliance against the Blood and Safety Quality Regulations. It is recognised that significant effort has been undertaken by the team in BTL to improve the quality management system within the service. Whilst progress has been made since the last inspection (December 2018) and the team are in the process of embedding those improvements, the pace of this improvement was seen by the regulator as slow. The inspector also raised concerns about the level of very senior management oversight. Significant work has been undertaken within the service to bring all metrics within expected compliance.

22nd January 2019, the Human Tissue Authority undertook an inspection in the Stem Cell unit (the service is delivered by Specialist Clinical Board in partnership with CD&T who provide laboratory services). The purpose of this visit was to assess compliance against the HTA standards and assess the suitability of premises on which HTA licensed activities take place. The inspection identified a small number of shortcomings. In response to this the Clinical Board and service developed an immediate response plan in order to begin corrective actions within a governed framework. The HTA continues to be satisfied with the actions taken and the quality of our submissions.

24th January 2019, the MHRA undertook a regulatory visit against compliance with Good Manufacturing Practice and Good Distribution Practice (GMP/GDP) in St Mary's Pharmaceutical Unit (SMPU). The inspection raised a concern that SMPU lacks the necessary resource to complete all Quality Management tasks. There was also a concern that there was insufficient pace with progress with remediation, and resource difficulties at SMPU. The Licensing Authority reviewed our submitted response and considers that the commitments/proposed actions are acceptable. However, the quality resource in this area remain challenging and delivery of the required improvement is unlikely without additional resource. This resource is captured within the 'Quality Led Governance' business case.

14th March 2019, Welsh Risk Pool undertook an assurance review of standards to ensure that abnormal unexpected findings identified during image reporting are acted upon in a timely manner. The review found that in services through the whole Health Board, there is substantial assurance that a process is in place whereby if a critical or emergency finding is identified and included on a diagnostic imaging report it will be notified to requesting clinicians and support provided in determining the appropriate clinical pathway or treatment.

In relation to urgent, unexpected or abnormal findings, there is reasonable assurance that receipt and action will be achieved within a satisfactory timescale. The report recommended that as a matter of urgency the NWIS lead for RADIS explores the options for initiating an electronic solution that can provide flagging, alerting and auditing tools that will reduce the risk of delayed or missed response to abnormal diagnostic results and make a recommendation for an all-Wales solution.

The report concluded that 'the RADIS solution does not offer a long term solution and a more bespoke intervention will be necessary to provide a more robust assurance against the risk of failure to act. Whilst recommendations other than an electronic solutions have been made in the past, and there has been attempts at implementing non electronic solutions in many services, the installation of an electronic solution is considered by the study authors to be the only cost-effective measure which will provide an increased assurance in this area of risk'. Therefore, a recommendation was made that Welsh Government should consider options for an all-Wales electronic flagging and alert tool to support all organisations in managing the risks associated with this issue.

30th April 2019, Natural Resources Wales undertook a regulatory visit against compliance with the Environmental Permitting Regulations (radioactive waste management). The inspector noted overall we had demonstrated very good compliance with the conditions of our permit. He recommended one small change to a form which has been completed.

23rd July 2019, the MHRA undertook a regulatory visit against compliance with GMP/GDP in Pharmacy Aseptic Unit in Llandough. A small number of shortcomings were identified which are being addressed.

25th July 2019, the MHRA undertook a regulatory visit against compliance with GMP/GDP in the Radiopharmacy, UHW. The Inspector found that the UHB had failed to comply with the provisions of the manufacturers licence due to

- the existing Radiopharmacy facility not meeting current design and maintenance expectations;
- site management had not ensured that a sufficient number of staff and resource were in place to support site activity;
- Pharmaceutical Quality Systems were deficient;
- production controls and process design did not minimise contamination risks.

The Clinical Board are currently managing the response to the MHRA through its enhanced governance and monitoring arrangements. Shortly after the inspection microbial trending in the Radiopharmacy indicated an on-going risk to product sterility and the Radiopharmacy was closed to enable some remedial works to take place. This is a short term solution and the Clinical Board continues to be engaged with the capital scheme for replacement of the Radiopharmacy.

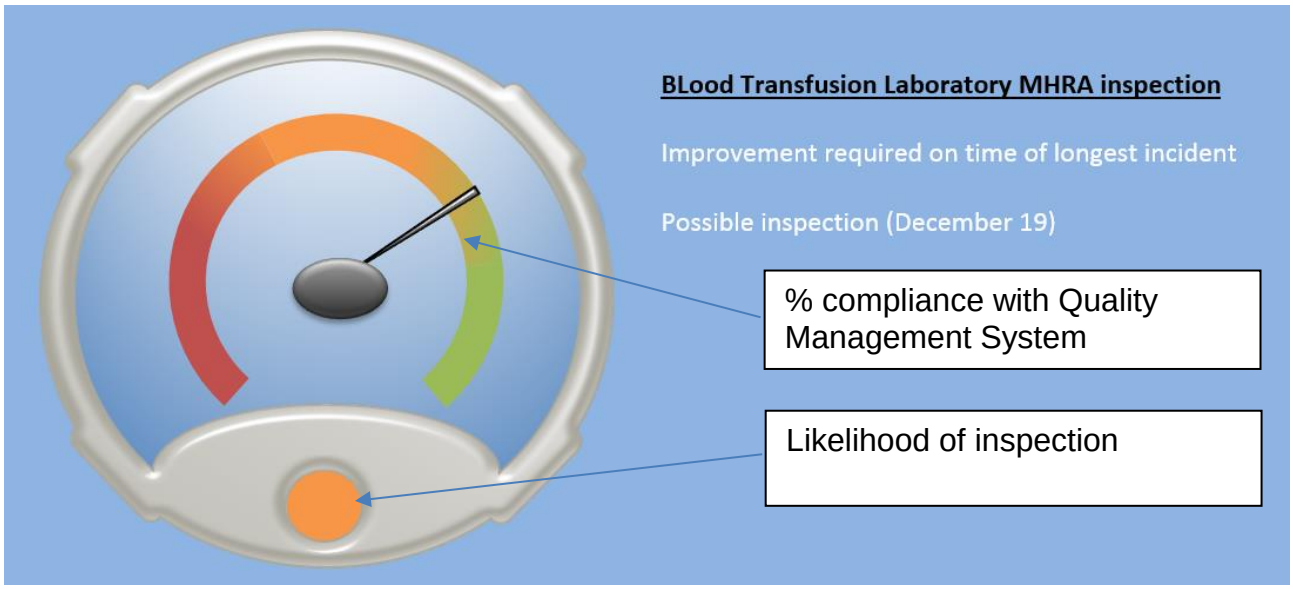
29th October 2019, the HSE undertook a visit following our report to them of an Interventional Radiologist receiving an eye dose in excess of the annual limit. The UHB was issued with two improvement notices and two recommendations on material breaches of the Ionising Radiations Regulations.

Laboratory Medicine underwent a number of surveillance accreditation visits against ISO15189 and successfully maintained accreditation across all laboratories. Accreditation ensures safe delivery of services, technical competence, timely, accurate and reliable results and good quality management.

It has been another challenging year of inspections with regulation bodies increasing their focus on quality management and resource in light of their perceived ‘squeeze’ on financial resources across the NHS. This has led to the Clinical Board re-evaluating its governance arrangements with regards to regulation by ensuring appropriate senior management oversight, escalation of issues, and monitoring of performance. This governance arrangement is through the Clinical Board Regulatory Compliance Group which uses a combination of metrics to drive the compliance dashboard.

Each regulated area is provided with a compliance dial which demonstrates their Quality Management System (QMS) compliance against a range of metrics. These metrics have been given varying weightings and are aggregated to give a compliance score (% compliance). This is displayed on the dial along with an indicator of the likelihood of inspection based on known inspection cycles.

An example of the dial is shown below:



The Clinical Board has undertaken a review of the Quality workforce resource and recommended a workforce model designed to gain synergistic benefits from cross-board working which was presented as 'Quality Led Governance' as part of the Clinical Board IMTP submission.

Central to the Quality Led Governance framework is the requirement for an independent quality function which will

- provide the necessary capability and capacity to deliver the framework moving quality resource between directorates to ensure improvement across regulated and accredited services
- present an opportunity to create a system-wide approach to quality improvement
- support the bi-directional quality accountability and escalation route from the service to the CD&T Clinical Board and to the Executive Board
- provide oversight of decision making processes for the various groups that monitor quality and safety
- offer independent assessment/audit and provide scrutiny of independent investigation reports
- allow opportunities for shared learning
- ensure effective communication and closer working with all partners and stakeholders

The Clinical Board awaits the outcome of its Business Case submission for this scheme.

Patient Safety Incidents

In the period 1/4/18 to 31/8/19 (17 months) there were five Serious Incidents reported in the Clinical Board. These were:

Mortuary	Delayed return of fetal remains
Pharmacy	Dispensing error leading to 10x overdose of Furosemide in a paediatric patient
Biochemistry	Software error leading to incorrect Troponin results being issued
Speech and Language Therapy	Safeguarding referral following choking incident in a patient who had undergone SLT assessment. The patient later died.
Radiology	Delayed rupture of cerebral aneurysm post flow diversion in neuroradiology which led to the patient death.

Between 1/4/18 and 31/8/19 there were eleven IR(ME)R reportable incidents (reported to HIW).

	Total incidents	Reportable incidents
Referrer error: wrong patient (wrong addressograph)	5	4
Referrer error: illegibility of information	2	1
Operator error: failure to ID patient	4	3
Operator error: no check back of previous	2	
Operator error: wrong anatomy/laterality	4	
Operator error: wrong exposure set	1	1
Operator error: modality selection	2	2

This is significant increase on the four IR(ME)R incidents reported the previous year (8 reported in 16/17). A theme and trends review was undertaken and actions implemented to reduce the number of IR(ME)R incidents.

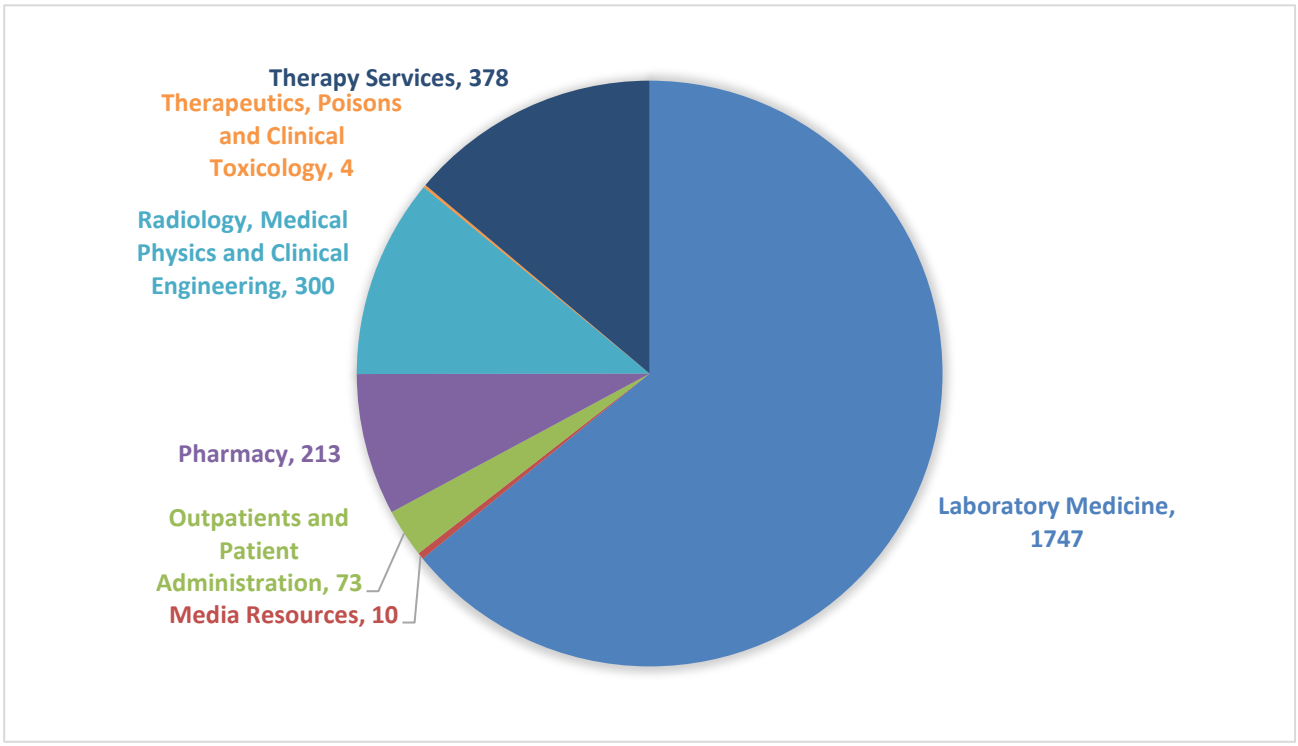
Learning from serious and adverse incidents is shared at the Clinical Board QSPE sub-committee and recorded in the risk register where appropriate. There are adequately trained staff to

undertake robust investigations including RCA. Significant effort has been made to ensure closure of old incidents and submission of closure forms within WG timescales.

Incident Reporting

For the period 1/9/18 to 31/8/19, 2725 incidents (previous year 2681) were reported by Clinical Board staff using e-Datix.

E-Datix queue are regularly reviewed and managed with emphasis placed on managers and DIF2 users to action and close incidents in a timely manner. There has been significant improvement in the number of incidents held in 'queues' and this work will further continue into 2019/20.



The top 10 reported incidents were (previous year in brackets):

		Reported in this period	Number reported last year
1	Diagnostic processes/procedures	1139	924
2	Blood/plasma	331	315
3	Patient medication	218	249
4	Documentation	207	395
5	Patient falls	176	175
6	Staff accidents	111	116
7	Service disruption	110	59
8	Staff exposure to environmental hazards	83	67
9	Behaviour towards staff (including violence and aggression)	76	72
10	Communication	39	

Some themed analysis work has been undertaken with regards to incidents; these include patient identification and medication errors. The Clinical Board are supporting the work being undertaken by the Patient Safety Team to reduce addressograph errors and continues to petition for core IT systems which allow electronic referral for diagnosis to mitigate some of the risk.

Laboratory Medicine reported that with the current paper request form, there are many incidences of the wrong patient information being written on the form; clinical information is missing or the form is illegible; requester details are not always completed; and the wrong tests have been requested or important tests missed out. This has resulted in a number of Datix incidents.

In August 2019, 1221 sets of test were rejected for EAU alone. 1045 patients were affected and needed to be re-bled. These errors were a result of incorrect samples, insufficient samples and labelling errors, however majority were incorrect/insufficient sample types received. These errors could have been avoided if the unit was utilising Electronic Test Requesting (ETR).

On ETR, patient details, the requesting clinician and a contact number are mandatory fields. The system reduces the need for duplicate and unnecessary testing and improves turnaround times. Requests are typed and are legible. This decreases the number of Datix incidents. It allows the ability to communicate urgent results and the ability to discuss investigations with the requester.

Whilst ETR takes longer to complete, it allows for bulk requesting and groups tests.

ETR is rolled out across outpatients and inpatients and presentations are being delivered across all Clinical Boards to encourage uptake of the system. Laboratory medicine are working with the Patient Safety Team to develop a safety briefing to encourage the use of ETR.

Health and safety issues

Clinical Board Health and Safety meetings are held monthly. There is a Clinical Board Health and Safety priority work plan in place which is used as a framework to drive improvement. The meeting also receives feedback from workplace inspections.

There have been 8 RIDDOR reportable incidents in the period 1/4/18 to 31/8/19:

- Fall on step (2)
- Trip (2)
- Manual handling (4)

No common themes were noted. All cases have been managed with the support of the Health and Safety Unit.

Concerns and compliments

The management of concerns continues to be a key priority for QSPE and significant efforts have been made towards timely response to patient concerns.

The number of concerns is relatively small with 66 being raised in the period 1/4/18 to 31/3/19 (compared to 70 last year). The themes were:

Theme	Number
Clinical diagnosis & treatment	26
Communication between staff & pts	24
Deficiency of treatment & facilities	4
Waiting times	6
Case notes issues	4
Staff shortages	2

Tracking of concerns is undertaken and every effort is made to ensure compliance with timescales for formal responses. The average 30 day response rate for the Clinical Board is 81%. Delays in response times were due to complexity of some of the concerns and multi-disciplinary and multi-clinical board input requirements.

In contrast, 105 compliments were received by the Clinical Board in the same period and it is pleasing to note the positive reports received from patients.

Key patient safety risks

Preventing Pressure and Tissue Damage

E-Datix is used to monitor the number and grade of pressure ulcers reported by Clinical Board staff. In the period 1/9/18 to 31/8/19 there were 8 reported incidents, none of these were graded as major harm.

The Podiatry service within CD&T is responsible for the management of all heel pressure ulcers across all healthcare boundaries including instigating treatment plans for in-patients and out-reach settings to manage these wounds.

Education of Nursing and HCSW is imperative in risk management of these compromised patients to reduce incidence of pressure damage and Podiatry are involved in the delivery of this education. In particular at:

1. Pressure ulcer pressure study days
2. HCSW induction days (diabetic foot awareness)
3. Undergraduate education of nurses and use of diabetes e-tool to identify diabetic foot risks

Appropriate beds, chairs and other equipment are made available to reduce the risks of pressure and tissue damage and all staff are trained in manual handling/moving techniques.

Falls prevention
E-Datix is used to monitor the number and severity of falls within the Clinical Board.

108 patient falls were reported in 2018/19 (reduced from 140 in 17/18 and 195 in 16/17). The majority of falls (94%) resulted in no, or minor, harm. There have been no injurious falls reported in the Clinical Board.

Risk assessment of environments and of individual patient needs have been undertaken. Patient flow has been assessed to ensure patients can safely traverse clinical areas along with removal of potential trip hazards. Physiotherapists and Occupational Therapists assist with mobility and transfer assessments and the majority of falls (89/108) were associated with this. Appropriate beds, chairs and other equipment are made available to reduce the risks of falls. A review of safe staffing support for therapy sessions has also been undertaken. In the Mental Health environment, physiotherapy are leading on work to reduce falls associated with dementia. Guidance for falls in out-patient areas has been produced and the Clinical Board is represented on the UHB Falls Delivery Group and the Community Falls Alliance.

Infection Prevention and Control (IP&C)
There are Clinical Board Governance structures in place for IP&C. There are Directorate leads across the Clinical Board who champion IP&C and link workers in each Directorate. There is a bi-monthly IP&C group which links through the chair to the UHB IP&C committee. There is Clinical Board membership on the Decontamination Committee, Ultrasound Governance, IP&C committee, and Water Safety group. IP&C risk assessments have been undertaken in all Directorates. E-learning compliance in IP&C and Environment and Waste is monitored by QSPE sub-committee. Physical environments are maintained and cleaned and there is good compliance with the Decontamination of Reusable Medical Device policy.

The Clinical Board has reported a single bacteremia this year related to Transrectal Ultrasound Biopsy and an RCA is currently underway.

Proper arrangements exist for handling and disposal of waste including human tissue.

Nutrition and Hydration
Nutrition and Dietetics sit within the Clinical Board. Their work involves menu work, auditing, training staff, patient satisfaction and events. Nutrition and Dietetics also deliver structured education programmes. Speech and Language Therapy (SLT) also sit within the Clinical Board. People with swallowing difficulties are assessed by SLT and where necessary training in assisting people to swallow food or drink safely is given.

In July 2018, funding was secured for 1 whole time equivalent band 6 dietitian to lead the enhanced recovery after surgery (ERAS) in Thoracics. Dietetic involvement in ERAS includes presence at all UHW based, new patient consultant clinics, followed by one to one dietetic input. During this consultation, the patient's body composition was measured using a combination of bioelectrical impedance analysis (BIA) and hand grip strength. Based on these results, advice was tailored specifically to the patient to optimise them for surgery. The results suggest that early dietetic intervention could promote positive outcomes. The length of stay reduction of 1.3 days, compared to length of stay pre ERAS in thoracics, has the potential to contribute to a substantial cost saving within the Health Board whilst delivering a higher quality of care to patients. This research will also be presented at the British Dietetics Association Research Symposium later this year.

Medicines Management

Pharmacy sits within the Clinical Board. The Clinical Board also has a number of diverse specialties where medications are administered and stored in departments i.e. out-patient department (OPD), radiology and podiatry. Nutrition nurses and dieticians treat inpatients and administer nutritional supplements on the wards. Medication audits have been undertaken in Outpatients and Radiology departments by the Clinical Board Senior Nurse. Improvement in compliance with medication storage has been demonstrated with new cupboards /fridges and digital locked key holding cupboards being installed. Patients are given information to enable them to make informed choice in OPD. Medications used for invasive and non-invasive procedures in radiology are explained to patients and are also incorporated in patient pre-assessments. Nutritional supplements are also explained by nurses and dieticians.

The Medicines Information and Yellow Card service are hosted within the Clinical Board. Pharmacy are involved in the development of medicines-related treatment pathways and medicines-related education and training sessions are provided regularly

Medication errors are reported as per UHB policy and monitored through e-Datix. Themed work on dispensing errors and extravasation of contrast has been undertaken.

As part of the IMTP submission this year the Clinical Board proposed the development of an 'invest to save' plan for the implementation of an antimicrobial stewardship team within the Health Board.

Safeguarding Children and Safeguarding Adults at Risk

There are two Designated Lead Managers (DLM) for Safeguarding within the Clinical board. There is Clinical Board representation at Health Board meetings and Safeguarding is a standing item on the Clinical Board and Directorates QSPE meeting agendas. Due to the diversity of

directorates/ departments in the Clinical Board staff require different levels of competence depending on their roles and their degree of contact with children, young people and their families and adults. The Clinical Board intend to develop a Safeguarding training strategy to provide a process by which the Clinical Board can audit the type, level and frequency of safeguarding training required.

Due to the relatively low numbers of referrals, the Clinical Board has a 'buddy' arrangement with other Clinical Boards to ensure the DLMs maintain their competence.

Blood Management

The Blood Transfusion service sits within the Clinical Board. The Transfusion Laboratory is fully compliant with the BSQR cold chain regulations and systems are in place to achieve 100% traceability of blood components. Regular audits of transfusion practice are undertaken including participation in relevant National Comparative audits and implementation of any findings.

There is comprehensive documentation available for patients with massive haemorrhage or persisting haemorrhage to ensure they are treated within defined pathways and receive timely haematological advice. Adherence to pathways is audited and significant delays in intervention investigated. The Transfusion Laboratory regularly participate in the Welsh Blood Service blood management scheme and there is evidence of acting on findings to optimise stock and reduce wastage.

All staff involved in the transfusion process receive regular training and have been competency assessed. There are systems in place to ensure ongoing compliance. Staff are able to recognise and report transfusion reactions and incidents. These are promptly investigated and corrective and preventative actions are implemented. Incidents with actual or potential risk of harm and/or recurring incidents are escalated within the organisation, discussed at the appropriate governance meeting and lessons shared through the organisation.

There are systems in place to ensure effective communication of transfusion information to medical and nursing staff.

Medical Devices, Equipment and Diagnostic Systems

Clinical Engineering sits within CD&T. Clinical Engineering manages medical devices within the UHB, ensuring compliance with required regulations and policies. The Clinical Engineering Equipment Management Policy outlines the core areas of activity from pre purchase to disposal.

Part of the equipment base is directly managed through the equipment libraries ensuring decontamination after every use. A fully planned maintenance programme is in place for all equipment for which Clinical Engineering is responsible, ensuring compliance, with reference to manufacturer instructions.

Training and competency within Clinical Engineering is covered in various ways. Infusion devices are covered by two specialised trainers ensuring user training and ongoing competency assessment.

Technical training takes place with instructions from manufacturers and where appropriate, through an internal training programme with documented training assessment forms.

Incident investigations are carried out on various pieces of equipment, when reported, linking in with Datix and patient safety team. Field safety notices are managed and actioned for equipment managed by Clinical Engineering and reporting to MHRA takes place in appropriate circumstances.

Disposal of medical devices is managed through Clinical Engineering, ensuring it is clearly documented, with the asset register being updated, with some valve items auctioned through approved auction companies.

ISO registration to 9001:2008, a quality management system, ensures we have the necessary protocols and procedures in place to cover all activities within Clinical Engineering. Audited regularly, the MEG (Medical Equipment Group) is in place to ensure compliance and governance for medical devices within Cardiff & Vale.

Effective Care (Theme 3)

The Clinical Board is committed to delivering effective clinical audit in all the clinical services it provides. The Clinical Board sees clinical audit as an important component of its arrangements for developing and maintaining high quality patient centred services. In addition to national, mandatory audits, enormous benefit is gained from small-scale clinical audit projects designed by local teams, and focused on local care. The Clinical Board has a Clinical Audit Lead and there are Clinical Audit Leads in each of the Clinical Board Directorates.

Best Practice guidance received from WG/NICE/Royal Colleges at QSE sub-committee. Implementation involves evaluation of likely impact on other services. New evidence has resulted in adoption of new techniques/approaches which demonstrate measurable improvement.

The Clinical Board has an active Research and Development committee and it is keen to further develop this area of practice. Service Improvement initiatives are supported and encouraged and there are regular participants from the Clinical Board on improvement programmes.

The Clinical Board is actively engaged in cross-cutting work including stroke, dementia, diabetes and cancer and fully supports pathway redesign and the reduction of waste, variation and harm.

The Clinical Board are actively engaged in the Transformation work and have developed an innovation forum to encourage and develop new ideas.

The associated increase in demand for walking aids, and lack of accompanying budget, required an innovative solution to meet patient need. This challenge was met by expanding opportunities for walking aid refurbishment to enable patients to gain and regain mobility, and facilitate their hospital discharge. Refurbishment was increased on-site, but required healthcare support worker time. In order to limit the clinical impact, additional capacity was provided outside the NHS, from a collaborative partnership formed with the Probation Service, where offenders sentenced to Unpaid Work by the Courts 'pay back' to the local community by refurbishing walking aids for the NHS, benefitting patient care. The cost avoidance of walking aids expenditure was more than £30,000 during 2018. This initiative makes prudent use of public resources, benefits patients, reduces waste, improves our environmental footprint and helps build a sustainable future together, in line with the Well-being of Future Generations (Wales) 2015 objectives. This also helps the UHB achieve the Waste Strategy for Wales: Towards Zero Waste (2010) targets.

Record Keeping

The Clinical Board provides a vast range of core services to a myriad of departments and partners. It does so through a variety of processes and mechanisms, all of which record, process and manage data in different ways.

Most departments will have trainers, or roles with training functions, often complemented by UHB training. Passwords for electronic systems such as PMS, are only provided after training has been completed and an IT security form signed and approved. Restricted access is in place to areas storing records (often via electronic entry). Plans are in place to extend this. Access reviews form part of some departments' audit / operational plans.

The Clinical Board has key involvement in the UHB Records Groups. There is also close alignment to relevant recommendations in the Internal Audit Department's report on Records Management (2015) and the ICOs Audit Review (May 2016).

Health Records service manages over 1 million records. 400,000 are stored at UHW in a limited number of libraries. In 2017 there were numerous service complaints and issues relating to health and safety. There were trip hazards and constraints to locating records timely and higher levels of missing records. Clinicians need the timely provision of medical records for decision-making and treatment of patients. However staff external to the department can take away notes which significantly increases the risk of notes not being properly tracked.

Capital funding was secured for a reception area to be created in the department and there is now partial restricted access to the libraries. Location based filing has been implemented and the number of missing files has significantly reduced. There has been a successful trial in library 3 of restricted access libraries and a click and collect service. This has saved time which has been reinvested into better stock management. It avoids pinch points and is keeping the floors and bays tidy. Positive feedback has been received from directorates and users.

Looking forward the aim would be to restrict access to all libraries. Room 1 will commence from September 2019. Also for the future a mobile tracking app is being developed by IM&T and there will be further expansion of digital records resulting in less paper. The department is also aiming to move from click and collect to click and drop.

The department are now very proud of the libraries and patient notes are getting to where they need to be more efficiently.

There are good examples of audit and monitoring i.e. in Laboratory Medicine with Quality Assurance systems such as QPulse. However, this contrasts with other departments, which require a strengthening of their Records Management plans and / or structure to support this. Some areas have looked to do this by adjusting role profiles accordingly i.e. Health Records.

Dignified Care (Theme 4)

Staff are supported by the Clinical Board senior nurse, professional leads and directorate management teams to implement measures to ensure dignified care and support continuous service improvement.

The staff in the Mortuary have been working with a charity called 'Little Things & Co' who provide bespoke clothing designed to dress babies born too small and too soon, where standard clothing is too big. The staff also purchased luminous stars and battery operated candles to go alongside the babies in the paediatric refrigerator so that it is 'not so dark inside the fridge'.

The CHC environment audits are regularly conducted and improvement plans are robustly monitored to ensure completion of actions.

Equality and Diversity are embedded within the Clinical Board Values. There is a developing Equality Champion network and partnership working is an integral component of the Clinical Board governance process.

The Clinical Board has developed a dementia action plan including the role of the Dementia Champions and the Dementia Friends initiative. Clinical staff have undertaken Mental Capacity Act (MCA) training and a baseline audit of MCA compliance has been undertaken within the Clinical Board. Further development of this work will take place in the coming year,

The Clinical Board is involved in the development of use of the Welsh language in the workplace and recognises the importance of providing care through the medium of Welsh.

The All Wales Therapeutics and Toxicology Centre (AWTCC) have a Welsh Language Lead to ensure AWTTC comply with the Welsh Language Standards. Work undertaken to date includes:
- A bilingual All Wales Medicines Strategy Group (AWMSG) and AWTTC website is in development.
- An English and Welsh language Twitter account has been launched.
- Bilingual signage is provided for external meetings.
- Welsh language computer software has been provided to all staff.
- The IPFR and AWMSG annual report is produced in English and Welsh.
- A bilingual telephone answer service is in operation and bilingual signatures and out of office notifications have been implemented.
- An internal compliance document has been produced to monitor progress against compliance with the Welsh Language standards.

Timely Care (Theme 5)
Meeting the Diagnostic and Therapeutics Waiting Times access targets is a key priority for the Clinical Board. A number of IMTP schemes have been developed for meeting Planned Care needs. These schemes aim to ensure diagnosis and treatment that is compliant with national target delivery times and best practice guidance, and also efficient, affordable and sustainable.

Performance against these targets is monitored on a weekly basis and improvement actions implemented as required. Proactive capacity planning is undertaken to ensure capacity meets demand. Where patients are not able to be seen within the access target their risk is assessed through a process of clinical prioritisation.

The Clinical Board is actively involved in pathway redesign and is keen to ensure effective and efficient use of resources.

Excellent progress has been made against the delivery of diagnostic wait targets. Further work is being undertaken to ensure on-going improvement with the delivery of report turnaround times for Radiology and Cellular Pathology tests.

Individual Care (Theme 6)
Patient feedback is received in a number of ways for example informal, two minutes of your time, national surveys, concerns and compliments and Datix reports. Stakeholder surveys in Laboratory medicine have been undertaken and Imaging services patient surveys have been conducted in Radiology.

Issues that are observed or raised in patient feedback are received by the Clinical Board and discussed at QSPE. Trend analysis of patients concerns has also been undertaken. Complaints and resulting improvement plans are fed through QSPE structures to allow for shared learning. Targeted 'customer care' training has been delivered in response to identified 'hot spots'.

The Clinical Board has developed a 'Patient Experience and Engagement Framework' with the aims:

- To listen to and learn from user experiences to improve services together in partnership.
- To increase the volume of feedback received from patients through a number of methods
- To demonstrate feedback received is acted upon
- To demonstrate improvements in user/patient experience, satisfaction and outcomes
- To develop co-production partnerships with patients/families/users and the wider community

Work has been undertaken by the Clinical Board to increase the number of National User Experience Framework questionnaires completed and returned. Particular effort has been taken to improve return rates.

Patient feedback has been collected in Radiology and OP utilising some of the technology available (e.g. touch points, interactive kiosks).

The Clinical Board has further developed the use of patient stories within the QSPE agenda.

Medical Illustration are undertaking a Patient Experience review. A questionnaire will be distributed to approximately 40 patients who have been referred for clinical photography by Dermatology. All patients referred for Mole Map/Body Map Photography will be asked if they are willing to participate. The results of the questionnaires will be collated and analysed to give an understanding of patient experience and perception of the benefits of clinical photography in dermatology.

Staff and Resources (Theme 7)

The Clinical Diagnostics and Therapeutics Clinical Board (CD&T) consists of approximately 2022 wte staff as at September 2019.

At September 2019, CD&T had a turnover rate of 7.17% and a cumulative sickness absence rate of 3.82% (against a sickness target of 3.24%). The Operational HR Team continue to undertake a significant amount of work in ensuring that our staff are appropriately supported and that sickness absence is managed in a timely manner.

A considerable proportion of the CD&T workforce is made up of registered professionals (including Scientists, Therapists, Pharmacists, Nurses, Radiologists and Radiographers) and as such, regulatory compliance continues to be both of significant importance and risk to the Clinical Board. This is noted within the relevant Directorates' and Clinical Board's Risk Registers.

The Clinical Board considers staff appraisal to be invaluable and all Directorates are working hard to improve their PADR compliance. The current compliance as at September 2019, is 48.3% for non-medical staff. The roll-out of Values Based Appraisal is on-going and PADRs are planned to improve this figure.

The Statutory and Mandatory training compliance rate at September 2019 is 81.77% against a target of 85%.

The engagement of staff in the development of the Board is inherent to its values, as is working in partnership with Trade Union colleagues. The Clinical Board has an engagement place in place for 2018/19, which was developed in partnership with the Clinical Board's Lead Trade Union Representative. The Board has also undertaken a significant amount of work to improve engagement amongst our Medical Workforce.

The Board's quarterly Newsletter continues to be a huge success and provides great opportunities to showcase the fantastic work and achievements of our staff. In addition to this, our bi monthly 'Lunch with the Board' and a 'day in the life of' scheme (whereby members of the

Board shadow different professionals within their workplace) have been beneficial in getting to know our workforce much better, as well as the challenges they face on a regular basis.

The Clinical Board continues to ensure that the UHB's values and behaviours are evidenced in everything we do – from recruitment, induction and PADR processes, through to Board meetings and team discussions. Through our Reward and Recognition Scheme, the Board has strategies in place to recognise those who 'live out' the values in their everyday working life, as well as robust mechanisms to manage those who fail to adhere to the required standards.

Rhodri John, Operational Service Manager has produced a recognition card in conjunction with the Medical Illustration Team. The purpose of the recognition card is for them to be handed to a member of staff working in the Clinical Board for a job well done and making a difference to someone's day.

With staff leading the way, the CD&T Clinical Board continues to maintain and drive the key quality improvements required to ensure optimum patient experience and staff development.

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **NOTE** the progress made by the Clinical Board to date and its planned actions
- **APPROVE** the approach taken by the Clinical Board

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

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

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

REPORT TITLE:	**HEALTH AND CARE STANDARDS**								
MEETING:	Quality Safety and Experience Committee						**MEETING DATE:**	**17:12:2019**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	**Patient Safety and Quality Assurance Manager**								

PURPOSE OF REPORT:

SITUATION:
The Health and Care Standards set out the Welsh Government's framework of standards to support the NHS organisations in providing effective, timely and quality services across all healthcare settings.

The standards provide a consistent framework that enable health organisations to look across the range of their services in an integrated way, to ensure that the care that they provide is of the highest standard and they are doing the right things, in the right way, in the right place, at the right time with the right staff and to allow service users to understand what they can expect.

REPORT:

BACKGROUND:
The current set of Health and Care Standards came into force on 1 April 2015 and incorporates a revision of the "Doing Well, Doing Better" Standards for Health Services in Wales (2010) and the 'Fundamentals of Care Standards (2003).

Since 2016 there has been a programme of alignment of Health and Care Standards to existing groups and committees within the health board, the aim of this approach was to reduce variation and to support ongoing monitoring and quality improvement. A corporate assessment of each standard that has been aligned to a group or committee is undertaken annually to give assurance about the UHB performance against that standard and to develop a set of actions to address requisite improvements. Currently 17/22 standards have been aligned with a group and where an appropriate group or committee has not been identified the Clinical Boards will undertake a self assessment of their performance against that standard. The identified corporate lead will use the information included in the self assessment to develop an assurance report incorporating the identified board actions.

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

ASSESSMENT:

The Committee received a report on the outcome of the 2018/2019 self-assessment at the June 2019 Committee**.** An additional 6 monthly update on the progress against the requisite actions set out in the self- assessment has now been completed and the results are outlined in Appendix 2.

Overarching themes from progress reported on actions

The majority of health and care standards have reported RAG ratings as green or amber. For those actions reported as red there does not appear to be a common theme emerging. Two standards report a lack of resources as impeding progress ie, Standard 2.5 Nutrition and Hydration report a lack of a funded dietitian impacting upon the service provided in the Emergency Unit, while Standard 3.3 Quality Improvement, Research and Innovation report a lack of resources available to facilitate national clinical audits such as paediatric asthma, paediatric epilepsy and vascular audits.

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

The 2019/2020 approach will remain the same as the previous year and the additional 6 monthly update on the progress against the requisite actions set out in the self- assessment will again be incorporated and presented to the December 2020 QSE Committee.

The overall approach and timescales for 2019/20 assessment:

Timescale		Activity	Lead
Start	End		
06/01/20	24/01/20	Revision of HCS Driver Diagrams	Corporate Leads
27/01/20	24/04/20	Self Assessment of standards 1.1 3.1 3.3 3.5 4.1 4.2 6.3	Clinical Boards Quality and Safety Leads
TBC		Internal Audit Assessment	Internal Audit Manager
27/04/20	07/05/20	Corporate Validation of self assessments and completion of Corporate Assessments	Corporate Leads
	07/05/20	Assessment of compliance against standards 2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 3.2 3.4 5.1 6.1 6.2 7.1	Related Group/committee
11/05/20	15/05/20	Executive member Sign Off	Executive Leads
18/05/20	22/05/20	Independent Member Sign Off	Independent Leads
16/06/20		Paper to QSE	Patient Safety and Quality Assurance Manager
12/2020		Update paper to QSE	

RECOMMENDATION:

The committee are asked to:

Note the progress made against the actions identified in each of the Health and Care Standards

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

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

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

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

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

Appendix 1

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

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

Standard 7.1 Workforce	Executive Director of Workforce and Organisational Development	Assistant Director of Workforce	Strategy and Delivery Committee Chair	Strategy and Delivery Committee

SAFETY NOTICE

Immediate action	
Action	✓
Update	
Information Request	

ATTENTION

All staff in areas that possess a Resuscitation Trolley.

SITUATION

It has become apparent during formal inspections of Clinical Areas that the formal checking of the contents and operational functionality of Resuscitation Trolleys is not being undertaken within the correct timescales as specified within the Cardiff and Vale UHB Resuscitation Procedure.

BACKGROUND

The Resuscitation Procedure stipulates the contents of the UHB Resuscitation Trolleys, and also the checking procedure. This procedure is in line with the Quality Standards for Resuscitation Equipment as defined by the Resuscitation Council (UK) guidelines 2016

The Cardiff and Vale UHB Resuscitation Procedure section 10 states

"10.0 RESUSCITATION EQUIPMENT
All departments within Cardiff and Vale UHB will ensure that they have a Resuscitation Trolley with the appropriate equipment as designated by the Resuscitation Committee.
10.1 Acute Hospital Resuscitation Equipment

- Pocket masks should be easily accessible throughout clinical areas as well as with the resuscitation equipment. These are used to prevent direct person-to-person contact, and may reduce the risk of cross infection between patient and rescuer (*Quality Standards for cardiopulmonary resuscitation practice and training, 2016)*

- Adult and paediatric resuscitation equipment should follow the standardised equipment list, which has been based on current

UK Resuscitation Council guidelines and ratified by the UHB's Resuscitation Committee.

- Trolleys should be located on each ward or appropriate clinical area with additional portable oxygen and suction equipment distributed so that it is rapidly available to all other areas of the hospital.

- Portable oxygen and suction devices should always be available on or adjacent to all resuscitation trolleys. Where piped or wall oxygen and suction are available, these should always be used in preference.

- Each ward or department should have access to a manual or automated external defibrillator, so those patients who require defibrillation do so within three minutes of collapse as recommended by RC (UK).

- All resuscitation equipment on the acute hospital sites, including portable suction devices, wall suction and defibrillators must be checked daily.

- Community hospitals must check their resuscitation equipment and defibrillators on a weekly basis.

- If the Resuscitation trolley is wrapped, then a sticker with the earliest expiry date must be displayed on the trolley. A member of staff must still sign daily to confirm that the expiry dates have not been exceeded and that the cling film is still intact. Monthly, the cling film should be removed, all equipment thoroughly checked and then the trolley should be re-cling filmed with the expiry sticker as before.

ASSESSMENT

There appears to be significant variance in the frequency of checking of Resuscitation Equipment within Cardiff and Vale UHB. This does not comply with the Cardiff and Vale UHB Resuscitation Procedure as explained above. As such, this represents a clear risk to patient safety, as during a Resuscitation attempt, equipment may not have been checked and/or available for use.

RECOMMENDATIONS

1. Clinical Boards and directorates are asked to disseminate this Internal Safety Notice to their clinical staff. Please confirm dissemination to the Patient Safety Team by **16th October 2019**

2. The Patient Safety Team will circulate this notice via the CAV You Heard newsletter process.

3. All staff within areas that possess a Resuscitation Trolley are asked to familiarise themselves with the relevant section(s) of the Resuscitation Procedure.

4. Checking of Resuscitation Equipment should comply with the standards set within the Cardiff and Vale UHB Resuscitation Procedure as detailed within the Background of this Safety Notice.

5. It should be Registered Practitioners who check the Resuscitation Trolleys (GMC, NMC, HCPC, GDC)

6. Staff that check the Resuscitation should be rotated, so that the Resuscitation Equipment is not checked by the same staff each day/month.

7. The checklists attached to this Safety Notice are to be used for recording the checking process.

8. Ward areas may wish to appoint Resuscitation Trolley Champions to ensure compliance with Quality Standards.

9. The Resuscitation Service will audit compliance of Resuscitation Trolley checks during audit processes and report any issues in the most appropriate manner.

10. Staff checking the Resuscitation Trolley should use the checklists attached to this Safety Notice.

11. For further information or advice on Resuscitation Equipment, or the procedures surrounding Resuscitation, please contact the Resuscitation Service

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

Daily Resuscitation Trolley Checklist

Month: Year:

Day	Clingfilm Intact	Defibrillator Operational	Comments	Print Name
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
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31				

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

Monthly Resuscitation Trolley Checklist

Year:

	Contents Checked and Present Y/N	Contents all working? Y/N	Trolley Clingfilmed Y/N	Comments	Print and Sign	Date
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						

Safe practice reminder

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

October 2019

For all areas with a resuscitation trolley

This safe practice reminder has been published as part of Internal Safety Notice 2019/003. Formal inspections of clinical areas have found that checks of resuscitation trolleys are not being carried out correctly.

If the correct equipment is not available during a resuscitation event, patient safety could be compromised.

What do I need to know?

The guideline for checking resuscitation equipment is available on the Resuscitation Services intranet page.

Only registered practitioners should check the resuscitation trolley.

Staff should rotate the responsibility for checking resuscitation equipment so that it is not checked by the same individual each time.

At acute hospital sites, resuscitation equipment must be checked daily.

At community hospital sites, resuscitation equipment must be checked weekly.

For resuscitation trolleys that are clingfilm wrapped, this must be removed and the trolley contents checked monthly.

For further information, please contact the Resuscitation Service

[Appendix 2]

Health and Care Standard Update on actions from Corporate Assessments

Standard	Action	Update	RAG
1.1 Health Promotion Protection and Improvement	1. Adopt a systematic approach to recording of smoking status and referral to smoking cessation services	1. The number of patients (Outpatients, in-patients and EU visits) with smoking status systematically recorded on the electronic patient management system for Qtr 1 2019, 2020 was 1,177 which is similar to the same quarter, last year (1,155 2018-2019). Of these, 37% of smokers were referred to the UHB's hospital based Smoking Cessation Service, which is an increase from 19%, for the same quarter last year (2018-2019). Overall, 23% of all patients booked/admitted were recorded as smokers suggesting a higher smoking prevalence rate than the general population (16%, National Survey for Wales, 2017-2018). Community based smoking cessation services have transferred into the UHB from 1st October 2019 providing an opportunity to provide a fully integrated service with the smoker's needs at the centre of provision, offering hospital and community based support by reviewing the current smoking cessation pathway	**A**
	2. Deliver the UHB commitments in the Active Travel Charter	2.Cycle storage being procured for Woodland House; EV chargers available at Woodland House; Nextbike staff membership agreed (jointly funded with UC12:C15nison) and due to launch autumn 2019; regular comms messages on healthy travel; regular visible senior leadership; increased availability of videoconferencing facilities	**G**

	3. Maintain a focus on improving uptake of staff flu immunisation	3. Staff flu campaign launched 7/10/19. Steady increase in uptake since the launch, currently approximately 33.7% uptake. Some delays in vaccination to some staff groups due to vaccine supply and delivery delays	G
	4. Improve recording of BMI in patients and appropriate onward referral to weight management services	4. Referrals to Dietetic Weight Management Services continue to increase. Recording of BMI improving in some areas. Additional focus required.	A
	5. Increase the numbers of people accepting the invitation for screening	5. Screening uptake kept under regular review with Screening Division; inequalities evident, with lowest uptake in areas of deprivation, particularly for bowel screening; bowel screening adopted as a specific focus and action plan developed to increase uptake and reduce inequalities; action to promote bowel screening also included in partnership plans	G
2.1 Managing Risk and Promoting Health and Safety	1. Implement plans to further reduce both the number of Actual Fires and False alarms by a minimum of 10% during the coming period	1. • Working group with Fire& Rescue service • Agreed 32% reduction in False Alarms over 2018/19 achieved • Reviewed mental health smoking controls and monitoring resulting in significant reduction (9-3) fires	G
	2. Health & Safety & Fire Annual Report on performance and submit for assurance to the H&S Committee	2. • Annual Fire Safety Report submitted and considered at the October H&S committee	G
		3. • Board has approved a revised Risk management Strategy and Risk Register approach • Director of Governance has revised and issued procedure on risk assessment inc inter-relationship with above	G

	3. Review the interrelationship between updated of Board Assurance Framework and Risk Assessment system and progress e Datix for risk assessment data base	• Working and Managing safety course amended to reflect above	
	4. Assess the compliance and status of the key risks of Manual Handling and Personal Safety with an aim implement finding to diminish the risk	4. • H&S Dept undertaken briefing and audit of training status of both Man Hand & Personal safety reporting finding to both Operational H&S Group and H&S Committee • Audit of patient Hoisting equipment completed showing significant improvement in age and condition status • Review of Link worker role initiated to minimise need for classroom based training	G
	5. Progress and deliver Health & Safety Training for managers	5.• Training course developed and delivered on regular basis –take up good current frequency 2 course per month offered and filled • On- going programme to managers training offered	G
2.2 Preventing Pressure Damage	1. Update and review the UHB audit tool documentation	1.Complete - however may need to be looked at again as policy has been updated due to Purpose T	G
	2. Input into the UHB Total Bed Management contract	2. Taken out of scope of group – to be taken forward by Deputy END	R
	3. Developing a standardised approach to formulary ordering and management	3. Progressing	A
	4. Progressing work to meet the Welsh Information Standards for reporting of all stages of pressure damage to WG and the safeguarding process	4. Delayed as does not fit in with new WHC. Clinical areas are reviewing pressure damage incidents using the investigation tool set out in the Welsh Health Circular. An issue is timely completion of the reviews. Where the reviews are completed we are reviewing them to ensure we report on to WG as Serious	A

		Incidents where required. A revised safeguarding flowchart was also circulated in 2019 and we are aiming to ensure that any changes needed on Datix align to the safeguarding flowchart and WHC requirements.	
	5. Implementation of Welsh Health Circular WHC (2018) 051 to ensure the correct reporting processes are in place	5. Rolled out. Timely review of incidents using the pressure damage tool is a challenge.	G
	6. Monitoring of Welsh Health Circular WHC (2018) 051 developing a SoP to ensure and robust governance arrangements are in place	6. Patient Safety Team has made some amendments to the Datix incident reporting module to help us to monitor pressure damage incident forms with greater rigour and in line with the Welsh Health Circular. We have made changes and tested them in order to see if further customisation is needed on Datix. A revised flowchart is in place from Safeguarding regarding management of referrals to them in relation to pressure damage and the Patient Safety Team needs to ensure that Datix changes now align to this where appropriate. A key factor is timely review of reported incidents by clinical areas and timely completion of the pressure damage investigation tool where applicable.	A
	7. Roll out of the 'Guidelines for the Prevention and Treatment of Moisture Associated Skin Damage' (MASD)	7. This has been rolled out across the UHB	G
	8. Roll out the All Wales PURPOSE–T risk assessment across the UHB and all wales	8. Roll out in Dec 2019	G
	9. Developing a process to review the learning from all serious incidents which were reported in 2018	9. Alterations required in Datix for this to progress. The SIs reported in 2018 were all reviewed in order to determine themes from them. This now needs to be developed into an improvement project.	R
	10. Review of our heel off-loading products as no standardisation across Wales	10. Audit results shared and objectives need developing	A

2.3 Falls prevention	1. The Falls pathway has been identified as a priority for the Health Pathways programme of work associated with Canterbury the Cardiff and Vale way.	1.Progressing and being taken forward by the Alliance	**G**
	2. The Falls Delivery Group will form the basis for the development of a falls alliance for Cardiff and The Vale of Glamorgan	2. Complete	**G**
	3. Evaluation of the Pace setter funded model for the Community		**A**
	4. Simulation suite training to spread and embed	4.Training established monitoring of uptake by area	**G**
	5. Follow up audit of call bells	5. To be undertaken early 2020	**A**
	6. Review of the procurement and governance of hover jack equipment and training	6.Adequate hoverjacks procured to support UHL and UHW however further work required to ensure a sustainable solution	**A**
	7. Standardisation of advice around lying and standing BP recording	7. Agreed approach Lanyards available in two clinical boards to provide guidance. Needs rolling out across other Clinical Boards	**A**
	8. Set up of an inpatient falls alliance	8.This will be taken forward by falls delivery group from January 2020	**A**
	9. Ongoing development of Nursing e-documentation related to falls risk on wards (All Wales)	9. This work stream is being led on an All Wales basis. A pilot is scheduled	**G**
	10. Pursue funding for improved pathway from EU to community services for people aged 75+ at risk of falls	10. A transformation bid has been submitted to support this work-stream	**A**
2.4 IPC and Decontamination	1. Support the Clinical Boards to deliver the standard	1. Progressing	
	2. Continue to support the antimicrobial resistance delivery plan	2.The Senior Nurse for IP+C attends the CAVUHB Antimicrobial Group meetings	**G**
		3. The Senior Nurse for IP+C meets with members of the procurement team to identify stock and equipment	**G**

	3. Work closely with C&V and NHSSS procurement departments to standardise products and equipment in use and to eliminate unnecessary costs to the Health Board	that can be standardised for use throughout the Health Board e.g. Fluid repellent surgical masks, however there is room for improvement. Members of the IP+C team also attend many of the All Wales procurement groups overseen by NHSSS Procurement to standardise equipment throughout Wales e.g. Hand Decontamination product group	
	4. To support Clinical Boards to roll out ANTT to all relevant staff, including medical staff, and ensure allocation of time for staff to attend training, time and IT access to undertake the e-learning module, and purchase of appropriate equipment.	4. IP+C have included ANTT in all educational sessions delivered to clinical staff and most front line nurses have undertaken the e-learning and have been assessed as ATTA compliant. However, Clinical Boards have struggled to ensure Medical staff have completed the e-learning and/or get competence assessed. There is no central place to capture the medical staff compliance with ANTT	A
	5. Work with relevant Clinical Boards to develop further robust winter plans to deal with outbreaks of infections e.g. norovirus, influenza, to avoid disruption to patient flow	5.The Senior Nurse for IP+C met with the DON for MCB and Virology to develop a plan for Rapid Testing for Influenza during the winter season and the CNS in IP+C aligned to MCB has been working closely with the CB to ensure robust pans are in place for managing the winter season	G
	6. Continue to work with companies and suppliers to ensure support with audit and education and promotional opportunities e.g. WHO Hand Hygiene Awareness week	6. The IP+C team work closely with our suppliers, they have undertaken audits of practice to identify areas for improvement and they also support the team with delivering education.	G
	7. Continue to develop the IP&C Link Practitioner programme to ensure that engaged and knowledgeable staff are out in clinical areas to support the IP&C agenda	7. Most areas throughout the Health Board have identified Link Practitioners for IP+C. The IP+C team hold 3 full study days a year for the link practitioners and have an average attendance of 50+ staff	G
	8. Continue to support the AMR Patient Safety walkabout programme with the Medical Director	8.Arrangements with new medical director to be agreed for 2020.	A
	9. Support the Clinical Boards with the RCA process to ensure a multidisciplinary approach and to make sure	9. All Clinical Boards are undertaking RCA's for target bacteraemia, supported by the IPCN's when required, as and when requested. The lessons learned are	G

	lessons are learned from incidents/outbreaks of healthcare associated infection	shared and discussed at either the CB IP+C or the Q+S meetings	
	10.Monitor the Clinical Board rolling programme for maintenance or replacement of equipment	10. The team are not aware of CB rolling programmes for equipment replacement therefore cannot monitor. IP+C audits of equipment are still identifying items of equipment not suitable to be in use.	R
	11. Monitor the Clinical Board work with Capital & Estates to develop a rolling programme for ward/department refurbishment and to ensure the IP&C team is involved at the start of Capital projects related to new builds	11. The Senior Nurse for IP+C meets monthly with Capital, Estates and Facilities where new schemes, trials and issues are discussed	G
2.5 Nutrition and Hydration	1. The Nutrition & Hydration Bed plan to be embedded in ward routine and processes as the tool that is used to record patients dietary needs and for the Nursing and Midwifery Board to mandate its use for all wards across the UHB requires further work	1.Audit of bed plan usage and nutritional safety briefing is planned for specific medicine wards by lead nurses and the outcome will inform number 2 and 3 (Deputy Executive Director of Nursing Jason Roberts has undertaken a walk around to understand situation)	A
	2. Ward managers take up the role of supporting the implementation of the bed plan on the ward through raising awareness of the benefits of using the tool and auditing its use on the ward	Dependent on action 1	A
	3. Review the role of the qualified nurse in overseeing the meal service and develop a role profile	Dependent on action 2	A
	4. Ensure new descriptor for dysphagia International Dysphagia Diet Standardisation Initiative (IDDSI) knowledge is embedded across the Health board	4.Health board wide training has been carried out but ongoing training is continuing in specific areas eg mental health AAU	A
		5. Meeting has been undertaken with Cardiff University regards curriculum nutrition content for undergraduate nurses, Newsletter updates have been developed,	A

	5. Development of a suite of models of delivery for nutrition training offer in the light of reduction in nurse induction time	online updates available. Further training to be planned with practice development nurses	
	6. Address concerns highlighted in the CHC visit and HIW report around nutrition and hydration at front door following. No funded dietetic service in the Emergency Unit	6.Immediate concerns addressed but remains no funded dietetic service at front door	R
	7. Subject to business case approval the Implementation of All Wales catering IT system	7. Trial of the system is currently being undertaken on UHL site	A
	8. Roll out of model ward for Nutrition and Hydration to other wards in the UHB subject to a funding stream	8. Executive team currently looking at the outcome measures.	A
	9. Roll out of essential nutrition training for ward based caterers to include allergy and IDDSI.	9.Programme in place	G
2.6 Medicines Management	1. Strengthen medicines-related audits in non-ward areas and address findings	1. Following the release of updated guidance from the Royal Pharmaceutical Society (2019) and an embedded audit programme for medicines storage and practice in ward areas in the UHB, a plan to amend and extend this audit to non-ward areas will be taken forward in 2020. PSN 030 R Medicines Storage – Cupboards a revision of the original PSN030 is expected early in the new year with an associated risk rated audit tool.	A
	2. Medicines storage, security and destruction compliant with UHB Medicines Code (and updated MARRS policy when available	2. The UHB Medicines Code is a live document that sets out medicines procedural guidance in the organisation as recommended by the Nursing and Midwifery Council and the Royal Pharmaceutical Society. It is updated every six months as a minimum. The code is in alignment to current national and local guidance.	G
		3. Some limited work completed with hearing loops installed in all UHB dispensaries and staff trained to use. Further work is required to support visually	A

	3. Specific support to patients/carers in presence of sensory loss	impaired patients with medicines labels. To note we are committed to 100% of the pharmacy staff being Dementia friends and over 85% of staff have had some training	
	4. Work to understand and reduce medicines-related admissions	4. This work is progressing as part of the WHO medicines safety challenge. A research project protocol is under development with the aim of initiating early in 2020	A
2.7 Safeguarding Children and Adults at Risk	1. PCIC CB will introduce Annual Governance review visits during this year to include questions on safeguarding policies and staff training.	1. PCIC found the visits to be unfeasible however they are able to evidence regular safeguarding processes are in place for GPs, Dental and Pharmacy	G
	2. Ensure C&W CB audit of the effectiveness of the Looked After Child service during 2019.	2. The Looked After Children Team are working on this and will be reporting progress to the SSG meeting in March. Objectives have been discussed.	A
	3. Monitor MH commencement of a pilot to support the Public Service call centre in conjunction with ABMU and Cwm Taf Health Boards.	3. Pilot has been extended to end of March 2020	A
	4. Oversee the (DOSH) completion of an audit during 2019 of the use of SERAF.	4. Previous audit in 2018. Another will be completed in the next 6 months	A
	5. Monitor MH improvement in mandatory training compliance	5. Safeguarding training is monitored on a bi-monthly basis through SSG.	G
	6. Undertake a corporate audit to ensure that the needs of children aged 16-17 years admitted to adult wards are met and documented on a risk assessment check list	6. This audit is underway and will be completed by March 2020	G
	7. The UHB will undertake an audit during 2019 to evaluate the support offered to staff involved with a child or adult practice review	7. This audit is underway and will be completed by March 2020	G
	8. Continued compliance with the duty to report and investigate cases of child or adult at risk cases where abuse	8. This is on-going work in safeguarding. With the introduction of the new Wales Safeguarding	G

	or neglect is suspected using the framework within the Social Services and Well-being Act (2014)	Procedures in November additional training for all areas will be required. This will need to be introduced in a new work plan from April 2020	
2.8 Blood Management	1. Competency assessments for pre-transfusion sampling and the administration of blood products to be held within the Electronic Staff Record and discussed as part of annual PADR Monitoring of the compliance position will be a standing agenda item at the Transfusion Group 2. Review of the pre transfusion sampling process 3. The UHB to look towards the implementation of electronic blood tracking and electronic fating of blood products at the patient bedside.	1. The ESR is now able to be populated with the transfusion competency assessments and the transfusion team are in the process of uploading the backlog of data. This is time consuming as there is little info on Staff number in our records. We hope to be in a position to use this information in the new Year 2. The LIPs project has been completed. We are presently setting up a pilot project with the E.U department to trial a new procedure. We have good anecdotal evidence that the number of duplicate samples has significantly reduced following the 'Urgent communication from Executive Team for all staff who undertake pre transfusion sampling' sent out in April 2019. Our LIPs findings have been shared with the Welsh National Oversight Group for transfusion and it is recognised that this is a national issue 3. No progress	**G** **G** **A**
2.9 Medical Devices	1. Revision of UHB Medical Equipment Management Policy in line with the pending revised MHRA guidance 2. Progress delivery of the UHB's Medical Equipment Strategy 3. Implement the welsh Audit Office Improvement Plan	1. Awaiting publication of MHRA revised guidance therefore not able to progress until this happens (publication is anticipated in time to meet planned timescales) 2. Delivery via IMPACT programme underway	**N** **G**

		3. Necessary structural changes implemented to facilitate continuous improvement	G
3.1 Safe and Clinically Effective Care	1. Implementation of the Falls Framework	1. Plans to appoint to a position to oversee the implementation of the falls framework.	A
	2. Implementation of the revised WG guidance for pressure ulcer reporting and investigation	2. Complete	G
	3. Embedding a human factors approach through education and training	3. Incorporated in to LIPS, RCA and Action planning workshops. Funding to be identified for specialist training .	A
	4. Putting in structures to support the medical examiners role	4. Progress around the medical examiners role is progressing in line with the national work-stream.	G
	5. Focus on national safety standards for invasive procedures in particular Central Line, Chest Drain and Nasogastric Tube insertion	5.Some progress towards compliance with safety standards but individual components remain outstanding	A
	6. Introduction of an electronic clinical audit system	6.Consideration is being given to a collaborative approach between health boards in Wales in commissioning a system	A
	7. Continued increase in compliance with patient safety solutions	7.Some progress towards compliance with safety standards but individual components remain outstanding	A
	8. Focus on compliance with level 1 mortality reviews and further review processes	8.Mortality reviews now form part of the Executive performance reviews and compliance is reported as part of the Key Performance indicators	G
3.2 Communicating Effectively	1. An action plan is developed and implemented so that the UHB can continue its work on implementing the Welsh Language Standards	1. The organisation has now received its Welsh Language Standards Compliance Notice. We have begun work on implementing the Standards. About a third of the standards have been started or completed. However, there are some standards that are really challenging for the organisation. With this in mind, Len and Martin are meeting with the Welsh Language Commissioner in early December to have discussions	G

	2. Developments are progressed within our IT systems to record communication preferences and flagging as a priority. 3. The UHB develops its next four year Strategic Equality Plan ready for implementation from April 2020	about our progress and how we can find re/solution to the challenges that we face. 2. Our PMS systems and PARIS have the ability to do this in terms of the Welsh Language and as required by the Welsh Language Standards. The RADIS system is proving a more difficult proposition as it a more Wales wide system. Discussions with others, i.e. NWIS, is taking place as to how we can make this happen. 3. Consultation on this has begun with staff and the public. We are also working in collaboration with Velindre and other national bodies to a wider perspective. The development on the plan is on time. Our new Strategic Equality Plan- Caring About Inclusion 2020-24 will be ready for its April 1st deadline	G G
3.3 Quality Improvement Research and Innovation	1. Implementation of the All Wales R&D Finance Policy	1. UHB agreement to implement All Wales Finance Policy given in March 2019. Research Delivery Management Board (RDMB) first meeting on 1/5/19. RDMB has met monthly to agree on internal allocation of R&D budget from Welsh Government. R&D Cost centres set up at Clinical Board and Directorate level at month 6. Work is ongoing to allocate a small proportion of yet unallocated budget. Further work is planned for 2020/21 to ensure Commercial Trial income and grant income is also managed transparently through established cost	A

	2. Progress with the vision of a Joint R&D Office with Cardiff University 3. Continue to develop capacity and capability in R&D, Audit and improvement skills	centres to ensure reinvestment in R&D. Processes to ensure adequate oversight of new cost centres is ongoing	
	4. To develop a clinical audit plan aligned to clinical Board quality and safety priorities 5. To identify the resources required to facilitate the National Paediatric Asthma audit, the National Paediatric Epilepsy audit and to support the National Vascular audit 6. To further develop governance arrangement for reporting Clinical Board level clinical audits. 7. To increase PPI where applicable	2. Implementation Board meetings have continued through 2019. 'Transforming Services' work-stream in Cardiff University has caused some unavoidable delays with progressing at a faster pace. Regular meetings to work on a Framework agreement continue. A suitable location for the Joint Office has been identified on the UHW site and plans for refurbishment have been discussed. 3. Capacity in terms of open trials and patients recruited is on target (no official figures yet available). Issues remain with both Pharmacy and Radiology support in terms of capacity. 14 new R&D posts agreed at Research Delivery Management Board which has the potential to markedly increase capacity. Capability agenda is being driven forward by a comprehensive training and education agenda led by the Senior Nurse, Research Education and Training.	**A** **A**

		4. A clinical audit report was taken to QSE that identified all Tier 1 and 2 clinical audits planned for 2019/20	G
		5. The Clinical Board has been tasked with identifying the required resource to facilitate these audits	R
		6. A Governance framework is being developed as part of the QSI framework and will incorporate this detail	A
			G
3.4 Information Governance and Communications Technology	1. To ensure that the key GDPR requirements are known, understood and followed by all UHB staff.	1. All CBs engaged, e-learning module developed and made available.	C
	2. Ensure that CBs can ensure continuity of core business delivery in the event of temporary IT system failure	2. Business continuity (BC) plans in place	G
	3. All clinical board BC plans are monitored via the Chief Operating Officer as part of their quarterly performance plans	3. In place is a quarterly business continuity review with each of the Clinical Boards chaired by the COO.	G
	4. Continued investment in line with agreed plans will be required to ensure resilience of IT systems and to counter Cyber security threats.	4. Reported to DHI committee and aligned to digital fund allocations	G
	5. Implementation of the IMTP workplan including national and local IM&T Projects continues in line with plan and resources assured via IT & Governance sub-committee (ITGSC).	5. Priorities for local and national plans agreed - digital funding agreed	G

	6. Co-ordination of IT assurance process is through continuous review via the ITGSC.	6.Assurance via quarterly reporting to the Digital/HI committee of the UHB Board	**G**
3.5 Record Keeping	1. Record keeping audits and more regular reviews need to be further developed and applied consistently throughout the organisation	1. See point 2.	**A**
	2. The outputs of these need to be better aligned with corporate assurance mechanisms	2. Mechanism for governance is delayed. Medical Records and Non-Medical Records Management Groups dissolved, with the Information Governance Executive Team (IGET) established as the route to providing assurance to DHIC. Changes related to incoming and departing senior UHB personnel have impacted on the regularity and defined scope / work plans of IGET, and as such, related groups e.g. the Data Quality Group and Medical Records Operational Group	**A**
	3. Key assurance indicators need to be developed to support the above audits and reviews	3. See point 2.	**A**
	4. Continued and enhanced promotion of good record keeping practice, particularly through targeted staff training	4. Digital progress and work streams, such as the E-Nursing Record and local 'Case Note Tracking App' are aiding the prominence of good record keeping requirements and positively improving practice	**G**
	5. Improved attendance and participation at relevant assurance groups; both at Clinical Board and Corporate levels	5. See point 2.	**G**
	6. To gather specific evidence and assurance is required of good record management arrangements for non-medical records	6. See point 2.	**G**
4.1 Dignified Care	1. Continence- review of provision of continence products and training	1. Revised training package is complete and a review of continence products is complete. Wrap around pads can now only be ordered for specific patients that meet defined clinical criteria. Procurement process has been	**G**

	2. Trans awareness training 3. Evaluation of mouth care provision 4. Wider adoption of Red to Green days 5. Continue to build on work undertaken to improve environment of care for patients with cognitive impairments	reviewed- the variations in the ordering system have been revised. 2.Training has been undertaken relating to transgender awareness and vocabulary 3. Questions relating to mouth care provision have been incorporate into internal inspection process, to establish the extent to which mouth care assessments are being undertaken. Currently 40> wards reviewed. 4 .Roll out completed in Medicine clinical board. Roll out now extended to surgery clinical board 5. Local examples of charity bids, estates requests, and refurbishments are evident in the improvement of ward environments.	 G A G A
4.2 Patient Information	1. All CBs to ensure that at least 75% of their medical staff have undertaken MCA training. 2. All CBs to undertake an audit of mental capacity assessments and report their findings at a CB quality and safety/audit meeting. 3. PKB is being rolled out across other specialities and pathways. 4. To further develop the learning disability questionnaires and to share more widely the services changes that has resulted from this feedback.	UHB level 2 MCA compliance for medical and dental workforce is 19.95%. This ranges from 12.99% in Specialist Clinical Board to 30.18% in Children and Women's. In progress 3. There is a roll out plan agreed	R A G

	5. Ensure compliance with the Welsh Language Standard. 6. To develop the information centres and use more interactively the screens installed in the centres to share information in a variety of formats eg visual. Audio, BSL and other languages.	4. We have ongoing LD surveys sent out to patients and carers on a monthly basis 5. As per standard 3.4 -The organisation has now received its Welsh Language Standards Compliance Notice. We have begun work on implementing the Standards. About a third of the standards have been started or completed. However, there are some standards that are really challenging for the organisation. With this in mind, Len and Martin are meeting with the Welsh Language Commissioner in early December to have discussions about our progress and how we can find re/solution to the challenges that we face. 6. We have developed a BSL video with our deaf community on how to raise a concern-we are in discussion with the deaf community regarding further BSL leaflet translations.	G G G
5.1 Timely Access	1. Complete roll out of new primary care models to increase capacity and improve access to in hours primary care services	1. On schedule to roll out the MSK and Mental Health cluster based services by the end of the financial year as planned 2. Good progress made to date: UHB shadow reporting from June. Improvement seen in performance - from 75% in June to 81% in September. Work continues on development of Tentacle to meet immediate requirements and PMS functionality to	G G

	2. Implementation of single cancer pathway	replace Tentacle and integrate with other systems. With support of WG funding, recruitment being progressed to support increased capacity in radiology and endoscopy Local improvement projects in urology and GI. Further work to be done re. national optimal pathways	
	3. Elimination of patients waiting over 36 weeks for elective treatment and over 8 weeks for a diagnostic	3. RTT - As at the end of September, the UHB reported 683>36 week breaches. This position represents 261 fewer patients than last September but 133 above IMTP trajectory Diagnostics - As at the end of September, the UHB reported 51 > 8 weeks; a 95% reduction on the previous September Some specialty specific challenges but the main risk remains the adverse impact on capacity as a result of staff not willing to undertake additional sessions due to NHS pension taxation charges related to exceeding the 'annual allowance' for pension growth – a UK wide issue. The UHB continues to identify and implement actions e.g external capacity to mitigate this risk	**A**
	4. Improved access for specialist child and adolescent mental health services following repatriation of the service to the organisation	4. Specialist CAMHS repatriated from CTMUHB in early 2019 and is now a mainstream service in C&VUHB. Work is ongoing to integrate the service with the primary CAMHS service and increase capacity to reduce waiting times.	**A**
		5. Good progress made in reducing length of stay - in particular for those patients with longer lengths of stay (>14 days) - through the roll out of Red 2 Green and the development of new services such as Get Me	**A**

	5. Continued improvement in the performance of emergency services 6. Roll out of health pathways to continue to improve the interface between primary and secondary care and reduce waste, harm and variation.	Home+. Demand for unscheduled care has increased significantly again this year (4% increase in EU attendances, 5% increase in admissions) eroding some of these gains and contributing to increased pressure in the system. 6. 63 pathways now in place within Health Pathways.	G
6.1 Planning Care to Promote Independence	1. Move from a position of service improvement to service transformation in promoting independence, focusing on Primary Care and Community. 2. Monitor the use of Advocacy services within the hospital setting	1. Work is ongoing to offer every patient who requires support at home is provided the opportunity to experience a period of rehabilitation and assessment at home or care home prior to long term care decisions being made. CRT trial team established and working from S&E offices. The team are testing out an asset / strengths based approach to supporting people in the community, but focussing on 'what matters' to the person, 2. Through working in partnership with Cardiff and the Vale of Glamorgan local authorities, the UHB has extended the access for hospital inpatients to a wider range of Advocacy services through the Cardiff and Vale Advocacy Gateway. The Gateway supports access to Independent Professional Advocacy and compliments the long established routes for IMCA and IMHA to ensure that all eligible people have access to an advocate.	A G

	3. Develop further opportunities for alliance work with all sectors to create patient focussed Pathways	3. CRT to test out MDT Triage approach from Hospital discharges. Go live date planned for 11th of November. The aim of the pilot is to simplify the process for hospital wards wishing to expedite a safe discharge. The MDT team will comprise, FPOC workers with links to third sector, social worker, clinicians and Homecare Managers. The aim will be to identify how best to support the person to return home from hospital safely, and to maximise their independence.	G
	4. Monitor and review of Model ward		G
	5. Evaluate the opportunities within the new St David's model aimed at prevention of deconditioning and encourage active reablement		A
	6. Evaluate and monitor the services provided by Third Sector colleagues within the hospital environment	6. A range of activities are now available within St David's hospital environment. Funding has been approved to develop a Cognitive Impairment therapeutic suite within UHW ,which will offer a range of activities from third sector providers, project delayed due to lack of confirmation of WG funding	A
	7. Monitor and improve attendance at discharge planning training	7.Training programme developed , attendance improved at Get Me Home workshop ward based training available which enables easier access for staff	G
	8. Continue the deconditioning campaign and promote independence via comprehensive training programme	8. Get me home workshops actively promotes independence and emphasises the deconditioning agenda. Medicine Clinical Board has involved Prof Dolan in training seminars which have been made available to all staff	G
		9. Patients and Families are involved in DPM .The FPOC officers work closely with families and carers to ensure that they are provided with an opportunity to a participate in the What Matters conversation prior to	A

		any discharge arrangements. The recent National Dementia audit indicated an improvement in discharge planning arrangements from previous years	
	9. Explore further opportunities to involve patients with planning care and discharge planning		
	10. Continue to promote and roll out the 'Get Me Home' campaign strengthening linkage between HCS 6.1 Promoting independence and 2.1 Falls Prevention	10. See item 3 above. The pilot will focus on the GMH+ wards in the first instance with a view to a rapid roll out across all wards.	G
	11. Further roll out of John's campaign to more clinical areas within the health board.	11. Due to staff resourcing the roll out of John's campaign was placed on hold, however there is now a member of staff leading on the roll out who has begun to contact wards managers, concentrating in UHL, to arrange meetings to discuss taking the campaign forward. In addition Carers Trust Wales is approaching the wards undertaking the John's Campaign to be involved the Carer Friendly Award.	G
6.2 Peoples' rights	1. An increase to at least 85% in equality training compliance figures.	1.We have increased this percentage from 76% to 80%	G
	2. To undertake internal and external consultation on the next Strategic Equality Plan	2. Consultation on this has begun with staff and the public. We are also working in collaboration with Velindre and other national bodies to a wider perspective. The development on the plan is on time. Our new Strategic Equality Plan- Caring About Inclusion 2020-24 will be ready for its April 1st deadline	G

	3. More identifiable work in relation to the Rights of Older People and the UN principles	3. As part of our consultation work on the Strategic Equality Plan we are looking to develop actions on this particular protected characteristic	G
6.3 Listening and Learning from Feedback	1. Further development of patient feedback in our Children's Centres	1.Patient feedback machines insitu and volunteer roles developed to support feedback	G
	2. Reinstate the Dental Public and Patient involvement group	2. TOR and membership of such a group drafted and to be taken forward through Q and S meeting	A
	3. Broaden Feedback to the ward areas in Medicine and individuals so that key messages and experiences are shared; Development of Sister/Charge feedback session from Serious incidents and RCA so that they in turn can share this with their ward staff	3. Ward based reports shared but further work on developing a triangulated report is underway	A
	4. Development of an over-arching action plan in Mental Health following untoward events will assist in the implementation of action plans and the development of theme specific training		G
	5. Continue to develop the planning in PCIC to secure patient and service user feedback and engagement against the PPE framework	5.Primary care activity is underway and planned throughout the year	G
	6. Ensure compliance in Specialist with regard to response times for informal and formal concerns as per KPI's	6.Response times improved and sustained	G
	7. Explore options for Surgery to action feedback from PKB (patient Knows Best)	7. PKB is being rolled out and further engagement is required regarding use of feedback	A
	8. Train over of 500 staff across the UHB in basic BSL training	8. 500 plus staff trained	G
	9. June 2019 sign the BSL charter	9. BSL charter signed in June 2019	G

	10. Further public meetings with seldom heard groups to listen and engage with communities to focus upon improving their experiences and access to our services.	10. Further meetings planned -awaiting confirmation of dates	A
7.1 Workforce	1. Leadership Capability through engagement and development for the leaders of the UHB which commenced in March 2019 and will continue throughout 2019/20	1. Leadership Capability through engagement and development for the leaders of the UHB which commenced in March 2019 and will continue throughout 2019/20	G
	2. By September 2019 we will streamline our Employment Policies, and we will continue to monitor their effectiveness in partnership	2. By September 2019 we will streamline our Employment Policies, and we will continue to monitor their effectiveness in partnership	C
	3. By March 2020 9 clinical boards / service boards will have robust workforce plans which will be aligned to SOFW and the IMTP	3. By March 2020 9 clinical boards / service boards will have robust workforce plans which will be aligned to SOFW and the IMTP	G
	4. By March 2020 we will recruit to 95% of the nursing establishment in line with Project 95%	4. By March 2020 we will recruit to 95% of the nursing establishment in line with Project 95%	G
	5. Continuation of developing the diversity of our workforce through entry level apprenticeships and widening access for example working with Elite and Wallach organisations	5. Continuation of developing the diversity of our workforce through entry level apprenticeships and widening access for example working with Elite and Wallach organisations	A

REPORT TITLE:	**Point of Care Testing**								
MEETING:	**Quality, Safety and Experience Committee**						**MEETING DATE:**	**17/12/19**	
STATUS:	**For Discussion**	✓	**For Assurance**		**For Approval**		**For Information**		
LEAD EXECUTIVE:	**Dr Stuart Walker- Medical Director**								
REPORT AUTHOR (TITLE):	**Seetal Sall** **POCT Service Manager**								
PURPOSE OF REPORT:									

SITUATION:

The Point of Care Testing (PoCT) Department is under pressure and struggling to provide a robust service for its users. The areas of major concern are categorised as follows:-

1. Unclear governance/ reporting arrangements:

Appendix 1 details the perception of the PoCT organisational structure and reporting arrangements, as held by the PoCT team. Whilst most agree PoCT should be managed within the Clinical Diagnostics and Therapeutics Clinical Board there is not agreement that the operational structure as described has ever actually been in existance. The CD+T CB Leadership team do not hold that view for example.
In addition, the reporting arrangements/ escalation route via the POCT Group are currently also unclear within the organisation. Furthermore, there has been poor engagement/ representation from Clinical Boards at the PoCT Group meetings.

2. No succession plan for Head of Service:

Currently, there is no Head of Service/ PoCT Clinical Lead, as the prior incumbent has 'retired and returned' to a new role in WEQAS, and a succession plan has not yet been implemented.

3. No secure funding for PoCT Service to join Clinical Board:

There are no secure funding arrangements in place for the PoCT Dept to become part of the C,D+T CB. A business case was submitted in the CD&T 2018 IMTP. However, that PoCT case was then not approved by the BCAG process.

4. Accommodation

The PoCT Dept. is located within Unit 6, Parc Ty Glas Llanishen, a unit which is primarily occupied by Weqas, an International EQA organisation hosted by Cardiff and Vale. Rent, rates, furniture and fixings and all services for this building are financed by Weqas. Weqas is expanding its services and requires the office and laboratory space currently in use by POCT to be released back to them. Furthermore, PCIC Clinical Board have submitted a business case for their '*Pacesetter*' Programmes. The programme proposals advocate possible investment of additional resource for the PoCT Dept. to help oversee implementation of PoCT Services across the Community/ Primary Care Clusters. If successful, additional staff will need to be recruited and accommodated within the PoCT Dept.

REPORT:

BACKGROUND:

Point-of-Care Testing (PoCT) is defined as “any pathology test performed for a patient by a healthcare professional outside the traditional centralised laboratory”. Users of PoCT within Cardiff and Vale Health Board (UHB) include:- medical practitioners, nurses, midwives, healthcare assistants, pharmacists, podiatrists, medical students and other Healthcare professionals. These tests may be carried out in a wide range of non-laboratory sites, including: A&E, ITU, SCBU, general ward areas, theatres, clinics, outpatient departments, general practice, pharmacy, community dental services, community nursing services, family planning clinics, Out-of Hours services and any other third party services commissioned by the UHB.

As the focus shifts to managing patients in a primary care/ community-based setting, PoCT will inevitably become more integral to both the needs of patients and clinicians, thus helping to facilitate the reduction in acute admissions. It is important, therefore, to ensure that the right equipment is used in the right clinical setting, it is managed appropriately and the effectiveness of PoCT in the clinical pathway is reviewed. The governance and management of POCT within the UHB is described in the PoCT Policy and PoCT Procedural documents.

The PoCT Department is responsible for agreeing a specification for proposed acquisition of PoCT devices and their integration into patient care pathways, as part of clinical effectiveness. Its remit is extensive and covers procurement advice, equipment evaluation, training and competency assessment, device connectivity, quality assurance, performance surveillance, audit, governance surveillance and incident reporting within the UHB. Accuracy and imprecision of results, robustness of device and traceability of results all need to be evaluated before acquisition; the POCT Department will advise on the suitability of devices. The POCT Department works with the respective Departments in this process. The repertoire of devices managed by the PoCT Department includes, glucose, ketones, urinalysis, pregnancy testing, anticoagulation, thromboelastography, thromoelastometry, haemoglobin, HbA1c, fetal fibronectin, blood gases and co-oximetery devices.

ASSESSMENT:

The effect of not supporting the PoCT Dept. will ultimately result in a decline in the quality and safety of PoCT used across the UHB and the risks identified in the Failure Mode Effect Analysis matrix. The investment required to maintain the PoCT Department is small compared with the risks to the UHB of not providing this service. The benefits of providing a robust PoCT Department are clear and will ultimately enable efficiencies of resources and effectiveness of service delivery.

Potential Failure Mode	Potential Effect	Frequency of failure mode	Likelihood of effect	Risk Probability
Failure to maintain quality assurance, performance surveillance and governance aspects of the service	Oversight of the UHB Policy on PoCT management will become unsustainable. Uncontrolled and unsafe testing.	4	5	20
Failure to support audit and risk assessment.	Increased clinical incidents.	5	5	25
Failure to provide training and competency assessment of operators on PoCT equipment.	Quality and safety of patient testing not safeguarded.	5	5	25
Non-compliance with National Policies covering PoCT regulation. UHB PoCT Policy/ Health	Increased litigation	4	5	20

Standard.				
Lack of co-ordination for procurement of PoCT equipment,	No-harmonisation of equipment and consumables leading to increased errors. Inappropriate equipment purchased, unsuitable for purpose and waste of resources. Inefficiency.	4	5	20
No evaluation of devices	Inappropriate methods/ devices used. Inefficient. Poor quality. Unsafe. Ineffective.	4	5	20

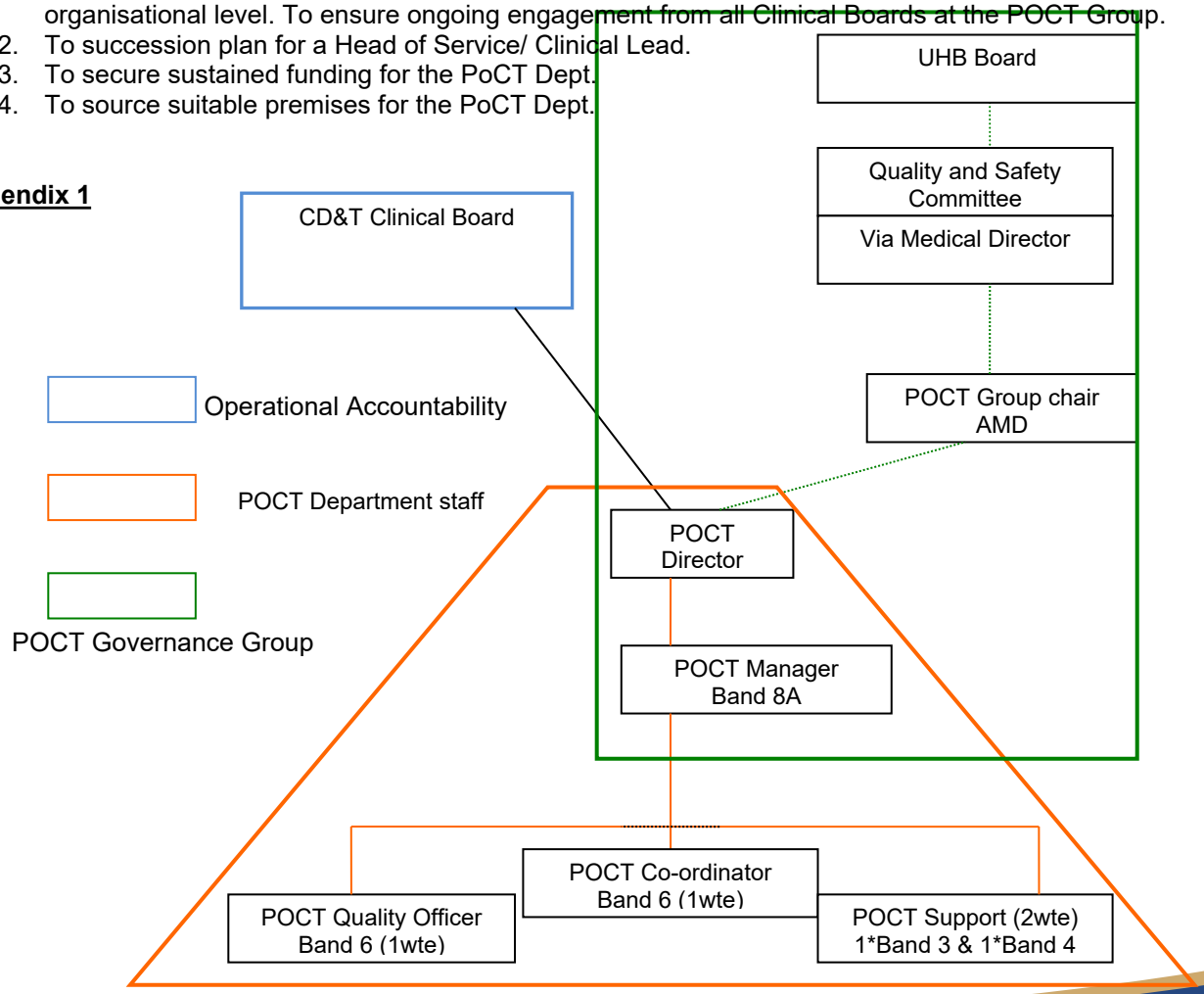
The PoCT Dept. have recently been approached to collaborate with UKRI/ Life Sciences Hub in new R&D evaluations/ proposals. If the Department is unsupported it will be unable to deliver on key Health Board and National strategies. Furthermore, PoCT is rapidly expanding due to increasing demand and is a crucial requirement for the future of Community-based diagnostics.

RECOMMENDATION:

This SBAR was presented to a Task and Finish group consisting of Medical, Nursing and Executive Leads for initial discussion on 31/10/19. It was agreed that the group escalate the matters described in the SBAR to the QSE for further discussion and that the PoCT Dept. should be incorporated within CD&T Clinical Board, with appropriate resource support. Thus, the following matters require further discussion and resolution:-

1. To clarify the governance reporting arrangements/ escalation route for the PoCT Group on an organisational level. To ensure ongoing engagement from all Clinical Boards at the POCT Group.
2. To succession plan for a Head of Service/ Clinical Lead.
3. To secure sustained funding for the PoCT Dept.
4. To source suitable premises for the PoCT Dept.

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.

REPORT TITLE:	**CLINICAL AUDIT PLAN UPDATE 2018 / 2019**							
MEETING:	Quality Safety and Experience Committee					**MEETING DATE:**	**17.12.19**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**	
LEAD EXECUTIVE:	Executive Medical Director							
REPORT AUTHOR (TITLE):	**Head of Patient Safety and Quality Assurance**							

PURPOSE OF REPORT:

SITUATION:

The purpose of this paper is to present an update of the UHB 2019 / 2020 Clinical Audit Plan and additional clinical audit activity.

REPORT:

BACKGROUND:

A targeted programme of clinical audit measuring the standards of care delivery against evidence based guidelines is a valuable tool in providing assurance and also in informing quality improvement projects.

The NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) is developed annually by Welsh Government and confirms the list of National Audits and Outcome Reviews which all health boards and trusts are expected to participate in. In addition there are a significant number of national clinical audits administered by national professional bodies eg Royal College of Physicians, that are not included within the NCAORP but that provide valuable assurance around the quality of care provision.

The National Clinical Audits are an integral part of the quality improvement process and are embedded within the Welsh Health and Care Standards. The requirement to participate and learn from the audits is a central component of the Delivery Plans developed for NHS Wales.

The results of audits should be used as part of the Clinical Board assurance arrangements, informing on the effectiveness of care delivery. Full assurance can only be obtained if the requisite improvements are implemented and performance is re audited post improvements. The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in accordance with contemporary standards of practice a requirement for all relevant staff.

Local clinical audit functions best as part of a planned programme of quality improvement activity. The development of a clinical audit plan should be informed by local quality and safety priorities and should meet the priorities of each Clinical Board. Clinical Boards should have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. When deciding on clinical audit activity consideration should be given to recent:

- Serious Incident / Never Events
- Patient Safety themes
- Patient outcomes

- Release of new or revised best practice guidance.

ASSESSMENT :

In May 2019 the 2019 / 2020 clinical audit plan was presented to the committee. The plan comprised Tier 1 and Tier 2 audits planned by directorates.

- **Tier 1** National clinical audit.
- **Tier 2** Local clinical audit undertaken to address the patient safety and quality agenda,
- **Tier 3** Local clinical undertaken for any other reason including revalidation and CPD purposes.

The audits incorporated within the clinical audit plan were identified as being a priority to inform the Directorates and Clinical Boards through the systematic review of their services against explicit criteria. It is therefore implicit that progress with these audits are monitored and all clinical audit outcomes are presented at the Directorate Quality Safety and Experience Committees or similar forums where the results can be considered and where the appropriate support can be provided to implement improvements. Where necessary clinical audit results should be escalated to mitigate any risk associated with the findings. Appendix 1 details the progress made against the 2019 / 20 clinical audit plan and where the audits have been completed a brief outline of the results.

In addition there is significant Tier 3 clinical audit activity throughout the Health Board. All Tier 1, 2 and 3 audits are registered with the Clinical Audit Department to quality assure the projects and to ensure that Information governance requirements are adhered to.

RECOMMENDATION:
The Committee are asked to **note** the progress being made against the 2019 / 20 Clinical Audit Plan and the overall clinical audit activity for 2018/19.

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

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

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

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

Appendix 1 - Cardiff and Vale University Health Board - Local Clinical Audit Plan 2019 / 2020

Clinical Board	Directorate	Tier	Audit Title	Progress	results and recommendations
PCIC	primary Care	Tier 1 National Audit	National COPD Audit	Continuous	The national COPD audit results support data sharing across primary, community and secondary care teams, notably in the provision of diagnostic spirometry in order to improve outcomes for patients.
PCIC	primary Care	Tier 1 National Audit	Acute Kidney Injury	Ongoing	GPs should review the procedures in place to identify patients with CKD stages 3-5 to improve regular review. Further research is required to understand the link between primary care CKD coding, hospital admissions and mortality rates.
PCIC	primary Care	Tier 1 National Audit	National Audit of Diabetes	Ongoing	Develop and implement systems for GP practices that clarify who has attended patient education courses. Reduce variation in perfromance between practices and clusters. Seek new approaches to improving management for the group with the worst results, i.e. people of working age and younger
PCIC	community pharmacy	Tier 2 Quality and Safety priority	Short Beta Antagonists in asthma patients	Complete	Over ordering was noted in 942 /1696 patient records audited. 86% of pharmacists actively target respiratory patients for MURs; 96% check inhaler technique as part of that review while 47% use an in-check device to do so
PCIC	primary Care	Tier 2 Quality and Safety priority	ANTT	Complete	Compliance with ANTT e-learning varies between 50% and 100% across Cardiff and the Vale (including nursing homes), with specialist team compliance generally 100%. Compliance with face-to-face training generally comparable or higher.Compliance re DOPS assessment varies between 62% and 100%.
PCIC	Primary Care	Tier 1 National Audit	NATROX	Ongoing	anticipated completion date March 2020
PCIC	NW Locality and CRT	Tier 2 Quality and Safety priority	Falls	Completed	results to be reported to PCIC QSE January 2020
PCIC	Localities		National Audit if Intermediate Care		Cardiff CRT sees a much higher rate of referrals than the Vale CRS (VCRS). Referral time between the two are comparible but significantly longer that the national average. The majority of care goals set on admission to the service were met. There is a large discrepancy in the average contact hours between Cardiff CRT and VCRS,
PCIC	Department of Sexual Health		Audit of management of Chlamydia in Cardiff department of Sexual Health	Complete	The provision of patient information leaflets was identified as an area for improvement
PCIC	Department of Sexual Health	Tier 1 National Audit	National Audit of HIV and Malignancy Services in Centres within South East Wales	Complete	A range of malignancies are being diagnosed in HIV positive patients, not just AIDS defining malignancies. At least 88% of patients were discussed between HIV and oncology services, and the communication was largely about treatment, both about antiretrovirals and chemotherapy. 92% of patients were on antiretrovirals before beginning cancer treatment which adheres to the BHIVA guidelines

PCIC	Palliative Care Services	Tier 1 National Audit	National Audit of Care at the End of Life		Almost half of patients were identified as dying in the last 36 hours of life. Improved documentation around discussions with the dying patient, and families could be improved. Review capability and capacity within primary care, community services and social care, to provide appropriate care at the end of life, and to support families through to bereavement, with the aim of better meeting people's needs and preferences. Review should lead to service re-design where potential improvements are identified
PCIC	Palliative Care Services	Tier 2 Quality and Safety priority	Palliative Care Referral response Times	Complete	Extension of the services from 5 to 7 days has facilitated specialist support to those most in need of it seven days a week.Unification of 3 service providers has offered a level of flexibility and complexity to service delivery. Analysis of the service activity data clearly suggests whole service growth, although activity does not automatically translate into increased efficiency and effectiveness. Develop and widely disseminate a clearly defined core offer, which describes the aims and objective of the service, who can benefit from it and how to access it, giving consideration to equity of access
PCIC	Palliaive Care Services	Tier 2 Quality and Safety priority	Anticipatory Prescribing in Palliative Care:	Complete	73% of those who were discharged from hospital were discharged with anticipatory medications. Of the patients who were not discharged with anticipatory medication, 22% were prescribed them at a later date in the community. Only a very small percentage were not prescribed any anticipatory medication at all (6.5%).
W&C	Acute Child Health	Tier 1 National Audit	National Paediatric Diabetes Audit	Ongoing	The UHB are exceeding UK perfromance around young people with diabetes receiving all 7 care processes. The adjusted figure for children with HbA1c >80 mmol/litre was similar to national perfromance. Only 5.8% of children have continuous glucose monitoring less than 50% of the rate across Wales. Key improvements include the development of a nurse led clinic and the development of a new transition pathway.
W&C	Acute Child Health	Tier 1 National Audit	National Neonatal Audit	Continuous	administration of steroids to mothers delivering between 24 and 34 weeks gestation exceeds national rate. Administration of magnesium sulphate and recording of temperature on admission are all within national perameters. There was excellent recording of consultations with parents and senior members of the neonatal team but lower levels of parents present on ward rounds. 56% of babies born at 33 weeks receiving some of mothers milk at discharge from the neonatal unit.
W&C	Acute Child Health	Tier 1 National Audit	MBRACE- UK perinatal mortality reporting (and contributing to Each Babay Counts)	Continuous	Perinatal Mortality for 2017 is over 5% higher than the national average. Higher levels of deprivation is noted in women giving birth in the health board. Gap and Grow guidelines and safer pregnancy guidelines implemented. 2018 stillbirth rates will be reported in 12 months and will have dropped significnant drop.
W&C	Acute Child Health	Tier 1 National Audit	Vermont-Oxford Network-benchmarking	Continuous	Higher rate of late onset sepsis noted in particular central line associated blood stream infections. Introductions of blood culture taking, long line bundle and closed loop arterial line access bundle.
W&C	Acute Child Health	Tier 2 Quality and Safety priority	All Wales neonatal network: Neonatal Sepsis Risk calculator (SRC)	complete	Implementation of the sepsis risk calculator which has led to a 40-50% reduction in antibiotic prescribing in well babies with no increase in readmission rates or early onset sepsis cases
W&C	Acute Child Health	Tier 2 Quality and Safety priority	Annual service evaluation against All wales Neonatal Standards reporting to neonatal network		awaiting update
W&C	Acute Child Health	Tier 2 Quality and Safety priority	Review of Necritising Enterocolitis cases	Ongoing	This audit remains in progress
W&C	Acute Child Health	Tier 2 Quality and Safety priority	Review of term admissions	Complete	annual average unplanned term admission to the neonatal unit of 3.6% comapred to the UK target of 5%. Admission rates have dropped over the past 2 years.

W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Knowledge and understanding of Diathermy safety		awaiting update
W&C	Obstetrics and Gynaecology	Tier 1 National Audit	BSGE national audit of complex endometriosis surgery outcomes and complications		awaiting update
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Quality of image optimisation in gynaecology outpatients department		awaiting update
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Use of TVT		awaiting update
W&C	Obstetrics and Gynaecology	*Tier 2 Quality and Safety priority*	Quality of image optimisation in gynaecology outpatients department after teaching intervention		awaiting update
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Hysterectomy methods and complications		awaiting update
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Antibiotic use in gynaecology		awaiting update
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Consenting for fetal tissue		awaiting update
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	evaluation of minitouch		awaiting update
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	evaluation of Resectr		awaiting update
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Evaluation of Transrectal ultrasound in outpatients		awaiting update
W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	management of Hyperemesis	ongoing	This audit remains in progress

W&C	Obstetrics and Gynaecology	Tier 2 Quality and Safety priority	Antenatal routine enquiry audit		This audit was presented in June 2019. The results for the year 2018/2019 have shown an improvement compared to 2017/2018. The Routine enquiry (RE) should be asked on 2 separate occasions. The results for 2018/2019 are given with the previous year in brackets. The RE was asked once in 99% of cases (90% in 2017/2018). The RE was asked twice in 95% of cases (67% in 2017/2018). the number of recorded disclosures of Domestic abuse in 2018/2019 was 249 cases out of 5406 biths compared to 88 disclosures the year before
Surgery	Dental	Tier 2 Quality and Safety priority	An audit of compliance by UDH OMFS department to new MRONJ protocol guidelines (SDCEP) prior to extractions.	abandoned	This audit was abandoned
Surgery	Dental	Tier 2 Quality and Safety priority	Re-audit WHO checklist in oral and maxillofacial surgery	Complete	WHO checklist was completed corrently in 89% cases. Students and Consultants were most likley to complete the forms correctly.
Surgery	General Surgery	Tier 1 National Audit	National Lung Cancer Audit	Continuous	performance around lung cancer is in keeping with national performance. Systemic anti cancer treatment rates in non small cell lung cancer are 51.5% (audit standard 65%). Weekly reviews of oncology treatment delivery clinic capacity with a system to idenitfy delays
Surgery	General Surgery	Tier 1 National Audit	National oesophago Gastric Cancer Audit	Continuous	National report pending
Surgery	general Surgery	Tier 1 National Audit	National Audit of Breast Cancer in Older People	Continuous	UHB perfromance around breast cancer in older adults meets or exceeds national performance, with the execption of rates of women over 70 years old with high risk early invasice cancer having radiotherapy following a mastectomy. A shared decision making tool has been introduced into the clinic and PROMS is about to be intirduced into the clinic.
Surgery	Urology	Tier 1 National Audit	National Prostate Cancer Audit	Continuous	The national report relates to care delivery in the 2016/17 financial year. Perfromance was in keeping with national perfromance and under and over treatment exceeding UK performance.
Surgery	Urology	Tier 1 National Audit	Audit of Stress urinary Incontinence I Women		Update pending
Surgery	Urology	Tier 1 National Audit	Audit of Urethroplasty		Update pending
Surgery	Urology	Tier 1 National Audit	Audit of Cystectomy		Update pending
Surgery	Urology	Tier 1 National Audit	Audit of Nephrectomy		Update pending
Surgery	Urology	Tier 2 Quality and Safety priority	Audit of Scrotal Pain Pathway Audit		Update pending
Surgery	Urology	Tier 2 Quality and Safety priority	Audit of Consent for day of surgery admission patients		Update pending

Surgery	Opthalmology	Tier 1 National Audit	National Opthalmology Audit	Complete	The 2019 opthalmology audit report indicates issues in collecting post operative visual acuity data for the audit. A solution is being taken forward on an All Wales basis
Surgery	Anasthetics	Tier 2 Quality and Safety priority	Obs Cymru	Ongoing	This audit remains in progress
Surgery	Trauma and Orthopaedics	Tier 1 National Audit	National Joint Registry	Continuous	Reviesion rates for Primary Knee procedures is reportedly highre than should be expected. Work is underway to validate the data and to understand the issue.
Surgery	Trauma and Orthopaedics	Tier 1 National Audit	National Hip Fracture Database	Continuous	The 2019 national report is pending
Surgery	General Surgery	Tier 2 Quality and Safety priority	BAETS UK registry of endocrine and thyroid surgery	Continuous	Update pending
Surgery	General Surgery	Tier 2 Quality and Safety priority	PQUIP		Awaiting update
Surgery	General Surgery	Tier 1 National Audit	National bowel cancer audit	Continuous	National report pending
Surgery	General Surgery	Tier 2 Quality and Safety	SWORD pouch surgery database		Awaiting update
Surgery	General Surgery	Tier 1 National Audit	Pelvic floor national database (mesh rectopexy)		Update pending
Surgery	General Surgery	Tier 1 National Audit	National Vasular Registry	Continuous	National Report pending
Surgery	General Surgery	Tier 1 National Audit	National Emergency Laparotomy Audit	Continuous	National report pending
Medicine	Medicine	Tier 1 National Audit	National Diabetes in Pregnancy Audit	Continuous	A greater proprtion of C&V babies born to mothers with diabetes are cared for in the NNU compared with nationally. The proprtion of mothers with an HbA1c of <48 is in line with or exceeds national average.
Medicine	Medicine	Tier 1 National Audit	National Pulmonary rehabilitation Audit	Ongoing	national report pending
Medicine	Medicine	Tier 1 National Audit	National Asthma Audit	Continuous	National report pending
Medicine	Medicine	Tier 1 National Audit	National COPD Audit	Continuous	Compliance with oxygen prescribing will be improved by an ammended oxygen prescribing chart.A COPD admission bundle will improve compliance with data collection and work underway with Lightfoot will support renewed efforts to ensure respiratory patients are admitted to respiratory wards.

Medicne	Rheumatology	Tier 1 National Audit	National Early Inflammatory Arthritis Audit	Continuous	The UHB performs above national average for patients with suspected early inflamatory arthritis are referred to a specialist within 3 working days. There are above national average delays between referral and date of initial clinic assessment. 40% of patients start treatments within 42 days of referral. 81% of patients are provided with patient eduction within 3 months
Medicine	Medicine	Tier 1 National Audit	National Diabetes Inpatient Audit	Continuous	A hospital Characteristics report was published in May 2019 and wales will be excluded from the next inpatient audit.
Medicine	Medicine	Tier 1 National Audit	National Stroke Audit	Continuous	82.5% of patients spend 90% or more of their stay on a stroke unit 47% are supported by an early supported discharge team. The number of patients admitted to a stroke unit within 4 hours is subject to seasonal effects. In order to mitigate against this there is focused work underway around the stroke pathway beds have been ring fenced for use in the pathway.
Medicine	Medicine	Tier 1 National Audit	National Audit of Dementia	complete	Documetation of assessment of delirium is below the national average for both UHL and UHW. Improvement actions include the ammendement of clerking documentation to include the 4AT tool, training of staff around delirium and assessment and a Think Delirium campaign to be held on World Delirium Day in March 2020.
CD&T	Podiatry	Tier 1 National Audit	National Diabetes Footcare Audit	Continuous	21.7% of patients with a severe ulcer had a foot related admission within 6 months of expert assessments compared with 33.3% nationally. A walk in clinic for foot emergencies is being taken through NDFA quality improvement collaboration. Podiatry colaboration with Vascular out patients clinic
CD&T	Audiology	Tier 1 National Audit	National Audiology Audit	Ongoing	National report pending
Specialist	Cardiology	Tier 1 National Audit	National Heart Failure Audit	Continuous	secondary preventative medication prescribing above national average. Patients undergoing echcardiography below national average
Specialist	Cardiology	Tier 1 National Audit	Cardiac Rhythm Audit	Continuous	National AF ablation targets not met .
Specialist	Cardiology	Tier 1 National Audit	National Adult Cardiac Surgery A	Continuous	The 2019 summary report - Waiitng time to first CABG 113 days , reoperation for any cause 4.35% reoperation for bleeding 4.35% Deep sternal wound infection 1.09% , Any new post operative CVA / TIA 1.36 New post operative kidney failure 3.28%
Specialist	Cardiology	Tier 2 Quality and Safety priority	National Audit of Percutaneous Coronary Interventions	Continuous	Door to balloon median time 30 minutes DTB within 90 minutes 92.67% within 60 minutes 83%. Radial access 94.29%. Drug eluting stents use 96.59%
Specialist	Cardiology	Tier 1 National Audit	National Congenital Heart Disease Audit	Continuous	2019 summary published with some data for commisisoned service. (Post surgical use of ECMO 1.62%, Incidence of post surgical renal replacement therapy 6.47% Post surgical requirement for pacemaker 2.26% Post surgical requirement for prolonged pleural drainage 4.09%, Catheter procedure requirement for emergency complication related procedure 1.0%)
Specialist	Cardiology	Tier 1 National Audit	Myocadial Ischaemia National Audit Project	Continuous	The proportion of NSTEMI patients having angiogrpahy during admission is above national average. Door to Balloon time is keeping with national average. Unadjusted 30 day mortality below national average. Patients undergoing echcardiography below national average
Mental Health	Adult Mental Health	Tier 1 National Audit	National Audit of Psychosis	complete	Peformance on physical monitoring was a little above the national average for glucose control however monitoring of interventions was below average. Availability of psychological therapies was below average
Mental Health	Adult and Older people's Mental Health	Tier 2 Quality and Safety priority	Care and Treatment Plan Audit	ongoing	This audit remains in progress

Mental health	Adult and Older people's Mental Health	Tier 2 Quality and Safety priority	Matrics Cymru Compliance with Psychological Therapies	Ongoing	This audit remains in progress
Mental Health	Adult Mental Health	Tier 2 Quality and Safety priority	Patient Own Medication Audit	Ongoing	This audit remains in progress

presented to department QSE
presented to Clinical Board QSE
Presented at Clinical Governance Session
Results escalated to Clinical Board

Complete
Abandoned
Ongoing

Tier 1 National Audit
Tier 2 Quality and Safety priority

Report Title:	**Cancer Peer Review**								
Meeting:	Quality, Safety and Experience						**Meeting Date:**	December 2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	√	
Lead Executive:	Dr Stuart Walker, Medical Director								
Report Author (Title):	Alicia Williams, Cancer Services Lead Manager								

SITUATION

The purpose of this report is to present the committee with an update regarding the Cancer Peer Review process. Following peer review of each cancer tumour site, a report is forwarded to the UHB and an action plan agreed by the multidisciplinary team and relevant Clinical Board. The action plan is reported back to the Wales Cancer Network and Welsh Government.

As no actions plans are available for submission (please see assessment section below), this report provides an update regarding the most recent Peer Reviews undertaken.

REPORT

BACKGROUND

Peer review is a collaborative, quality improvement process which allows for the evaluation of scientific, academic or professional work by others working in the same field and constitutes a form of self-regulation by qualified members of a profession. It is designed to allow peers to share information, learn where their strengths and weaknesses lie and agree plans for improvements to patient care.

Peer review methods are employed to maintain standards of quality, improve performance and provide credibility.

In 2011 Welsh Government recommended that the peer review process for cancer services be led by Health Inspectorate Wales (HIW), working in partnership with the Cancer Networks. Peer review was then launched in Wales in 2012.

In 2017, through Welsh Health Circular WHC/2017037 the NHS Wales Peer Review Framework was published and tasked the NHS Wales Health Collaborative to oversee an all-Wales programme for peer review.

A three yearly re-review process has been developed by the cancer network. Following the peer review meeting, a report is sent to the UHB. An action plan is then developed and implemented to address the concerns raised at each peer review and re-review.

ASSESSMENT

The most recent Peer Reviews held are summarised in the table below:

Peer Review Tumour Site	Review Held	Report Received	UHB Action Plan Developed / Update
Thyroid	December 2018	February 2019	Submitted to April QSE
Teenage and Young Adults	July 2019	Not received	To be submitted to next QSE
Lung	November 2019	Not received	To be submitted to next QSE

Unfortunately as Teenage and Young Adult report has not been submitted to the UHB to date, we are unable to develop a formal action plan for submission to this Committee. However it is worth noting that the clinical teams are proactively taking forward actions to improve the service based on the verbal feedback given at the visit in July.

The Lung Peer Review was held recently (18th November 2019) and it is anticipated that an action plan will be submitted to the next Committee meeting.

ASSURANCE is provided by:

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

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **Note** the contents of the report and the delayed action plans awaited from the Wales Cancer Network.
- **Note** that reports and action plans will be submitted to the next meeting.

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 *If "yes" please provide copy of the assessment. This will be linked to the report when published.*								

Thyroid and Endocrine Peer Review Action Plan 2019

Cardiff and Vale University Health Board

	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
1	Rare, advanced and complex cancer cases were said to be treated within cancer units (e.g. anaplastic and medullary cancers). As the number of cases are small the panel suggest the MDT should agree the criteria for rare and complex cancer cases to be referred to a nominated specialist centre/s for treatment and management.	The Peer review panel recommended that these patients should be treated in centres where cardiothoracic services are available – this is Morriston and UHW. The health boards need to agree to refer such patients to these two Units and a referral process needs to be implemented	High	MDT Lead / Surgical clinical board and Cancer lead	End 2019	
2	The South Wales MDT functions mainly outside of the MDT meeting where all aspects of patient care may not be discussed, certainly prospectively. More regular meetings would ensure all aspects of care are considered in a multidisciplinary approach. The South Wales MDT should be adequately supported by administrative provision.	Having an MDT more frequently than 1 x month is desirable but will place a challenge on current job plans, especially for support services such as radiology and pathology. A plan should be developed to have a more frequent (2 x month) meeting and need to have 1) An MDT room 2) Agreement from members of the MDT with backing from Health boards for a change to job plans	Medium	MDT Lead / DOO CD&T / Cancer Services / surgical clinical board	End 2019	
3	An annual service review or	The establishment of the Thyroid Cancer Site Group under the	Medium	MDT Lead	End 2019	MDT Lead has invited expressions of

	business meeting would aid the South Wales MDT in service development, education and sharing of audit/improvement project findings.	umbrella of the All Wales Cancer Network will provide the forum for educational meetings. A core group is being established to develop this programme				interest to join the Core Group
4	There is one clinical nurse specialist providing support for all thyroid cancer patients in the region who is based in Velindre Cancer Centre. The CNS will see patients attending Velindre Cancer Centre but can only try to make contact by telephone with other patients. This does not extend at all to patients in south west Wales routinely who may/may not have some support from the H&N CNSs. An essential part of this role is to support a patient at diagnosis, which needs to be looked at by stakeholders and the South Wales MDT to develop a way of improving the support for patients, especially those within South West Wales.	This is a matter for South West Wales to make an investment. Regional discussions required with development of a business case.	Medium	Lead Cancer Nurse / MDT lead	End 2019	
5	An MDT of this size should have core membership that includes surgeons, endocrinologists, oncologists, pathologists, radiologists, clinical nurse specialists and an MDT co-ordinator. Core members must	There is currently no capacity to cover oncologist Need to recruit an endocrinologist – this could be done at the same time as increasing the frequency of MDT meetings	Medium		Summer 2019	

	have a second clinician to cover absence. The current challenges to provide cover arrangements relate to the positions of: • Oncologist • Endocrinologist • Clinical Nurse Specialist • MDT Co-ordinator			Velindre / Medicine Clinical Board / Cancer Services		
6	USC cancer waiting time performance is at 73%, where the target is 95%. The Health Board should work towards achieving the national target.	An all Wales discussion about the SCP is being developed through the cancer network	Medium	MDT Lead	End 2019	MDT Lead is convening a Core group within the thyroid WCSG
7	There are no guidelines to support the requirements of what supportive services are provided locally or regionally. In addition, there was no follow up process or policy in place that may aid patients who may have a requirement to access such services as Lymphoedema, physiotherapy, speech and language therapy (SaLT), welfare and benefit advice, and psychological support.	SALT has already been engaged and a discussion is being held in Cardiff. The remainder is not relevant to patients with thyroid cancer	Medium	MDT Lead	Spring 2019	SALT team engaged

REPORT TITLE:	**Internal Inspection Overview**									
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**17.12.19**		
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**/**		
LEAD EXECUTIVE:	Executive Nurse Director									
REPORT AUTHOR (TITLE):	**Aron White (Senior Nurse – Standards & Professional Regulation)**									

PURPOSE OF REPORT:

SITUATION:

This report provides an overview of the UHB's internal inspection process, the findings obtained throughout 2019 and recent changes being piloted.

REPORT:

BACKGROUND:

Internal inspections of wards, departments and outpatient services are undertaken across the UHB. Since January 2019, 109 clinical areas have been visited. These visits are undertaken exclusively by Nurses and Midwives. In most instances, these inspections are undertaken by Senior and Lead Nurses. Two inspectors are allocated to attend each clinical area. The average length of time it takes to complete an inspection is just over 2hours. Inspectors are allocated an area to visit, but choose what time of day to visit. 70% of inspections take place on early shifts, 30% take place on late shifts. Inspectors enter each clinical area 'blind', with no background information or detail about clinical incidents that may have recently occurred. Inspectors record their observations within the following headings:

1. Staffing	8. Falls prevention & management
2. Environment	9. Nutrition & Hydration
3. Patient Experience	10. Medicines Management
4. Staff Experience	11. Documentation
5. IP&C	12. Safeguarding
6. Continence	
7. Pressure Care	

In addition to producing a report about observations relating to each standard, inspectors note areas of good practice and identify areas that require improvement.

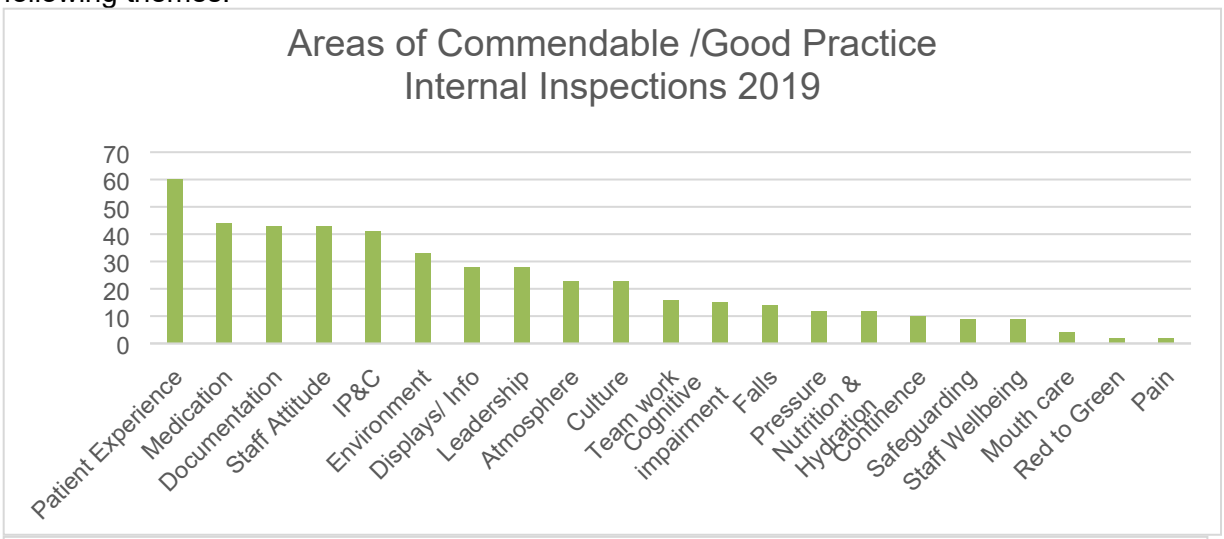
ASSESSMENT:

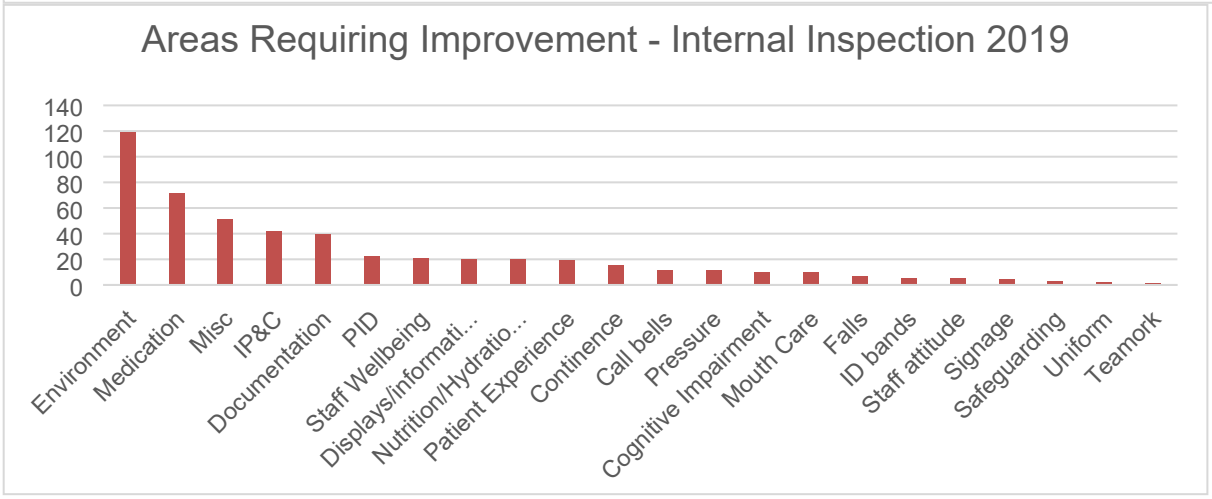
109 inspection have been carried so far in 2019. These inspection have highlighted:

- Approximately 500 observations of good/notable practice
- Approximately 550 areas that require improvement

On receipt of an inspection report, clinical areas are required to produce an 'action plan' detailing work

undertaken to improve practice. Each area for improvement will likely generate 1-3 actions. Consequently, over 1,000 actions will be generated throughout a year.
In 2019, the areas of good practice and aspects that require improvement can be categorised within the following themes:





As with any form of inspection, it's easiest to comment on what is most readily observable in the clinical area. As such, the second graph demonstrates that at least 60% of required improvements relate to:

- A high number of outstanding estates issues
- Broken equipment
- Inadequate storage facilities
- Medication storage, CD checks, fridge temp recordings, out of date stock
- Unclean environment and instances of staff not being BBE
- Missing documentation or documentation not reviewed within timeframes
- Displaying personal identifiable information

Ongoing Improvements to Internal Inspection Process.

Several changes to the inspection process have been introduced or piloted in 2019, whilst ensuring the requirement to undertake at least 120 inspections is achieved. These changes include:

1. **Electronic audit platform for standardisation and time saving.**

Historically, inspectors visited an area and then later typed up their report. Inspectors were asked to

make free text comments under the headings identified in table 1. This created several difficulties, three of which include:

- The quality of reports were inconsistent
- Inspectors tended to write more about the standards of care they were most familiar/knowledgeable about.
- There could be delays in receiving finalised reports from inspectors. Inspectors generally protected diary time to undertaken an inspection, but not to type up findings.

The use of an electronic platform 'iauditor' and procurement of x3 ipads, has enabled the standardisation of inspection reports and has removed the need the need to later type up inspections.

2. **Triangulating data to prioritise actions that improve patient safety.**

With over 1000 actions generated in a year, it can be difficult to know what actions will most likely improve patient experience/safety. Likewise, it can be difficult to know which areas for improvement should be prioritised.

A pilot is being undertaken within the areas inspected in Medicine Clinical Board. The findings from inspections are being triangulated against six months of Datix reports and a year's worth of patient feedback. When an inspection finding resonates with clinical incidents/ patient feedback, it is included in a 'fact sheet'. The aim is to help sisters and charge nurses recognise what they should prioritise for improvement.

The 'fact sheet' from a ward has been included, as an appendix, to demonstrate our attempts to align inspection observations with patient safety data. As an example, the fact sheet for this ward shows that there can be delays in responding to patient request for assistance. The ward may benefit from focusing on assisting patients between 5-9pm because 35% of all falls occur in these four hours and are mainly caused by patients trying to mobilise from their chair/bed.

3. **Inspecting systematically, rather than randomly.**

For the most part, action plans are developed by ward sister/charge nurse in collaboration with their senior nurse. However, the volume of actions can be difficult for a clinical board to monitor because they observe a continual flow of new action plans throughout the year.

A pilot is being undertaken to inspect all areas within one clinical board at a time. Rather than asking for an immediate action plan to be returned, the totality of the findings will be presented at one time. Medicine Clinical Board have agreed to pilot this approach, so that it can determine which of their 300+ actions should be prioritised over the coming year. Likewise, many inspection findings are beyond the remit of ward sister/charge nurse to change (ie. estates requests). Feedback will be obtained as to whether this approach makes it easier for clinical boards to plan their improvement priorities before the next round of inspections in a year's time.

RECOMMENDATION:

- To Note the content of the paper

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.

Report Title:	**Patient Notification Exercises in Cardiff and Vale of Glamorgan populations: Hepatitis C Virus Infection Re-Engagement Project**							
Meeting:	Quality, Safety and Experience Committee					**Meeting Date:**	17.12.19	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**	
Lead Executive:	**Fiona Kinghorn, Executive Director of Public Health**							
Report Author (Title):	**Trina Nealon, Principal Health Promotion Specialist**							

SITUATION

Over 5000 individuals who have been diagnosed with hepatitis C, who for a variety of reasons have never been linked to care or who have never received follow up investigation or treatment, have been identified through laboratory data searches in Wales. For those with an identified General Practitioner (GP) and following consent, these patients have been contacted and offered treatment as Phase 1 of an on-going re-engagement programme throughout Wales and directed by Welsh Government.

Improvements in the effectiveness and tolerability of new direct acting antiviral treatments support the patient and public health benefit of re-engagement. Antiviral drug costs for hepatitis C have significantly reduce since 2015.

As part of this process, the Welsh Viral Hepatitis sub group of the Liver Disease Implementation Group had developed guidance and care pathways to support primary care in communicating with these patients and an all-Wales Hepatitis C Implementation Group, led by Public Health Wales (PHW) has agreed these procedures.

BACKGROUND

Wales is committed to a World Health Organisation global health sector strategy which sets out to eliminate hepatitis B (HBV) and hepatitis C (HCV) by 2030 (90% reduction in incidence and 65% reduction in mortality). New direct acting anti-viral medications have revolutionised the treatment of hepatitis C so that the disease is now essentially curable in the early stages**.**

In 2017 the Welsh Health Circular WHC/2017/048 outlined a series of expected measures from multiple organisations and partnerships to contribute to the elimination target:

1. Reduce and ultimately prevent on-going transmission of HCV within Wales
2. Identify individuals who are currently infected with HCV including those who have acquired HCV outside the UK and are now resident in Wales, and
3. Test and treat individuals currently infected with HCV who are actively engaged in behaviours likely to lead to further transmission

The WHC outlined expectation for organisations including Health Boards for action with regard to measures 1 and 3. A letter to Health Board CEOs confirmed these expectations.

This paper relates to individuals within Measure 2 which fall into 2 cohorts – those patients with a Polymerase Chain Reaction positive test registered with a GP (re-engagement activities

referred to as ‘Phase 1’), and those also with a Polymerase Chain Reaction positive test result but with no record of a GP, special groups (Genital Urinary Medicine, prison inmates), cross-border patients (Public Health England) patients with positive antibody results (with and without GPs), and all others (referred to as ‘Phase 2’).

ASSESSMENT

Initial data analysis of a mixed set of test results identified 3 categories of patients who may benefit from contact – with 1192 of those being resident in Cardiff and Vale University Health Board. An additional, 843 patients received their last HCV test in Cardiff and Vale University Health Board, across a range of services, but were not registered with a GP in Wales.

Public Health Wales provided a detailed process with timescales to Health Boards and an initial phased approach was agreed which commenced in Autumn 2018, with an intention to move to ‘Phase 2’ by summer 2019. This process has been monitored by the Hepatitis C Implementation Group (with attendance by Welsh Government and Cardiff and Vale University Health Board representation), GPC Wales, the PCIC and Medical Clinical Boards and the local Blood Born Virus (BBV) team. The Executive Director of Public Health provided an update to the Bro Taf Local Medical Committee in January 2019.

Phase 1 initially identified 134 patients with a known GP, and following GP confirmation, 61 of these were suitable to contact. Of the 61, 20% of patients contacted the BBV team following invitation and 67% of those attended an appointment and accepted treatment. To date, 177 patients have been treated from an overall elimination target of 179 patients treated 2019-2020, achieving 99%, the second highest Health Board in Wales.

Overall, it has been noted that there have been operational challenges in identifying and offering support to patients. Incomplete returns from GPs on appropriateness of contact and non-response from patients has led to the speed of progress being slower than originally anticipated. Working with GP Clusters has led to improvements locally in identifying patients eligible for contact and specific targeting of GP Practices with higher levels of patients with specific circumstances requiring tailored support, has helped improve Cardiff and Vale University Health Board treatment target.

Learning from experiences in implementing Phase 1, Phase 2 will commence from the end of December 2019. Those patients without a GP will require local collaboration with BBV specialist services, substance misuse and homeless services and groups representing individuals from high prevalence countries. Cardiff and Vale University Health Board is working with a GP Practice with a high practice population of homelessness and the PHW Health Protection Team to identify and implement a suitable pathway for offer of treatment for this group. It is acknowledged that encouraging engagement from patients and the public will need different approaches moving forward. Work has commenced with PHW, Cardiff Prison and Substance Misuse Services.

RECOMMENDATION

The Committee is asked to:

- Progress made so far in this exercise and support on-going implementation.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
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	

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:	Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

WARD -- UHW

Review of:

- **Quality Checks**
- **Clinical Incidents**
- **Patient feedback**
- **HCS Audit**

Good Practice & Compliments

Patient Feedback

100% of verbal feedback given during annual quality checks is complimentary

85% of written feedback about staff attitude is complimentary

"The caterer is so nice and knows my name and what food I like. All the nurses are angels. It's very good here."

"I've been treated superbly. The staff are all magnificent and deserve double what they are paid. They deserve a medal"

Quality Checks

- The management and care provided to patients that have fallen is provided to a high standard. Post falls procedures are followed reliably and consistently.
- Care plans and risk assessments for all patients reviewed are up to date.
- The ward has good displays and information. Especially relating to 'model ward'

Opportunities for Improvement

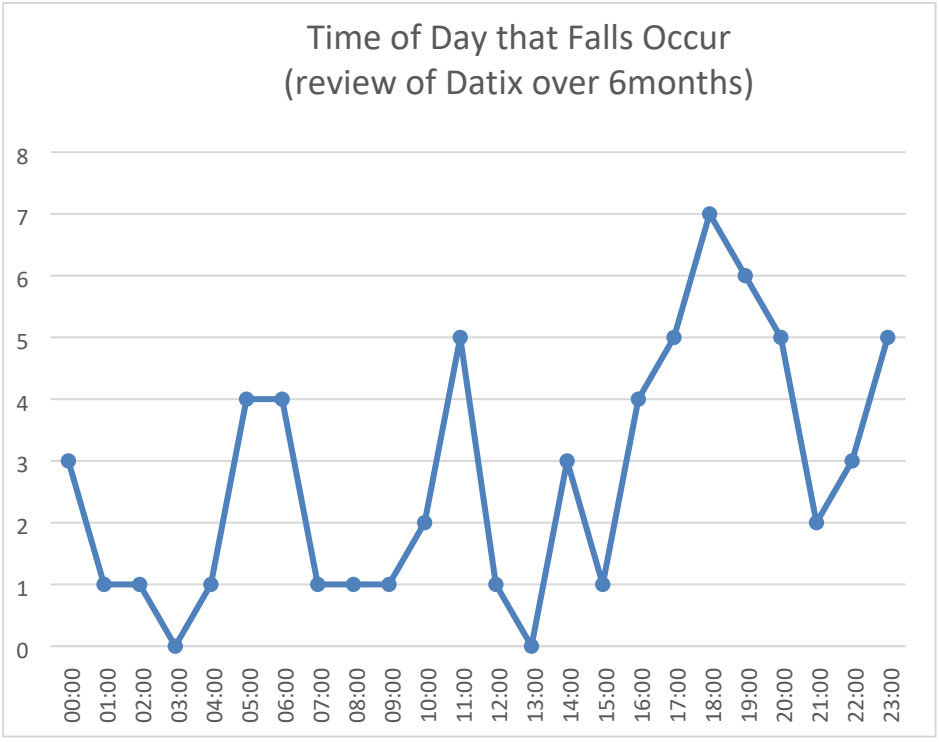
Falls Prevention

74% of falls are un-witnessed (52/70)

40% of falls occur when a patient attempts to get up from the bed or bedside chair

24% of falls occur when a patient is walking to or from a toilet

35% of all falls occur between 5pm-9pm



Call Bells

Patient feedback indicates that there may sometimes be delays in answering call bells.

"I couldn't reach the call bell when I was sat in my chair"

"There aren't enough staff to help me when I try to get back into bed"

"When I drop my buzzer, I can't pick it up again and I don't know what to do when I need the toilet"

Discharge Involvement

40% of patients say that they don't feel involved in discharge planning

A lack of involvement in care planning and discharge planning has been a concern raised by relatives

Medication Management

On 3 occasions a medication error was reported because transdermal patches were not removed, before a new one was applied.

Quality Check visits to the ward noted that nurses are distracted by colleagues whilst administering medication. A contributing factor to a medication error was reported to have been due to frequent interruptions during the administration of controlled medication.

REPORT TITLE:	**APPROVAL OF CONSENT TO EXAMINATION OR TREATMENT POLICY**						
MEETING:	Quality, Safety and Experience Committee				**MEETING DATE:**	**17-12-19**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
LEAD EXECUTIVE:	Executive Medical Director						
REPORT AUTHOR (TITLE):	Mental Capacity Act Manager, tel. 029 2183 6312						

PURPOSE OF REPORT:

SITUATION:

This policy sets out the legal framework that governs the provision of treatment and care to patients.

The policy has been reviewed and amended to comply with the All-Wales model Consent Policy

REPORT:

BACKGROUND:

The Consent Policy was last reviewed and updated in 2015, at which time the changes to case law made by the *Montgomery* judgment were incorporated.

In 2017, Welsh Government initiated a review of the all-Wales Model Consent Policy. This work was subsequently undertaken by a sub-group of the All Wales Consent to Treatment Group (Chair - Dr Ben Thomas, Betsi Cadwaladr UHB).

Welsh Government issued the revised all-Wales Model Consent Policy in November 2018 by way of a letter from the Deputy Chief Medical Officer.

ASSESSMENT:
The substance of the policy has not altered, although the layout and wording have changed. There is now an executive summary at the beginning of the policy.

Titles, web links and the names of organizations and of bodies have been updated where necessary.

The policy comes in two parts –

- Core guidance – this has to be included in the UHB's Consent Policy

- Supplementary guidance – this is optional

After consultation with the Mental Health Act Manager, it was decided to omit the mental health supplementary guidance, as the All Wales Mental Health Act Policy Group is developing a Consent to Treatment Policy. Procedures concerning consent and mental health can change rapidly - for example as a result of HIW inspections – and any such changes would mean that this Consent Policy would also need to be changed. Hence, it was agreed that consent issues should be covered by a Mental Health Act Consent Policy.

Consultation has taken place to ensure that the policy meets the needs of the Health Board. The document was added to the Policy Consultation pages on the intranet between 29th August 2019 and 26th September 2019

No comments were received.

The Quality, Safety and Experience Committee is responsible for keeping this policy under review.

Clinical Boards are responsible for ensuring that their staff understand and comply with the policy. The Clinical Boards will be notified of the adoption of the policy and the need for them to ensure that the policy is followed by their staff. In addition, the Medical, Nursing and Therapies Executive Directors will ensure that their senior clinicians are alerted to the policy and to the requirement that the policy must be complied with. They will also be asked to ensure that more junior staff are aware of and are familiar with the policy.

The primary source for dissemination of this policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

An Equality and Health Impact assessment is attached – Appendix 1.

RECOMMENDATION:

The Quality, Safety and Experience Committee is asked to:

APPROVE the Consent to Examination or Treatment Policy

APPROVE the full publication of the Consent to Examination or Treatment Policy in accordance with the UHB Publication Scheme

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.

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

Reference Number: UHB 100 **Version Number:** 3	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** T37

CONSENT TO EXAMINATION OR TREATMENT POLICY

Policy Statement

To ensure that Cardiff and Vale University Health Board (the UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will

- Formally ratify this model All-Wales Policy
- Ensure that all clinicians are made aware of this policy
- Ensure that clinicians are aware of the support and advice they can access in the UHB
- Ensure that consent training is available to clinicians

We recognise that to undertake assessment, imaging, examination, investigation, treatment, care or research without consent, or outwith statute law, could amount to a criminal offence and/or lead to a civil claim (such as for trespass to the person/ negligence).

Policy Commitment

We are committed to ensuring that the legal framework that governs the provision of treatment and care to patients is understood and adhered to by our staff.

We support staff in this by

- Publishing this policy and keeping it updated
- Providing intranet pages containing useful information on consent and capacity issues
- Providing training for staff on consent and capacity
- Providing support to staff with queries on consent and capacity issues

Supporting Procedures and Written Control Documents

This policy and the supporting procedures describe the following with regard to consent

- The legal framework which governs the provision of treatment and care to patients

Other supporting documents are:

- Guide to Consent for Examination or Treatment, WHC 2017/036
- Independent Mental Capacity Advocacy Procedure (Mental Capacity Act 2005), UHB 186

- Lasting Power of Attorney and Court Appointed Deputy Procedure (Mental Capacity Act 2005) UHB 113
- Mental Capacity Act 2005 Code of Practice
- Research Consent and Capacity: Standard Operating Procedure, UHB 147

Scope

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

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in 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	Health System Management Board (consent) Mental Health and Capacity Legislation Committee (capacity)
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	Approved by Quality and Safety Committee 21/02/2012		Revised document
1.1	Quality, Safety and Experience Committee 21/05/2015		Front page amended to confirm that policy is still current whilst review is underway.
2	Quality Safety and Experience Committee 23/02/2016	28/04/2016	7.2 Availability of forms 8.6 Parental Responsibility 9.3 Inclusion of *Montgomery* 19.3 Transition period

			Titles, organisations and bodies updated where necessary Weblinks amended where appropriate
3		17/12/2019	Revised All-Wales Model Policy for Consent to Examination or Treatment

CONTENTS

Appendix A **Link to current consent forms in use in the UHB**

Appendix B **Useful contact/link details**

Appendix C **How to obtain legal advice**

Appendix D **Assessing *Gillick* competence in under 16s**

Appendix E **About the consent form: information for patients**

Glossary

ADRT	**Advance Decision to Refuse Treatment**
BMA	**British Medical Association**
BNF	**British National Formulary (Supplementary guidance only)**
CAD	**Court Appointed Deputy**
CANH	**Clinically Assisted Nutrition and Hydration**
CoP	**Court of Protection**
DBD	**Donation after brainstem death**
DCD	**Donation after circulatory death**
DNA	**Deoxyribonucleic Acid**
DNACPR	**Do Not Attempt Cardiopulmonary Resuscitation**
ECT	**Electroconvulsive Therapy**
EPO	**Emergency Protection Order**
GMC	**General Medical Council**
HFEA 1990	**Human Fertilisation and Embryology Act 1990**
HFEA	**Human Fertilisation and Embryology Authority**
HIW	**Healthcare Inspectorate Wales (Supplementary guidance only)**
HRA	**Human Rights Act 1998**
HTA 2004	**Human Tissue Act 2004**
HTA	**Human Tissue Authority**
HTA 2013	**Human Transplantation (Wales) Act 2013**
IMCA	**Independent Mental Capacity Advocate**

ICSI	**Intracytoplasmic sperm injection**
IVF	**In vitro fertilisation**
LPA	**Lasting Power of Attorney**
MCA	**Mental Capacity Act 2005**
MHA	**Mental Health Act 1983**
MCS	**Minimally Conscious State**
Montgomery	**Montgomery v Lanarkshire NHS Health Board**
OPG	**Office of the Public Guardian**
PPO	**Police Protection Order**
PDOC	**Prolonged Disorder of Consciousness**
PVS	**Persistent Vegetative State**
WHC	**Welsh Health Circular**

Executive summary

What is consent?

- Consent is a patient's ongoing agreement to treatment or care
- It is a process – not a one-off event
- For consent to be valid –
    - the patient must have the mental capacity to make the relevant decision about their treatment or care
    - consent must be given voluntarily
    - he or she must be properly informed about the proposed intervention
- Compliance, where a patient is not able to make an informed decision, is not "consent"

What information should be provided?

- Patients must be provided with all the information they require, in a format and language they can understand, so that they can make an informed decision about what treatment, if any, they want to receive. The following should be discussed with the patient:
    - ~~o~~ All reasonable treatment options
    - All of the intended benefits and material risks, including the risks/benefits of doing nothing
    - Any requirement to take and retain tissue samples, photographs etc
    - The presence of any trainees or students
    - The use of any experimental techniques
    - Any requests for further information or clarification should be met
    - Outside an emergency setting, patients should be given adequate time to consider all of the relevant information

What is a material risk?

The test of materiality is whether, in the circumstances of the particular case:

- a reasonable person in the patient's position would be likely to attach significance to the risk; or
- the clinician is, or should be, reasonably aware that the particular patient would be likely to attach significance to it

What are the exceptions to the duty to disclose all relevant information?

- Where the patient has made it clear that they do not want to know the risks involved; or
- Where treatment is required urgently, but the patient is unconscious or unable to make the decision for any reason (treatment is provided on the grounds of necessity); or
- Where advising the patient of the risks would be seriously detrimental to their health (this 'therapeutic exception' is limited and should not be abused)

When do healthcare professionals need to obtain consent?

- Before any kind of treatment or care is provided, if the patient has capacity to consent

Who is the right person to seek consent?

- The healthcare professional providing the intervention
- Seeking consent can be delegated to an appropriately trained colleague
- If you have been asked to obtain consent but don't feel competent to do so, you must refuse

How does a patient give consent?

- Consent is given through an ongoing dialogue between the patient and healthcare professional
- Consent will normally be given verbally or in writing, but consent may also be implied in certain circumstances (be very cautious about relying on implied consent)
- The consent form is a record of the patient's decision, along with the record of any related discussions in a patient's medical or nursing notes
- A signature on a consent form does not prove that valid consent has been obtained
- This consent policy explains when you should obtain written consent

Can children (aged under 16 years) give consent for themselves?

- Children under 16 years who are *Gillick* competent can give consent
- Where a child is not *Gillick* competent, someone with parental responsibility must give consent on their behalf, unless the situation is an emergency and they cannot be contacted
- If a competent child consents to treatment, a parent **cannot** over-ride that consent
- If a competent child refuses necessary treatment, legal advice should be sought

- Not all parents have parental responsibility for their children (e.g. unmarried fathers do not automatically have such responsibility)
- If you doubt whether a person has parental responsibility for a child, you must check

What about patients (aged 16 years and over) who lack capacity to give consent?

- Patients (aged 16 years and over) are presumed to have mental capacity unless demonstrated otherwise. A patient lacks capacity to make a specific decision if:

    - They have an impairment or disturbance that affects the way their mind or brain works; and
    - That impairment or disturbance causes them to be unable to make a specific decision at the time it needs to be made

- An assessment of a patient's capacity must be based upon their ability to make a specific decision at the time it needs to be made. A patient with an "impairment or disturbance" is unable to make a decision if they cannot do one or more of the following:

    - **Understand** the information relevant to the decision
    - **Retain** the information long enough to make a decision
    - **Use or weigh up** the information as part of a decision-making process
    - **Communicate the decision** – this could be by talking or using sign language and includes simple muscle movements such as blinking or squeezing a hand

  A patient is not to be treated as unable to make a decision unless all practicable steps to help the patient do so have been taken without success. A patient can only be said to be unable to communicate when all forms of communication have been explored.

- A person who has authority under a Health and Welfare Lasting Power of Attorney (LPA) or a Court Appointed Deputy (CAD) with appropriate authority can give consent when the patient lacks capacity

- In the absence of a person with authority under a Health and Welfare LPA or CAD, or a valid and applicable advance decision to refuse treatment, you must determine the patient's best interests in accordance with Mental Capacity Act 2005 (MCA)

- 'Best interests' includes past and present wishes, feelings, beliefs and values of the patient lacking capacity and any other factors which they

would take into account if they were able to do so. (It is not the same as "medical best interests").

- You must, where practical and reasonable, consult people who care for, or have an interest in the welfare of the patient, about the patient's wishes and beliefs

- Where there is nobody with whom you can consult, apart from paid staff, an Independent Mental Capacity Advocate (IMCA) **MUST** be instructed where decisions are needed about serious medical treatment (including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders). The only exception to this duty occurs when an urgent decision is required e.g. to save the patient's life. IMCAs will not make a decision for the patient, but healthcare professionals have a legal duty to consider their views.

What about refusal of treatment?

- Adults with capacity are entitled to refuse treatment or withdraw consent for any reason, at any time, no matter how unwise this may seem. The exception is where the treatment is for mental disorder and the patient is detained under the Mental Health Act 1983 (MHA)

- A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to the health of the foetus. If a woman in labour refuses treatment seek urgent legal advice

- If an *un-sedated* patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately and the event recorded in the notes

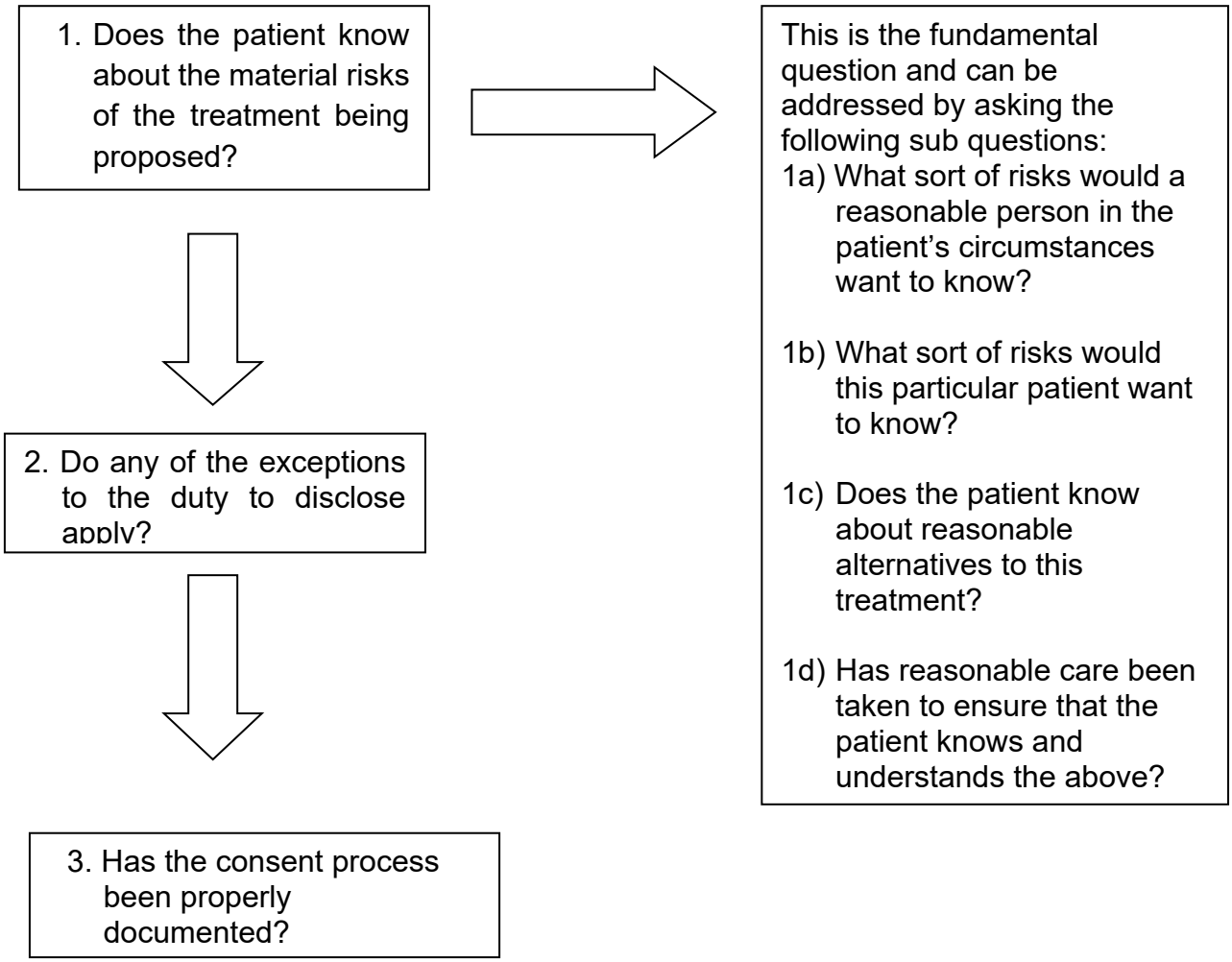
- If a patient lacks capacity but has clearly indicated in the past, while competent, that they would refuse treatment in specified circumstances (an advance decision), and those circumstances arise, you must abide by that decision if it is **valid** and **applicable**

- Advance decisions (made by patients with capacity aged 18 years or over) about life-sustaining treatment **must be** made in writing and contain a statement that the advance decision is to apply even if their life is at risk. The document must be signed by the patient (or by someone appointed by them), in the presence of a witness, who must also sign the document.

Informed Consent Flowchart

If a patient has capacity they are entitled to decide which, if any, of the available treatments to undergo and their consent must be obtained before treatment.

In order to obtain and document informed consent the three questions below, together with the sub-questions, should be addressed:



CORE POLICY

1. Introduction

About this policy

1.1 Cardiff and Vale UHB recognises that people have a fundamental legal and ethical right to determine what happens to their own bodies and this is reflected in this policy. Valid consent to treatment is absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is not only a legal obligation but also a matter of common courtesy between healthcare staff and patients. Both the UHB and healthcare staff may be liable to legal action if valid consent is not obtained.

1.2 Doctors, Nurses and Allied Health Professionals must at all times follow professional standards as set out in GMC, NMC, HCPC and other regulatory guidance. The Welsh Government's revised Welsh Health Circular (WHC) 2017/036: Guide to Consent for Examination or Treatment (the Guide) - sets out the legal framework for consent and can be found on the NHS Wales Governance E-manual at: http://www.wales.nhs.uk/governance-emanual/patient-consent/**.** The Supreme Court ruling in Montgomery v Lanarkshire NHS Health Board, has fundamentally changed the legal framework for consent to examination and treatment, enshrining the concepts of **informed consent** and **material risk** in UK law (discussed later in chapter 3), bringing the law on consent in line with existing regulatory guidance. Healthcare staff in this UHB must comply with the standards and procedures in this policy, which should be applied in conjunction with the principles set out in the Guide.

1.3 While this policy is primarily concerned with healthcare and refers to healthcare staff in all NHS settings, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

1.4 A patient may either be an adult or a child. Reference in this policy to an adult means a patient of 18 years or above and a child is a patient who is under the age of 16. Reference in this policy to a young person means a child aged 16 or 17 years.

What consent is – and isn't

1.5 Consent is a patient's ongoing agreement for healthcare staff to provide care or treatment. Before providing care or treatment, healthcare staff

should be satisfied that the patient has given his or her **consent**. Consent will only be valid if:

- the patient has capacity to give consent
- it is given freely and not under duress
- the patient has been properly informed

1.6 Consent can be given in writing, verbally or even indicated non-verbally (for example by presenting an arm for a pulse to be taken). In all cases it is essential that an adequate record of the consent is maintained for future reference.

1.7 The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of advice from a healthcare professional. In some cases, the healthcare professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the healthcare staff will help the patient to decide between the available options.

The relevant questions to consider

1.8 In seeking to obtain valid consent, healthcare staff should ask themselves a series of questions, as follows.

Is there reason to doubt the patient's capacity to give consent?

1.9 In determining whether an adult or young person lacks the mental capacity (either temporarily or permanently) to give or withhold consent, healthcare professionals must act in accordance with the MCA and the MCA *Code of Practice*. It is important to remember that nobody can give consent on behalf of an adult, unless they are an appointed attorney with authority under a Health and Welfare LPA or Court Appointed Deputy. A patient who lacks capacity can, however, be given treatment if it is in their best interests in accordance with the MCA, unless there is a valid and applicable advance decision refusing treatment (advance decisions are valid only for adult patients).

1.10 When treating patients who may lack capacity, healthcare professionals should give careful consideration to chapter 8 of this policy and the Guide, particularly the paragraphs set out below.

Is the consent given freely?

1.11 Pressure to agree to a particular treatment can be intentionally or unintentionally applied by family, friends or healthcare professionals.

Professionals should be alert to this possibility, and where appropriate, arrange to review the patient on their own to establish that the decision is autonomous.

1.12 When patients are seen and treated in environments where involuntary detention may be an issue, such as prisons and mental health hospitals, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent and care must be taken to ensure that the patient makes a decision freely. Coercion should be distinguished from providing the patient with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for their health. However, threats such as withdrawal of any privileges or loss of remission of sentence for refusing consent, or using such matters to induce the patient to give consent are not acceptable. Consent will not be valid in these circumstances.

Is the patient aware of all of the material risks and benefits of the proposed treatment and or any alternatives, including no treatment?

1.13 The healthcare professional must inform the patient about all the material risks, benefits and available alternatives, including no treatment. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, ‘seeking consent’ is better described as ‘joint decision-making’: the patient and healthcare professional need to come to an agreement on the best way forward, based on the patient’s values and preferences and the healthcare professional’s clinical knowledge.

1.14 The informed person may either be the patient or someone with parental responsibility. Where a patient lacks capacity to give consent to the specified treatment, the decision should be made in the patient’s best interests in accordance with MCA. It is important that a person acting under a Health and Welfare LPA or a CAD for health and welfare decisions is also aware of all material risks, benefits and available alternatives, including no treatment.

Cultural issues

1.15 Cultural diversity issues should be actively considered whilst obtaining patient’s consent. Members of some religious faiths, for example, are extremely modest in relation to exposure of parts of the body and may only consent to examination or treatment if it is undertaken by someone of the same sex.

1.16 If there is any doubt or uncertainty in relation to particular

consent/capacity issues, contact the Mental Capacity Act Manager/Patient Safety Team.

2. Documentation

2.1 Healthcare professionals must clearly document the information provided to a patient and any related discussions during the consent process. This may be recorded on a consent form (with further detail in the patient's medical note as necessary) or within an entry in the patient's medical notes. (See chapter 3).

2.2 Where the signing of a consent form is not required, healthcare professionals must document the consent process followed with an entry in the patient's medical notes, including details of any information provided or related discussions.

Valid forms of consent

2.3 It will not usually be necessary to obtain a patient's written consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be advisable to do so.

2.4 It is rarely a legal requirement to seek written consent[1], but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some healthcare professionals would describe as 'side-effects' or 'complications');
- the procedure involves general/regional anaesthesia or sedation;
- providing clinical care is not the primary purpose of the procedure;
- there may be significant consequences for the patient's employment or personal life;
- the treatment is part of a project or programme of research approved by this UHB (see chapter 15 of this policy).

2.5 If you are in doubt about whether a procedure requires written consent, then the safest course of action is to complete an appropriate consent form.

2.6 It is important to note that the place in which the treatment or procedure is to be carried out e.g. outpatients / theatre / clinic / in the

[1]The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances

patient's home, etc. should not affect the type of consent taken. The nature of the consent (i.e. written, verbal or implied) should be appropriate to the procedure concerned.

2.7 Abbreviations should never be used on consent forms.

2.8 Completed forms should be kept with the patient's medical notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and the relevant healthcare professional.

2.9 A patient's signature on a consent form does not prove that valid consent has been provided. If a patient has made a decision on the basis of inadequate information, or has not had sufficient time to make a decision, consent may not be valid. Conversely, if a patient has given valid verbal consent, the fact that they have not signed a consent form does not mean that consent is not valid. Patients may withdraw consent after they have signed a form; it is not a binding contract.

Standard consent forms – Consent Forms 1 and 2

2.10 There are two versions of the standard consent form:

- **Consent Form 1** for adults, young people or *Gillick* competent children
- **Consent Form 2** for parental consent for a child under 16 who is not *Gillick* competent

2.11 The consent forms have been designed to allow the patient to be given a copy in either Welsh or English. It is essential that the original top copy, which is in English, is the one filed in the patient's medical notes. See appendix A.

Form for patients aged 16 years and over who are unable to consent for themselves – Form 4

2.12 The standard consent forms (**Consent Forms 1 and 2**) should never be used for adult patients and young people who are unable to consent for themselves. Where an adult patient or young person does not have the capacity to give or withhold consent to a significant intervention, this should be documented in **Form 4** - Treatment in best interests: form for patients aged 16 years and over who lack capacity to consent to examination and treatment. See appendix A.

2.13 Although Form 4 is referred to as a consent form, it should be noted that no-one, other than a person who has authority under a Health and

Welfare LPA or a CAD for health and welfare decisions can give consent on behalf of an adult patient. If a person who has authority under a LPA or a CAD is giving consent then they should sign the appropriate section of Form 4. A copy of Form 4 should be offered to this person.

2.14 Form 4 requires healthcare professionals to document why the patient lacks the capacity to make this particular healthcare decision, and why the proposed treatment would be in his or her best interests, in accordance with the Mental Capacity Act 2005. Where the patient's family and friends have been consulted about the patient's wishes and feelings (in order to inform the determination of what is in the patient's best interests) the details of this discussion must also be recorded on the form. For further information regarding patients who lack mental capacity to give or withhold consent, see chapter 8 of this policy. For more minor interventions, this information should be entered in the patient's medical notes.

Patient information leaflet

2.15 Patients may find consent forms daunting or confusing and an explanatory leaflet "**About the consent form**" is available for patients with questions or concerns (Appendix E).

Availability of forms

2.16 Consent Forms 1 and 2 and Form 4 can be ordered via the 'Oracle' system.

Procedure/condition specific consent forms

2.17 Procedure specific consent forms may offer advantages for clinical practice and service organisations, providing standardised information about significant risks, benefits and alternative treatment(s). Space must be provided on these forms so that any additional material risks, which are specific to individual patients, can be recorded. The forms should also meet Welsh language requirements set down in the Welsh Language Act.

2.18 Where Clinical Boards determine that a customised consent form is necessary (e.g. for particular high volume procedures), they must abide by the following -

- Take responsibility for the design of the forms and paying for them. The forms must contain all the information included in the All-Wales template forms and replicate the format (i.e. triplicate forms –

English/Welsh/English). The guidance on use of the forms will need to be kept with the forms or printed on the cover of the pad of forms

- Before the forms are printed, they must be sent to the Mental Capacity Act Manager for review and approval
- The customised forms must then be formally approved at the Clinical Board's Quality, Safety and Experience meeting
- In the event of any dispute about the information on the forms, the Medical Director will arbitrate

3. When should consent be sought?

3.1 Outside an urgent setting, it is good practice to seek the patient's consent to the proposed procedure well in advance, so that there is time to respond to questions and provide adequate information for the individual patient to make a fully informed decision. Seeking consent should be viewed as a process rather than a one off event, reflecting a dialogue between the individual patient and the healthcare professional. The provision of information and related discussion are components of the shared decision-making process.

3.2 This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness and/or urgency of the situation. Healthcare professionals should take reasonable care to ensure that patients are made aware of all of the intended benefits, material risks and alternatives to the proposed treatment.

What is a "material risk"?

3.3 The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the healthcare professional is or should be reasonably aware that the particular patient would be likely to attach significance to it.

3.4 All clinical staff should have regard to the ruling in the case of Montgomery v Lanarkshire Health Board[2] given on 11th March 2015.

3.5 Following this Supreme Court ruling, healthcare professionals are reminded of their professional responsibility to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."

3.6 This standard of consent is similar to that required in GMC Guidance – *Good Medical Practice* 2013 – namely, work in partnership with patients. Listen to, and respond to their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patients' right to reach decisions with you about their treatment and care[3].

3.7 Healthcare professionals must be satisfied that:

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[2] https://www.supremecourt.uk/decided-cases/docs/uksc_2013_0136_judgment.pdf

[3] http://www.gmc-uk.org/guidance/good_medical_practice.asp

- The patient knows and understands all the material risks of the proposed treatment
- The patient is aware of all reasonable alternatives
- He/she has taken reasonable care to ensure that the patient understands all of the relevant information
- Valid exceptions to the duty to disclose apply

3.8 The three exceptions to the duty to disclose are:

- The patient tells the healthcare professional that he or she prefers not to know the risks
- The healthcare professional reasonably considers that telling the patient something would cause serious harm to the patient's health and wellbeing
- Consent is not required as the patient lacks capacity and urgent treatment is required

3.9 The Informed Consent Flowchart set out at the beginning of this document provides a useful reference guide for staff on the practical implications of the Montgomery case and is also available online[4].

Single stage process

3.10 In many cases, it will be appropriate for a healthcare professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient gives their consent, the procedure can go ahead immediately. Verbal consent will often be provided in this situation. This should be recorded in the patient's medical notes.

3.11 If a proposed procedure/treatment involves significant and important material risks for the patient concerned, it may be appropriate to seek written consent. Healthcare professionals should also consider whether the patient has had sufficient opportunity or time to process the information required for them to make the relevant decision.

Two or more stage process

3.12 In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure. This may be on just one occasion or it might be over a whole series of

[4] http://howis.wales.nhs.uk/sitesplus/documents/861/Legal%20and%20Risk%20-%20Montgomery%20flowchart.pdf

consultations with a number of different healthcare professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (verbal) decision, and the second being confirmation that the patient still wants to go ahead[5]. A careful record of the information provided and the related discussion with the patient should be detailed in the patient's medical notes. The consent form may be used as a means of recording the information stage(s), as well as the confirmation stage.

3.13 Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the consent form documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. However, if a form is signed before patients arrive for treatment, a member of the healthcare team (for example a nurse admitting the patient for an elective procedure) **must** check with the patient at this point whether they understand the procedure and the risks involved, whether they have any further questions or further concerns and whether their condition has changed. This is particularly important where:

- there has been a significant lapse of time between the form being signed and the procedure
- new information becomes available regarding the proposed intervention (for example, new evidence of risks or new treatment options)
- the patient's condition has changed significantly in the intervening period
- the patient's responsible clinician has changed since the form was signed

3.14 Similarly, if a patient is returning on multiple occasions for a course of treatment, a member of the healthcare team must check with the patient on each occasion that they still consent to the procedure. This confirmation of consent should be recorded on the consent form, or, if insufficient space, in the patient's medical notes.

3.15 When confirming the patient's consent and understanding, it is

[5] https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/consent-good-practice-guide/

advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with “tell me what you’re expecting to happen”, rather than “is everything all right?”

3.16 It should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient’s condition.

Postal consent

3.17 The patient’s consent may be obtained by post, as this may give the patient time to read and reflect on the consent form and information provided. However, any person carrying out a procedure must ensure, at the earliest opportunity following admission, that the patient has understood the information and that they still give their consent. If the patient has queries or concerns he or she must be given time to consider any additional information. It is important to remember that, whether a patient does or does not have capacity to consent, no relative or carer can sign on his or her behalf (unless in accordance with the MCA – see chapter 8 of this policy, or under parental responsibility, if the competent child or young person wishes the parent to take the decision for them).

3.18 Patients should not be given pre-operative sedation before being asked for their consent to proceed with treatment (although women in labour can consent to a caesarean section even if they have received sedation – see paragraph 17.2 of this policy). If a situation arises where a change to the consent form is required after the patient has received sedation, this should only be done if the doctor responsible for the patient’s care is clearly able to demonstrate that the patient still has capacity to be involved in the decision to make the required change. This must be documented in the patient’s medical notes. The outcome of the assessment, any changes made to the consent form and the reasons for the changes must also be clearly documented in the patient’s medical notes. If the patient does not have capacity due to the administration of sedation, any changes to the consent form should be delayed until capacity is regained (i.e. the effects of the sedation have worn off). If the urgency of the situation is such that a delay in undertaking the procedure would lead to harm to the patient, any decision that is made about continuing has to be made in the best interests of the patient. Best interests decisions and the reasons for them should be documented in the patient’s medical notes. Chapter 8 of this policy provides further guidance on assessing capacity and making best interests decisions.

Seeking consent for anaesthesia

3.19 Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and significant or material risks with the patient. In an elective setting it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient may not be able to make a considered decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in an outpatient setting, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is recorded in the anaesthetic record, the patient's medical notes or on the consent form. Where the healthcare professional providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

3.20 Where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has been provided all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

Emergencies

3.21 Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) may follow straight on from each other, and it may often be appropriate to use the patient's medical notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality and should still include benefits, significant and important (material) risks and alternatives relevant to the individual circumstances of the patient.

Treatment of children and young people

3.22 When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law and consider carefully whether the child or young person is competent to give his or her consent to the treatment. Chapter 7 of this policy provides further information.

Withdrawal of consent

3.23 A patient with capacity is entitled to withdraw consent at any time. Where a patient does object during treatment, it is good practice for the healthcare professional, if at all possible, to stop the procedure, establish the patient's concerns, and explain the consequences of not completing the procedure. If the patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately.

3.24 The healthcare professional should try to establish whether at that time the patient has capacity to withdraw consent. This is particularly important if the patient has been given sedation. If a patient lacks capacity, it may be justified to continue in the patient's best interests in accordance with the MCA.

3.25 If a sedated patient or one who otherwise lacks mental capacity to consent begins to struggle or resists treatment either verbally or physically, it is the responsibility of the healthcare professional to act in the patient's best interests. If this event occurs at a crucial time, which will have an impact on a successful outcome, then it would be wise to pause, attempt to regain co-operation and complete, perhaps with additional sedation. If the situation deteriorates, is irretrievable, and patient safety is likely to become compromised, then termination of the procedure is recommended. This must be recorded in the patient's medical notes.

3.26 For issues relating to withdrawal of consent by patients being treated in accordance with sections 57, 58 or 58A of the Mental Health Act, please refer to the *Mental Health Act 1983 Code of Practice for Wales*.

4. Provision of information

4.1 The provision of information is central to the consent process. Before patients can make an informed decision about their treatment, they need comprehensible information about their condition and any reasonable treatment options and their risks and benefits (including the risks/benefits of doing nothing). Patients also need to know the scope of the intended treatment and whether additional procedures are likely to be necessary, for example - blood transfusion or the removal of particular tissue.

4.2 Patients will differ in how much information they want about a proposed treatment. Some patients will want as much detail as possible, including details of rare risks, while others will ask healthcare professionals to make decisions for them. In such circumstances, the healthcare professional should explain the importance of understanding the significant risks and benefits of a recommended treatment, and making an informed decision. The *presumption* must be that the patient wishes to be well informed about the material risks and benefits of the various treatment options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented and the patient may be asked to sign the record to confirm their decision. It must be made clear to the patient that they can change their mind and have more information at any time.

Has the patient received sufficient information?

4.3 To give valid consent the patient needs to be provided with sufficient information to understand in broad terms the nature and purpose of the procedure. Information about any significant and material risks and benefits of the proposed treatment and any alternative options should be provided, including the option of no treatment. Any misrepresentation of these elements will invalidate consent. Where relevant, information about anaesthesia must be given (see paragraph 3.19 above) as well as information about the procedure itself.

4.4 The information provided should be tailored to the individual patient.

4.5 The use of patient information leaflets can help healthcare professionals to provide patients with the information they need, in order to arrive at an informed decision. Wherever possible patients should be sent information prior to their appointment so that they have time to read and absorb it, and can consider what questions they would like to ask when they meet with the relevant healthcare professional. This will help to ensure that they fully understand the treatment being

proposed and can make an informed decision regarding consent. However, the use of leaflets does not remove the healthcare professional's responsibility to provide a verbal explanation of often much the same information. In this context, the use of patient information leaflets is considered to be an example of best practice. The use and provision of the patient information leaflet should be documented on the consent form or in the patient's health records. A copy of the patient information leaflet should be inserted into the patient's health record. If an EIDO information leaflet has been used, its name, number and date can be documented.

4.6 Patient information in different formats and languages must be made available.

Communication Issues

4.7 A patient must not be assessed as lacking capacity to consent to the particular investigation, treatment or care merely because they have a limited ability to communicate. Care should be taken not to underestimate the ability of a patient to communicate, whatever their condition. Healthcare professionals should take all reasonable steps to facilitate communication with the patient, using communication aids as appropriate. Particular consideration should be given to the way in which information is presented to the patient. Drawings, diagrams and models may be useful for example. In emergency situations, taking these steps may not be possible, but good practice would be to record the reasons for this in the patient's medical notes.

4.8 Where appropriate those who know the patient well, including their family, friends, carers or staff from professional or voluntary support services, may be able to advise on the best ways to communicate with the patient.

Provision for Welsh speaking patients

4.9 Every effort should be made to ensure that the language preference of the patient is offered, established, recorded, acted upon and relayed to others within the UHB. Welsh must be treated no less favourably than English. Whenever possible discussions with Welsh speaking patients regarding consent should be conducted with Welsh speaking healthcare professionals.

For further information about the provision of Welsh language support, please see the Translation and Interpreter Services page of the intranet.

4.10 The All Wales consent forms (see chapter 2 of this policy) have been designed bilingually so that the patient can be given a copy in either English or Welsh. It is essential that the top copy, which is in English, is completed and added to the patient's medical notes. Availability of bilingual consent forms ensures that:

- Welsh and English versions of consent forms are equally accessible to patients
- both the patient and healthcare professional are clear about what is being agreed to in circumstances where a non-Welsh speaking healthcare professional is dealing with a Welsh speaking patient, and
- the needs of mixed-language families, other mixed-language audiences and Welsh learners are met

Provision for patients whose first language is not English or Welsh

4.11 This UHB is committed to ensuring that patients whose first language is not English or Welsh receive the information they need and are able to communicate appropriately with healthcare staff. This includes British Sign Language (BSL). In order to safeguard the consent process, unless the healthcare professional is fluent in the patient's language, an interpreter should always be used when seeking consent from the patient (except for minor, routine procedures).

4.12 It is not appropriate to use children or family members to interpret for patients who do not speak English.

For further information about the provision of language/communication support, please see the Translation and Interpreter Services page of the intranet.

Access to more detailed or specialist information

4.13 Patients may sometimes request more detailed information about their condition or a proposed treatment than that provided in general leaflets and every effort must be made to accommodate such a request.

Access to healthcare professionals between formal appointments

4.14 After an appointment with a healthcare professional, patients will often think of further questions which they would like answered before making a decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or wait until the date of an elective procedure, by which time it is too late for the patient to reflect upon the information.

Patients should be provided with appropriate contact details at the time of their appointment.

4.15 The provision of advice over the telephone needs to be undertaken by suitably qualified staff and must follow agreed guidelines, policies and procedures. Advice given must be evidence based and up to date. A record of the information given must be kept in the patient's medical notes. Where advice deviates from accepted guidance, the advice given must be clearly documented and the reasons for such deviation stated.

Open access clinics

4.16 Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need to give their consent before proceeding with an investigation or treatment.

Consent and inpatients

4.17 Irrespective of whether the patient is an inpatient or outpatient, the process of seeking consent must be adhered to. Just because a patient is already in a hospital bed, consent for examination and treatment cannot be assumed. As stated previously, the patient needs to be provided with sufficient time and information to understand in broad terms the nature and purpose of the procedure.

5. Who is responsible for seeking consent?

5.1 The healthcare professional carrying out the procedure is ultimately responsible for ensuring that the patient has given valid consent for the proposed treatment or procedure. He or she will be held responsible in law if the validity of consent is subsequently challenged.

5.2 Where verbal or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the healthcare professional responsible. However, team work is a crucial part of the way the NHS operates and, where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent e.g. providing information about the treatment or procedure.

Competence of those seeking consent

5.3 Consent must be obtained by a healthcare professional who is competent either because they themselves carry out the procedure or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit. Inappropriate delegation (e.g. where the healthcare professional seeking consent has inadequate knowledge of the procedure) may mean that the consent is not valid.

5.4 It is a healthcare professional's own responsibility:

- to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
- to work within their own competence and not to agree to perform tasks which exceed that competence

5.5 If you feel that you are being pressurised to seek consent when you do not feel competent to do so, please discuss this with your manager/supervisor/educational lead or the Patient Safety Team.

5.6 The Wales Deanery and the Welsh Government have made it clear that F1 doctors can only take consent in specific clinical situations where they have undertaken formal training and their competency has been assessed. Healthcare professionals are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary.

Completing consent forms

5.7 The standard consent form provides space for a healthcare professional to provide information to patients and to sign confirming that they have done so. The healthcare professional providing the information must be competent to do so.

5.8 If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a healthcare professional involved in their care on the day should sign 'Confirmation of Consent' section of the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

Attendance by students and trainees (i.e. pre-registration clinicians from any discipline)

5.9 Where a student or trainee healthcare professional is undertaking examination or treatment of the patient where the procedure will further the patient's care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the patient that the healthcare professional is a student, although it would always be good practice to do so and consent in the usual way will still be required.

5.10 In contrast, where a student proposes to conduct a physical examination which is not part of the patient's care, then it is essential to explain that the purpose of the examination is to further the student's training and to seek consent for that to take place. Verbal consent must be obtained and a record made in the patient's medical notes.

5.11 A patient's consent should be obtained when a student is going to be present during an examination or treatment purely as an observer. Patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment. Written consent must be obtained if students or trainees are going to be present during examination or treatment using sedation or anaesthetic.

5.12 Patients must be informed that they have the right to refuse consent to being observed, attended to or examined by students without any detrimental effect on their treatment.

5.13 It is essential that appropriate supervision of students is carried out in all of the above situations and that, where consent is required, the supervisor is reassured that valid consent has been obtained.

Attendance by company representatives

5.14 On occasions when company representatives need to be present for a procedure/treatment (e.g. where equipment is being used for the first time and the representative is there to assist with its use), written consent from the patient must be obtained.

6. Adults with capacity – refusal of treatment

Right to refuse treatment

6.1 An adult patient who has capacity can refuse any treatment, except in certain circumstances governed by the Mental Health Act 1983 (see chapter 14 of this policy). The following paragraphs apply primarily to adults. In determining whether a patient has capacity to make this decision the MCA must be applied. See chapter 8 of this policy.

6.2 An adult with capacity may make a decision which is based on their religious belief (e.g. Jehovah's Witnesses) or value system. Even if it is perceived by others that the decision is unwise or irrational, the patient may still make that decision if he or she has capacity to do so and it is a voluntary and informed decision. Any attempt to treat that patient against his or her wishes could amount to a criminal offence. It is the right of an adult patient with capacity to refuse treatment even if that refusal might result in their death. However in cases of doubt, healthcare professionals should always seek legal advice.

6.3 If, after discussion of possible treatment options, a patient refuses treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, the healthcare professional (and where possible the patient) should note this on the 'Patient has withdrawn consent' section of the consent form.

6.4 Where a patient has refused a particular intervention, the healthcare professional must ensure that he or she continues to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

6.5 If a patient consents to a particular procedure but refuses certain aspects of the intervention, the healthcare professional must explain to the patient the possible consequences of their partial refusal. If the healthcare professional genuinely believes that the procedure cannot be safely carried out under the patient's stipulated conditions, he or she is not obliged to perform it. They must, however, continue to provide any other appropriate care. Where another healthcare professional believes that the treatment can be safely carried out under the conditions specified by the patient, he or she must on request be prepared to transfer the patient's care to that healthcare professional.

6.6 Whilst a patient has the right to refuse treatment this does not mean

that they have the right to require a particular course of treatment.

Self harm and attempted suicide

6.7 Cases of self harm present a particular difficulty for healthcare professionals but the same law and guidance, as set out above, applies to treatment of these cases. Where the patient is able to communicate, an assessment of their mental capacity should be made as a matter of urgency.

6.8 If the patient is judged not to have capacity, decisions about their physical health treatment need to be made in accordance with the MCA (see chapter 8 of this policy). If treatment is required for their mental health, the MHA will apply. If a patient has attempted suicide and is unconscious, and there is insufficient time to undertake the usual best interests decision making process then he or she should be given emergency treatment unless the healthcare professional is satisfied that an advance decision to refuse treatment exists which is valid and applicable to the life-sustaining treatment in these circumstances.

6.9 Adult patients with capacity do have the right to refuse life-sustaining treatment, both at the time it is offered and in the future even if the healthcare professional believes that the patient's decision is unwise. If a patient with capacity has harmed themselves and refuses treatment, it may be appropriate to consider obtaining a psychiatric assessment. Unless the adult patient with capacity is detained under the Mental Health Act 1983 and the treatment is for, or a symptom of, a mental disorder, then their refusal must be respected although attempts should be made to encourage him or her to accept help and healthcare professionals should consult legal advisers.

Patients who refuse blood or blood components (e.g. Jehovah's Witnesses)

6.10 The same legal principles apply to any patient who refuses treatment whether they do so out of religious convictions or otherwise. No patient should be considered to be likely to refuse blood products merely on the basis of their religion. Every patient needs to be asked and informed individually.

Further information on Jehovah's Witness Patients

6.11 It is important to remember that not all Jehovah's Witnesses refuse blood products. Most practising Jehovah's Witnesses who do will carry with them a clear, signed and witnessed advance decision card prohibiting blood transfusions and releasing clinicians from any liability

arising from this refusal. If an applicable and valid advance decision is produced, then this should be acted upon. If the patient does not have capacity and a valid and applicable advance decision cannot be produced, the clinical judgement of a doctor should take precedence over the opinion of relatives or associates.

6.12 Further information can be found at the following:

- Royal College of Surgeons (2016) Caring for patients who refuse blood: a guide to good practice for the surgical management of Jehovah's Witnesses and other patients who decline transfusion
- Association of Anaesthetists of Great Britain and Ireland, 2nd Edition, (2005) *Management of Anaesthesia for Jehovah's Witnesses*
- Hospital Information Services for Jehovah's Witnesses (2005) *Care plan for women in labour refusing a blood transfusion*
- UK Blood Transfusion and Tissue Transplantation Services (http://www.transfusionguidelines.org.uk/index.asp?Publication=BBT&Section=22&pageid=510 *Better Blood Transfusion Toolkit: Appropriate Use of Blood: Pre-operative Assessment – Jehovah's Witnesses*
- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee chapter 12: Management of patients who do not accept transfusion

6.13 Further information or advice on the clinical management of this group of patients can be obtained from:

- A Consultant Haematologist within the UHB
- The local Hospital Liaison Committee for Jehovah's Witnesses

7. Treatment of children and young people

7.1 When treating or caring for children and young people, healthcare professionals should take account of chapter 5 of the Guide.

Children or young people with capacity to consent to treatment

7.2 When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law.

7.3 Careful consideration should be given to whether the child is competent to give his or her consent to the specified treatment. A child under the age of 16, who has sufficient maturity and intelligence to be capable of understanding the treatment and making a decision based on the information provided (*Gillick* competent) will have capacity to consent to treatment and care. If a competent child consents to treatment a parent cannot over-ride that consent. As with adults, consent will only be valid if it is given voluntarily by an appropriately informed patient who has capacity to consent to the particular treatment.

7.4 Young people aged 16 or 17 with capacity are assumed in law to be competent and can give consent for their own treatment. If a 16 or 17 year old consents to treatment a parent cannot over-ride that consent. This applies equally to young people with capacity who are to be admitted (informally) to hospital for treatment for a mental disorder.

7.5 It is not a legal requirement but it is advisable to include the child/young person's family in discussions regarding treatment. However, this can only be done with the consent of the child/young person.

See Appendix D for guidance on assessing whether a child is *Gillick* competent.

Children who are not competent to consent to treatment

7.6 If the child is not competent to give consent, then the healthcare professional may give treatment on the basis of parental consent. Parental consent may be given by any person who has parental responsibility for the child, provided that person has capacity to give such consent. This may not necessarily be the parents but, for convenience, "parents" in this policy means all persons with parental responsibility.

7.7 Healthcare professionals need to make reasonable enquiries as to who

holds parental responsibility for the child. Every effort should be made to include all those with parental responsibility in discussions regarding treatment options.

7.8 Not all parents have parental responsibility for their children. For example, unmarried fathers do not automatically have such responsibility - but they can acquire it. If you have any doubt about whether the person with the child has parental responsibility for that child, you must check. The Children Act 1989 (which applies to both children and young people) sets out the persons who may have responsibility for a child.

7.9 Parental responsibility is vested in:

- the mother automatically on the birth of the child
- the father if his name has been registered on the child's birth certificate (this only applies to births from 1st December 2003)
- the father/partner when he/she is married to the mother at the time of the birth
- an unmarried father can acquire parental responsibility in the following ways:-
    - by jointly registering the birth with the mother (only applies to births from 1st December 2003)
    - by entering into a Parental Responsibility Agreement with the mother
    - by applying to the courts for a Parental Responsibility Order
    - by being appointed as guardian either by the mother or the court (although he will usually only assume parental responsibility upon the mother's death)
    - by obtaining a residence order
    - by marrying the mother and agreeing with her that he will assume parental responsibility
    - marrying the mother and upon his application to the court
    - by adopting the child
- legally appointed guardian
- a person who has been granted a residence order in respect of the child
- a step-parent who has entered into a Parental Responsibility Agreement with the mother

- a local authority in whose favour a care order has been made[6]
- a person who has been granted an emergency protection order
- an adopter of a child in accordance with section 46 of Adoption and Children Act 2002
- a husband and wife in whose favour a parental order has been made under section 30 of the Human Fertilisation and Embryology Act 1990
- an adoption agency in accordance with section 25 of the Adoption and Children Act 2002
- the court in wardship procedures
- some same-sex partners in certain situations

7.10 If you are in any doubt about whether a person has parental responsibility or whether a parent is acting in the best interests of the child you should seek legal advice.

7.11 Consent is usually only needed from one person holding parental responsibility. However there have been legal cases where the Court has advised that all parties with parental responsibility must give consent; if consent cannot be agreed an order from the Family Division of the High Court must be obtained. Those cases have included:

- sterilisation for contraceptive purposes
- non-therapeutic male circumcision
- hotly contested issues of immunization

7.12 Where consent is being given on behalf of a child who is not competent to consent, the healthcare professionals, the child and the person with parental responsibility must meet to discuss and consider treatment options. This is particularly important if more than one person has parental responsibility for a child.

7.13 When children who are not competent to give consent are being cared for in hospital, it may not seem practicable to seek the consent of the parents on every occasion for every routine intervention such as blood or urine tests or X-rays. However, healthcare professionals should remember that, in law, such consent is required, although consent may be given in advance. Where a child is admitted, the healthcare professional should discuss with the parents what routine procedures

[6]Care should be sought as a Local Authority has the power to restrict the parental responsibility of the parents in relation to health care. It should always be established who has parental responsibility when an order is made and in what circumstances the parental responsibility can be exercised.

will be necessary, and, if it is not practicable to seek consent for every intervention, they may ask the parents if they are content to give their consent in advance for these routine procedures. If the parents are not content to give their consent, then consent should be obtained on every occasion. The parents may specify that they wish to be asked before particular procedures are initiated. You must then do so, unless the delay involved in contacting them would put the child's health at risk.

7.14 It is important to be aware that neither an Emergency Protection Order (EPO) nor a Police Protection Order (PPO) confers the consent for examination. If the person who has parental responsibility is not available, consent with directions, must be obtained from the Family Division of the High Court.

7.15 A healthcare professional must not rely on the consent of a parent if he or she has any doubts about whether the parent is acting in the best interests of the child. In order to consent on behalf of a child, the person with parental responsibility must also have mental capacity themselves.

7.16 For forensic examinations different rules may apply.

Young people (age 16 and 17 years) without capacity to consent to treatment

7.17 Healthcare professionals must follow the Mental Capacity Act when the young person lacks capacity to decide about treatment.

Children who are competent or young people (aged 16 or 17) with capacity who refuse treatment

7.18 Healthcare professionals should be very careful in cases where a young person or child refuses treatment. Such cases can be controversial and raise complex legal issues. Healthcare professionals should have particular regard to chapter 3 of the Guide. Please contact the Mental Capacity Act Manager/Patient Safety Team in the first instance.

7.19 Where a young person of 16 or 17 who has capacity, or a child under 16 who has been assessed as *Gillick* competent, refuses treatment, a person with parental responsibility for the child / young person or the Courts can be used as alternative sources of consent. In such circumstances legal advice should be sought. See Appendix C.

7.20 Where a child has refused treatment, and a decision is made to give

treatment on the basis of parental consent, it must be exercised on the grounds that the welfare of the child is paramount. The psychological effect on the child of having their decision over-ruled must also be considered.

7.21 Where a young person aged 16-17 who has capacity is to be admitted to hospital for treatment for a mental disorder, the MHA provides that where that person refuses to be admitted to hospital for treatment for a mental disorder, a person with parental responsibility for that person cannot overrule that refusal. The MHA should be used where appropriate.

Person with parental responsibility refusing treatment

7.22 If consent for treatment is refused by one or more of those with parental responsibility, or where an agreement cannot be reached between the persons with parental responsibility, seek legal advice. See Appendix C.

Young people aged 16 and 17 who refuse life-sustaining treatment

7.23 Where a young person aged 16 or 17 refuses life-sustaining treatment (e.g. a blood transfusion on the basis of their religious conviction) healthcare professionals should exercise extreme caution. In these circumstances, legal advice should be sought and, if necessary, the matter should be referred to the court. See Appendix C

7.24 The management of a young person in an emergency situation, who is likely to die or suffer serious permanent harm without immediate treatment, is viewed in law in a different light. There may not even be time for emergency application to the court. Senior clinicians may decide to treat without consulting the court. Parents may not prevent clinicians from administering treatment to their children if their child's life or health is in imminent danger. This includes cases where the parents wish to refuse blood products for their child on religious grounds. Staff may rely on the support of the courts to endorse decisions that are taken in good faith and in the best interests of the young person concerned. It is important, however that two doctors of consultant status should make an unambiguous, signed and dated entry in the patient's medical notes that the treatment is essential to save life or prevent serious permanent harm. The doctor who stands by and allows a 'minor' patient to die in circumstances where treatment might have avoided death may be vulnerable to criminal prosecution.

7.25 The courts have often commented that such a situation does not detract from the loving and responsible reputation of the parents

involved, and they have stressed the need for parents to be fully informed of the clinical developments regarding their child and of the intended action by clinicians.

7.26 When treating children or young people in these circumstances, healthcare professionals should consider carefully the guidance in chapter 5 of the Guide.

Parents refusing life-sustaining treatment for a child

7.27 Where a parent or parents intend to refuse life-sustaining treatment for a child under the age of 16, staff must always seek legal advice (see Appendix C). The well-being of the child is paramount and, if the parents refuse to give permission for the treatment, it may be necessary to apply for a court order to administer the treatment lawfully. Healthcare professionals should note that a court order can be obtained out of hours when necessary.

Emergency treatment

7.28 A life threatening emergency may arise in connection with a child when consultation with either a person with parental responsibility or the court is impossible, or the persons with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of that child. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health.

8. Patients who lack capacity to give or withhold consent

8.1 In determining whether a patient aged 16 years and over lacks the mental capacity - either temporarily or permanently - to give or withhold consent for themselves, healthcare professionals must act in accordance with the Mental Capacity Act 2005. A patient who lacks capacity can be given treatment if it is in their best interests, as long as the patient (when aged 18 years and over) has not made a valid and applicable advance decision refusing that specific treatment.

8.2 When treating patients who may lack capacity, healthcare professionals must have due regard for the MCA Code of Practice.

Does the patient have capacity?

8.3 The MCA applies in relation to determining whether a patient has capacity to give their consent. It is a key principle of the MCA that a patient is assumed to have capacity to make decisions for themselves unless it is established on the balance of probabilities that they do not.

8.4 In ascertaining a patient's capacity, the healthcare professional must not make a judgment on the basis of the patient's age, appearance, assumptions about their condition or any other aspect of his or her behaviour. It is important to take all possible steps to try and help the patient make a decision for themselves (see chapter 3 of the MCA Code of Practice). Where there is doubt about a patient's capacity, an assessment must be carried out and the healthcare professional must be able to justify their conclusions.

8.5 It is the healthcare professional proposing treatment or examination who should assess the patient's capacity to consent. More complex decisions are likely to need more formal assessments, which may include a professional opinion (for example from a speech and language therapist/psychologist), but the final decision about the patient's capacity must be made by the person intending to carry out the action.

8.6 Healthcare professionals who carry out actions related to the care and treatment of patients who lack capacity to consent to them at that time may be protected from liability if they reasonably believe (having assessed the patient's capacity where there is doubt) that the patient lacks capacity to make that particular decision at the time it needs to be made and the action is in the patient's best interests. (For further guidance see chapter 6 of the MCA Code of Practice and note that the

MCA imposes limitations on acts which can be carried out with protection from liability – including where there is inappropriate use of restraint or where the patient who lacks capacity is deprived of their liberty).

8.7 A patient lacks capacity if he or she is unable to make a specific decision for themselves in relation to a matter at the time it needs to be made because they have an impairment or disturbance of the mind or brain. This impairment or disturbance can either be temporary or permanent.

8.8 The MCA provides that a patient with an "impairment or disturbance" is unable to make a decision if they are unable to do one or more of the following:

a) understand the information relevant to the decision; or
b) retain that information; or
c) use or weigh that information as part of the process of making the decision; or
d) communicate his or her decision, whether by talking, using sign language or any other means

8.9 If a patient cannot do one or more of these as a result of their impairment they will be treated as being unable to make the decision. Point d) only applies in situations where the patient cannot communicate their decisions in any way.

8.10 The British Medical Association has published advice on the assessment of capacity - www.bma.org.uk/

8.11 Capacity should not be confused with a healthcare professional's assessment of the reasonableness of the patient's decision. The patient is entitled to make a decision which is based on their own religious belief or value system, even if it is perceived by others to be unwise or irrational.

8.12 Where there is any doubt about a patient's capacity to make a particular decision, after support has been provided without success, an assessment must be carried out. This should be done in accordance with the requirements of the MCA and the assessment must be recorded e.g. using Form 4.

8.13 An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. The healthcare professional undertaking the assessment of capacity is required by the MCA to take all practicable steps to help the patient make the decision, therefore they should involve appropriate

colleagues, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal formats where appropriate.

Advance decisions to refuse treatment (ADRT)

8.14 In accordance with the MCA, a person who is 18 or over and has capacity can make an ADRT. An ADRT may be withdrawn or altered at any time whilst the person has capacity.

8.15 Any ADRT that is valid and applicable to the treatment that is proposed is legally binding. A healthcare professional must follow a valid and applicable ADRT. If they do not, they could face criminal prosecution and or civil liability.

8.16 A valid and applicable ADRT that is made after a Health and Welfare LPA overrules the decision of any Attorney.

8.17 If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder, a healthcare professional may still give that treatment to the patient if he or she has authority to do so under Part 4 and 4A of the MHA and consent is not required. Informal patients are not covered by Part 4 of the MHA and their advance decisions refusing treatment are enforceable if valid and applicable.

Validity of an ADRT

8.18 An ADRT is valid if made voluntarily by an appropriately informed adult (aged 18 years or over) with capacity.

8.19 An ADRT is **not** valid if the individual:

a) was under 18 years of age when it was drawn up; or
b) did not have capacity when the decision was made; or
c) was acting under duress; or
d) has withdrawn the advance decision (verbally or in writing) at a time when he/she had capacity to do so; or
e) has done anything else clearly inconsistent with the ADRT remaining his fixed decision; or
f) creates a LPA after the date when the ADRT was made, conferring authority on the attorney to give or refuse consent to the treatment to which the ADRT relates.

8.20 Healthcare professionals should ensure that the ADRT that is being considered has been regularly reviewed and updated. However, ADRTs made long in advance of incapacity are not necessarily invalid unless, for example, there are reasonable grounds for believing that circumstances have since arisen which mean the patient would have changed their mind if they still had capacity. For example, there may be a medical advancement which the patient was unaware of at the time he or she made the advance decision, which could significantly improve their condition.

8.21 There are no specific legal requirements concerning the format of an ADRT (unless it involves life-sustaining treatment – see below). It may be a written document, a witnessed verbal statement, a signed printed card, a smart card, or a note of discussion recorded in a patient's health record. Although there is no legal requirement, if possible patients should be encouraged to put their ADRT in writing so that there is a clear record of their wishes.

8.22 If an ADRT relates to refusal of life-sustaining treatment, it will only be valid if it is in writing, contains the words 'even if life is at risk' (or words to that effect) and is signed, dated and witnessed.

Applicability of an ADRT

8.23 An ADRT must clearly specify the treatment that is being refused and in what specific circumstances it applies. It must be unambiguous and applicable to present circumstances. If the decision to be made falls outside of the scope of the ADRT, it will not be applicable.

8.24 An ADRT cannot authorize anyone to do anything which is unlawful (for example assist an individual in committing suicide), or make anyone carry out a particular treatment.

Responsibility of healthcare professionals

8.25 It is the responsibility of the person making the ADRT to ensure that it will be drawn to the attention of healthcare professionals when it is needed. However, healthcare professionals are also responsible for asking patients or their representatives about the existence of ADRT.

8.26 If a healthcare professional knows or has reasonable grounds to believe that an ADRT exists, and time permits, then they should make reasonable enquiries regarding its existence and content. Emergency treatment should not be delayed in order to look for an ADRT if there is no clear indication that one exists.

8.27 If an ADRT relates to refusal of life-sustaining treatment, then the healthcare professional must see a written, signed and witnessed ADRT which contains the words 'even if life is at risk' (or similar).

8.28 A healthcare professional will not be acting unlawfully if he or she treats a patient and is genuinely unaware of the existence of an ADRT. Similarly they will not act unlawfully if they act in accordance with an ADRT that they believe is valid and applicable at the time but is later proved to be invalid/ not applicable.

8.29 If there is any doubt about the validity or applicability of an ADRT it may be necessary to refer the matter to the Court of Protection (CoP). In this situation, healthcare professionals may provide life-sustaining treatment or treatment that prevents serious deterioration in the patient's condition whilst the decision of the court is awaited.

8.30 If an ADRT is not valid and applicable, it should still be noted as an expression of the patient's feelings and wishes about what should happen to them, and should be taken into account in deciding what is in their best interests.

Advance statements

8.31 An advance statement is different to an advance decision to refuse treatment in that it generally outlines a patient's wishes or preferences in relation to care or treatment that they want to have, as opposed to being a refusal of treatment. Although an advance statement is not legally binding it should be noted as an expression of the patient's feelings and wishes about what should happen to them if they lack capacity to decide for themselves, and should be taken into account in deciding what is in their best interests.

8.32 Some advance statements will express the patient's wishes that a particular course of action should be taken or that they should receive a particular type of treatment in the event that they no longer have capacity. The healthcare professional is not under a legal obligation to provide treatment because the patient demands it. The decision to treat is ultimately a matter for his or her professional judgment acting in the context of a best interests decision. In making that decision the healthcare professional will, however, be required to take into account the patient's wishes as expressed in determining what is in his or her best interests.

8.33 Further information about ADRT is available in chapter 9 of the MCA *Code of Practice*.

Decisions made in the patient's best interests

8.34 In determining what is in the patient's best interests, the healthcare professional must look at the patient's circumstances as a whole and not just at what is in the patient's best medical interests. They must try to work out what the patient would have wanted if he or she had capacity, rather than what that professional believes to be in his or her best interests. The healthcare professional must make all reasonable efforts to ascertain:

- the patient's past and present wishes and feelings
- any beliefs and values that would be likely to influence the patient's decision, and
- any other factors that the patient would be likely to consider if they were making the decision

8.35 Lack of capacity to make the decision in question will not automatically mean that the patient is unable to participate in the decision making process, and every assistance should be given to enable him or her to do so.

8.36 A healthcare professional must not make assumptions about someone's best interests simply on their age, appearance, condition or behaviour. They should also consider whether the patient is likely to regain capacity and if so whether the decision can be deferred.

8.37 They must also, so far as is practicable, consult representatives of the patient to see if they have any information about the patient's wishes, feelings, beliefs and values. In particular, they should try to consult:

- any unpaid person who is named by the patient as a person who should be consulted on such matters
- anyone engaged in caring for the patient or interested in his welfare
- any person who has been granted a LPA by the patient; and
- any deputy appointed for the patient by the CoP to make decisions for that patient

8.38 The purpose of consulting is to ascertain what the patient would have wanted if they had capacity, not what the persons consulted believe should happen. Where a patient has made a Health and Welfare LPA or a deputy of the CoP (for personal welfare) has been appointed, and if it is within their authority, it will be for the attorney or deputy to make the decision on the patient's behalf. However, they too must act in the patient's best interests and, where practicable and appropriate, consult the people indicated above.

8.39 If a patient has no one who can be consulted, healthcare professionals must consider whether the circumstances are such that an Independent Mental Capacity Advocate (IMCA) should be instructed (see below).

8.40 If the patient has made an advance statement (other than a valid and applicable ADRT), then the healthcare professional should still take that statement into account in deciding what is in the patient's best interests, as it is a reflection of the patient's wishes and feelings. However, if it is the healthcare professional's judgment that to act in accordance with the advance statement would not be appropriate and not in the patient's best interests, he or she is not bound to do so.

Temporary incapacity

8.41 Patients may suffer a temporary loss of capacity, for example, where they are under a general anaesthetic or sedation, or unconscious after a road accident. As with any other situation, an assessment of that patient's capacity must only examine their capacity to make a particular decision when it needs to be made. Unless the patient has made a valid and applicable ADRT of which you are aware, then they may be treated insofar as is reasonably required in their best interests pending recovery of capacity. This will include, but is not limited to, routine procedures such as washing and assistance with feeding. If a medical intervention is thought to be in the patient's best interests but can be delayed until the patient recovers capacity and is able to consent to (or refuse) the intervention, it must be delayed.

Fluctuating capacity

8.42 It is possible for a patient's capacity to fluctuate. In such cases, it is good practice to establish whilst the patient has capacity their views about any clinical intervention that may be necessary during a period of incapacity and to record these views. The patient may wish to make an advance decision to refuse certain types of treatment (see paragraphs 8.14 to 8.30). If the person does not make a relevant ADRT, the patient's treatment when incapacitated should accord with the principles for treating the temporarily incapacitated (see above).

Lasting Power of Attorney (LPA)

8.43 LPA was introduced by the MCA. An LPA may be executed by any person of 18 years or over whilst they have capacity and takes effect when they no longer have capacity. A Health and Welfare LPA appoints a person to act as an attorney to make decisions about a

person's welfare and medical treatment when that person lacks the capacity to make that particular decision. The attorney acting under a Health and Welfare LPA must make the decision in the person's best interests. The LPA must be registered with the Office of the Public Guardian (OPG) before it can be used and it is essential that healthcare professionals see the sealed (OPG stamp) LPA document to confirm that it has been registered, and to assure themselves of the authority that it confers on Attorney(s). An LPA does not authorise an attorney to refuse or give consent to life-sustaining treatment unless this is explicitly stated in the LPA. If two or more people have been appointed as attorneys, they may either be appointed to act jointly or jointly and severally. If they are acting jointly, any decision must be made by consensus. However if they are acting jointly or severally, then either of the attorneys can make a decision independently of the other.

8.44 If the patient has made a valid and applicable ADRT to refuse treatment, then this can be overridden by an attorney providing that the LPA was made after the advance decision and his or her authority under the LPA extends to making decisions about treatment that is the subject of the advance decision. An attorney, like any person who is making a decision on behalf of a patient who lacks capacity, must act in accordance with the MCA and must have regard to the MCA *Code of Practice*.

8.45 When acting on the basis of a decision by an attorney, a healthcare professional should, so far as is reasonable, try to ensure that the attorney is acting within their authority. Any disputes between a healthcare professional and an attorney that cannot be resolved, or cases where there are grounds for believing that the attorney is not making decisions that are in the best interests of the patient, should be referred to the CoP.

Court Appointed Deputies (CAD)

8.46 Whilst a decision made by the Court is always preferred, the MCA now provides that the Court can appoint deputies to make decisions on its behalf. This may be necessary if there are a number of difficult decisions to be made in relation to the patient. The CAD will normally be a family member, partner, friend or person who is well known to the patient. Healthcare professionals must always ensure that they see a sealed (CoP stamp) copy of the deputyship order so that they are clear what authority the CAD holds.

8.47 As with attorneys appointed under a LPA, a CAD may only make decisions where they have reasonable grounds to believe that the

person they are acting for does not have capacity, and any decisions they take will be strictly limited to the terms specified by the Court and in accordance with the MCA. A CAD is also subject to a number of restrictions in the exercising of their powers. For example, a CAD cannot refuse consent to the carrying out or continuation of life-sustaining treatment for the patient, nor can he or she direct a person responsible for the patient's healthcare to allow a different person to take over that responsibility**.** A deputy cannot restrict a named person from having access to the patient.

8.48 Healthcare professionals should co-operate with the CAD with the aim of doing what is best for the patient. Where a CAD acting within their authority makes a decision that a treatment (that is not life-sustaining) should be withheld or withdrawn the healthcare professional must act in accordance with those instructions. However a CAD cannot require a healthcare professional to give a particular type of treatment, as this is a matter of clinical judgement. In such cases where a healthcare professional has declined to give treatment, then it is good practice to seek a second opinion, although the CAD cannot insist that the healthcare professional steps aside to allow another professional to take over the case. A CAD is supervised by the OPG, and where a healthcare professional suspects that a deputy is not acting in the best interests of the patient, he or she should refer the matter to the Public Guardian.

8.49 A valid and applicable ADRT overrules the decision of the CAD.

Independent Mental Capacity Advocates (IMCA)

8.50 If a patient aged 16 years or older who lacks capacity is to receive serious medical treatment, and that patient has no one else to consult and support them other than paid or professional staff, then unless a decision has to be made urgently (e.g. to save the person's life), an IMCA must be instructed. The duty to instruct rests with the Health Board in the case of treatment provided in hospital. (Note that there are other situations when an IMCA must be instructed – e.g. decisions about whether to place people into accommodation (for example, a care home or a long stay hospital and under the Deprivation of Liberty Safeguards.)

8.51 The role of the IMCA is to represent and support the patient. They will not make decisions on the patient's behalf. Such decisions will still be made by the healthcare professional on the basis of what is in the patient's best interests. However the IMCA will speak to the patient and, so far as possible, try to engage them in the decision process. They will assist in determining what is in the patient's best interests and

the healthcare professional must take into account the views of the IMCA in deciding what actions to take. The IMCA is entitled to information about the patient and to see his or her relevant health records.

8.52 Where serious medical treatment is proposed, they will discuss with the professional the proposed course of treatment or action and any alternative treatment that may be available and may, if they consider it necessary, ask for a second medical opinion.

8.53 Serious medical treatment for this purpose means treatment which involves providing, withdrawing or withholding treatment in circumstances:

- where there is a fine balance between the benefits and burdens the treatment would have on the patient and taking into account the likely risks, or
- where there is a choice of treatments, a decision as to which one to use is finely balanced, or
- what is proposed would be likely to involve serious consequences for the patient

Referral to the Court of Protection

8.54 Where there are difficult or complex decisions to make on behalf of a patient who lacks capacity, the matter must be referred to the Court of Protection if all other options for making the decision or resolving differences have been exhausted.

8.55 The Court of Protection can deal with any matters covered by the Mental Capacity Act 2005, such as:

- whether the patient has capacity to make a particular decision
- whether an ADRT is valid and applicable
- what course of action/decision would be in a patient's best interests
- where there is a dispute between healthcare professionals, members of the family, partners, carers or any other interested persons such as an Independent Mental Capacity Advocate or the attorney of a Lasting Power of Attorney about what is in the patient's best interests
- where there is doubt about whether the patient lacks capacity to make a decision for themselves and is not likely to regain capacity in the short term
- where treatment of an experimental nature is proposed

8.56 Where a patient lacks capacity then ***a referral to the Court must be made*** in the following circumstances:

- where it is proposed that the patient should undergo non-therapeutic sterilisation (e.g. for contraceptive purposes)
- cases involving organ or bone marrow donation by a patient who lacks capacity to consent
- where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and, for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests, or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both persistent vegetative state (PVS) and minimally conscious state (MCS)
- where there are doubts or a dispute about whether a particular treatment would be in the best interests of the patient

This is not an exhaustive list and the courts may extend the list of procedures that should always be referred. Legal advice should be sought.

8.57 In cases of PDOC, if

- the MCA, MCA *Code of Practice* and regulatory framework are observed correctly
- there is agreement as to what is in the patient's best interests
- a second independent clinical opinion is available which supports the best interests decision and that the clinical decision to withdraw CANH is reasonable in the circumstances, given the diagnosis

then life sustaining treatment (including CANH) can be withdrawn /withheld without the need to make an application to the court. The second clinical opinion should be sought from a consultant with experience of PDOC, who has not been involved in the patient's care and who should, so far as reasonably practical, be external to the UHB. The consultant should examine the patient and review the patient's medical notes and the information that has been collected. Healthcare professionals should make a very detailed clinical record (covering many specified matters) and also full note of all discussions, meetings and reasons for decisions reached. Legal advice can be sought to support the decision.

8.58 The Court has held that therapeutic abortion and sterilisation where there is a medical necessity does not automatically require a referral,

although such procedures can give rise to special concern about the best interests and rights of a patient who lacks capacity. In the case of a patient with learning disabilities, it is good practice to involve a learning disability consultant psychiatrist, the multidisciplinary team and the patient's family/partner as part of the decision-making process and to document their involvement. Less invasive or reversible options should always be considered before permanent sterilisation.

8.59 Appendix C provides advice for healthcare professionals who need legal advice when they are faced with a situation that may require the intervention of the Court of Protection. Guidance on referring matters to the Court of Protection has also been issued by the General Medical Council and the BMA.

http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp
https://www.bma.org.uk/advice/employment/ethics/mental-capacity/mental-capacity-toolkit/12-court-of-protection-and-court-appointed-deputies

8.60 Where an adult or young person has been assessed to lack the capacity to give or withhold consent to a significant intervention, this fact should be documented on Form 4: Treatment in best interests (see chapter 2 of this policy) along with full details of the assessment of capacity and best interests.

9. Human Tissue

Removal, storage and use of human tissue

9.1 The Human Tissue Act 2004 (HTA 2004) makes consent the fundamental principle underpinning the lawful retention and use of body parts, organs and tissue from the living or deceased for specified health related purposes and public display. Human tissue is defined as material which has come from a human body and consists of, or includes human cells. Live gametes and embryos are excluded as they are regulated under the Human Fertilisation and Embryology Act 1990 (HFEA).

9.2 *The Human Tissue Act Codes of Practice and Standards* issued by the Human Tissue Authority (HTA) contain detailed provisions on consent to the storage and use of relevant material from the living and the deceased. The Codes and Standards can be found on the following link. https://www.hta.gov.uk/hta-codes-practice-and-standards-0

9.3 The HTA 2004 creates an offence of DNA theft. It is unlawful to obtain and store human tissue with the intention of its DNA being analysed, without consent of the patient from whom the tissue was obtained.

9.4 The HTA 2004 allows material taken from the living to be stored and used without consent for the following scheduled purposes on the basis that these are bound up with the general provision of clinical and diagnostic services:

- clinical audit
- education or training relating to human health
- performance assessment
- public health monitoring and
- quality assurance

9.5 However, if a patient actively objects to the use of their samples for such purposes, then that objection should be complied with. The Act and the Code contain a complex set of rules around the need for consent being required for the above purposes if the tissue is removed after death. There is also a set of rules about relevant material taken from a patient in their lifetime continues to be treated as such after death. It is the point at which the material is removed that determines how it is affected by the Act. The Code refers to concepts such as nominated representatives and qualifying relationships for the purpose of consent. It is too detailed to quote fully here and it should be consulted where relevant decisions need to be made.

9.6 Consent is required to store and use tissue removed from the living for:

- obtaining scientific or medical information about a patient which may be relevant to any other person (now or in the future)
- public display
- research into disorders, or the functioning of the human body and
- transplantation

9.7 The system must be well-publicised and transparent, making provision for patients to record their consent or objection to the use of such tissue and for this to be notified to the laboratory. Patients must also be able to record any objections to particular uses or use of particular tissues.

9.8 Written consent must be obtained from the patient either at the time of their procedure, or retrospectively, to indicate whether or not they give their consent to the use of removed tissue for a specific research project.

Consent to post mortem examinations

9.9 The Bereavement Intranet Page should be referred to for necessary details.

9.10 If a post mortem examination is ordered by the coroner, the consent of relatives is not required.

9.11 Other post-mortem examinations are hospital post-mortem examinations which are usually carried out at the request of doctors who have been caring for the patient or, sometimes, at the request of close relatives wishing to find out more about how a patient died. In some circumstances it may be appropriate to limit the examination to a particular region of the body.

9.12 All post mortems are carried out under an HTA licence held by the Health Board. It is a requirement of the HTA 2004 that appropriate consent is taken before a post-mortem can be carried out or any other tissue removed from the body of a deceased person. This consent must be obtained from a person in a "qualifying relationship" (see also above). The request for a hospital post-mortem should be made by the clinician who, after discussions, will liaise with the appropriate persons to ensure all statutory requirements are met.

9.13 For further information on post mortems the *Human Tissue Authority Code of Practice – Post Mortem Examination (Code 3, 2009)* should be consulted. For further information on retention of tissues, organs and

body fluids, please seek advice from the pathologist.

Transplantation - living Donation

9.14 The HTA is responsible for the regulation, through a system of approvals, of the donation from living people of solid organs, bone marrow and peripheral stem cells for transplantation into others. Information on the legal requirements is available - https://www.hta.gov.uk/

Transplantation - deceased organ donation

9.15 Consent to organ donation in Wales is governed by the Human Transplantation (Wales) Act 2013. There is an associated Code of Practice - https://www.hta.gov.uk/sites/default/files/HTA_CoP_on_Human_Transplantation_(Wales)_Act_2013_-_Final_-_May_2014.pdf. This system operates on the basis of deemed consent; it is assumed that the individual had no objection to organ donation unless they have registered or expressed a decision not to donate their organs following their death. Patient representatives should be consulted to obtain any evidence that a patient did not wish to be an organ donor.

9.16 Express consent to organ donation is required where a patient has not been an ordinary resident in Wales for more than 12 months before dying.

10. Clinical photography, video recordings and audio recordings

Making and using visual or audio recordings of patients

10.1 This chapter focuses on the consent aspect of making photographic, video or audio recordings of patients. 'Recordings' in this chapter means originals or copies of audio recordings, photographs and other visual images of patients that may be made using any recording device e.g. video.

10.2 Visual and audio recordings of patients may be made for any of the following reasons:

- As part of assessment, investigation or treatment of a patient, to be kept in the patient's medical notes
- For use in teaching, training or assessment of fellow healthcare professionals and students or other appropriate groups e.g. at a conference
- For use in clinical research
- For publication e.g. in a book, a journal, a patient information leaflet, on a poster or in publicity material, any of which may also be accessible on the internet
- As potential evidence e.g. following injuries sustained as the result of an accident or an assault or where there is suspected non-accidental injury

10.3 Because it is sometimes possible for people to be identified by tattoos or other distinguishing marks or features, or from the sound of their voice in an audio recording, it is the Health Board's policy that written consent must always be obtained prior to making a visual or audio recording of a patient (or part of a patient) for any of the purposes described in paragraph 10.2 (for exceptions see paragraph 10.9 below).

10.4 Healthcare professionals should always ensure that they ask for a patient's written consent in advance if any photographic, video or audio recording will result from a procedure (unless the patient is temporarily unconscious – see paragraph 10.18).

10.5 If you only obtain consent for use of photographic, video or audio recordings as part of treating or assessing a patient you must not use them for any purpose other than the patient's care or the audit of that care, without obtaining further consent from the patient.

General Principles

10.6 When making or using recordings you must respect the patient's privacy and dignity and their right to make or participate in decisions that affect them. The following general principles apply to most photographic, video and audio recordings:

- seek permission to make the recording and get consent for any use or disclosure
- give patients adequate information about the purpose of the recording when seeking their permission
- make recordings only when you have appropriate consent or other valid authority for doing so
- ensure that patients are under no pressure to give their permission for the recording to be made
- stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment
- do not participate in any recording made against a patient's wishes
- eyes or faces must not be blacked out in an attempt to conceal identity after the recording has been made. Every effort must be made to conceal the identity of the patient whilst the recording is being taken. You must ensure that the patient is informed if their face will be visible in the recording
- ensure that the recording does not compromise patients' privacy and dignity
- do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent
- make appropriate secure arrangements for storage of recordings

10.7 Before the photograph, video or audio recording is made, healthcare professionals must ensure that patients:

- understand the purpose of the recording, who will be allowed to see/hear it, the circumstances in which it will be shown/played, that copies are likely to be made if the recording is for educational purposes, and that the recording will be stored securely within the Health Board / Trust
- understand that, in the case of publication, they will not be able to withdraw their consent or control future use of the material, once the recording is in the public domain
- understand that withholding permission for the recording to be made, or withdrawing permission during the recording, will not affect the quality of care they receive
- are given time to read explanatory material and to consider the implications of giving their written permission. Explanatory material should not imply that permission is expected. It should

be written in language that is easily understood. If necessary, translations should be provided
- have signed a consent form

10.8 After the recording, the healthcare professional must ensure that:

- patients are asked if they want to vary or withdraw their consent to the use of the recording
- recordings are used only for the purpose for which patients have given consent
- patients are given the chance, if they wish, to see the recording in the form in which it will be shown
- recordings are given the same level of protection as with patient's medical notes against improper disclosure
- if a patient withdraws or fails to confirm consent for the use of the recording, the recording is not used and is erased as soon as possible

Recordings for which consent is not required

10.9 Permission and consent is not needed to make or use the recordings listed below, provided that, before use, they are effectively anonymised by the removal of any identifying marks (writing in the margins of an x-ray, for example):

- Images taken from pathology slides
- X-rays
- Laparoscopic or endoscopic images
- Images of internal organs (however, it is best practice to obtain written consent if the recording is to be used in education or publication and will be accompanied by verbal or written information which may enable inadvertent identification of the patient)
- Recordings of organ functions
- Ultrasound images

Children and young people

10.10 Where children lack the understanding to give their permission to photographic, video or audio recordings, healthcare professionals must get permission to record from the person with parental responsibility. Children under 16 who have the competence to give permission for a recording may sign the consent form themselves. Healthcare professionals should make a note of the factors taken into account in assessing the child's competence. Young people are assumed in law

to be competent and can give permission to recordings themselves, unless they lack capacity.

10.11 In cases of suspected non-accidental injury of a child, photographs may be taken without parental consent if necessary. However, these photographs must only be used as part of the clinical record, or as potential evidence. They must not be used for education, publication or research without written consent. If written consent is given for use in education, publication or research, it is recommended that images are not used for these purposes before or during likely legal proceedings.

Vulnerable adults

10.12 In the case of suspected non-accidental injury of a vulnerable adult, efforts should be made to obtain written consent to the taking and use of photographs as potential evidence.

10.13 If the patient is unwilling for recordings to be made for evidential purposes, then the patient should still be asked for consent to photographs being taken for their clinical record, if it is a valid addition to the record, or if it is not appropriate to seek their consent for evidential purposes at that time e.g. if the alleged perpetrator is present. Photographs taken for the clinical record cannot be used as evidence, unless, at a later date, the patient changes their mind. In this case the consent form can be modified at this later date, and these modifications must be signed and dated by the patient.

Foetal loss, stillbirth and neonatal death

10.14 Photographs taken solely for the purpose of giving them to the bereaved parents do not qualify as clinical photographs and therefore do not come under the auspices of this policy. Photographs taken on behalf of the bereaved must not be used for any other purpose without written consent from the person with parental responsibility.

10.15 If photographs are required for any other purpose (except during the course of a post mortem examination) the written consent of those with parental responsibility must be obtained.

Adults and young people who lack the capacity to consent for themselves

10.16 When adults or young people lack capacity to make a decision about an audio or visual recording for themselves, any decision must be made in accordance with the MCA.

10.17 As a general principle you should not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

10.18 The situation may sometimes arise where the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

Adults and young people who lack capacity - recordings made as part of clinical care, or as potential evidence

10.19 If it can be demonstrated that it is in the patient's best interests, then photographs, video and audio recordings can be made as part of the patient's clinical care, or as potential evidence. If someone holds a Health and Welfare LPA or is a CAD, they should be asked to consent on behalf of the patient. Otherwise the healthcare professional making the recording must confirm that they have assessed capacity and are acting in the patient's best interests.

Adults and young people who lack capacity - recordings made for education and publication

10.20 If adults or young people lack capacity to make a decision about photographs, video or audio recordings for themselves, then recordings can only be taken and used for education or publication if it has been determined to be in the patient's best interests.

Patients who have capacity but are unable to sign the consent form

10.21 Physical inability to sign a consent form does not detract from an individual's ability to give consent. Patients can indicate their consent verbally or non-verbally, in the presence of a witness, who should then sign the consent form to confirm that the patient's consent was given. Recordings can then be used in the same way as if the patient had signed the consent form.

Withdrawal of consent

10.22 Patients have the right to withdraw consent for the use of their audio or visual records at any time. This should be documented on the consent form and the form, or the appropriate section of the form, should be scored through. In the case of publication, it is particularly important to make it clear to patients, when consent is originally obtained, that once

the recording is in the public domain there is no opportunity for effective withdrawal of consent.

Further information

10.23 The above information is drawn from the GMC guidance: *Making and using visual and audio recordings of patients* (2011), which gives further detailed advice in the use of recordings when treating or assessing patients.

Telemedicine

10.24 Telemedicine should be viewed as a form of examination, and valid consent should be obtained in the same way as in any other examination, not just to the recording and exchange of information but to the process of telemedicine. The patient should understand that:

- it is not the same as seeing a healthcare professional in a face-to-face meeting
- the information/diagnosis received may be compromised by the technology
- they have a right to decline review via telemedicine

Healthcare professionals must abide by their IT Security Policy and Data Protection Policies in the handling of all images/recordings and data

11. Consent to specific procedures

Consent to screening

11.1 Healthcare professionals must ensure that anyone considering whether to consent to screening can make a properly informed decision. As far as possible, they should ensure that screening would not be contrary to the individual's interest. Particular attention must be paid to ensuring that the information the patient wants or ought to have is identified and provided. Those taking consent should be careful to explain clearly:

- the purpose of the screening
- the likelihood of positive/negative findings and possibility of false positive/negative results
- whether there are any reasonable alternatives
- the uncertainties and material risks attached to the screening process
- any significant medical, social or financial implications of screening for the particular condition or predisposition
- follow up plans, including availability of counselling and support services

11.2 If healthcare professionals are considering the possibility of screening adults and young people who do not have capacity to consent to the screening they must act in accordance with the MCA and ensure that decisions made are in the patient's best interests. In appropriate cases, account must be taken of the guidance issued by bodies such as the Advisory Committee on Genetic Testing.

Consent to cosmetic treatments (surgical and non-surgical)

11.3 From **1 June 2016** new GMC guidance for Doctors applies to both surgical (such as breast augmentation) and non-surgical (such as Botox) procedures. A link to this guidance can be found here: http://www.gmc-uk.org/static/documents/content/Guidance_for_doctors_who_offer_cosmetic_interventions_080416.pdf

12. Seeking consent for genetic investigations (or investigations likely to reveal the diagnosis as being a genetic disorder)

12.1 Consent to genetic investigations is a particularly complex and controversial area.

Information and likely implications

12.2 When obtaining consent for investigations which may reveal genetic disorders, it is important that patients have been given full information about the likely implications of the test.

12.3 If healthcare professionals are considering the possibility of performing investigations on adults and young people who do not have capacity to consent to the investigation, they must act in accordance with the MCA and ensure that they make decisions in the patient's best interests.

12.4 It is recommended that reference should be made to specialist guidelines such as guidance issued by the Joint Committee on Medical Genetics: http://www.bsgm.org.uk/media/39563/consent_and_confidentiality_2011_1_.pdf

13. Withholding or withdrawing life – sustaining treatment

General

13.1 The GMC guidance *Treatment and care towards the end of life: good practice in decision making* (2010) provides detailed guidance on withdrawing and withholding life - sustaining treatment.

13.2 A competent patient should always be consulted when making a decision to withhold or withdraw life-sustaining treatment unless the healthcare professional forms a view that involvement will actually 'harm' the patient. Recent case law has underlined the extent of the duty of the healthcare professionals to consult a competent patient or those with an interest in the welfare of the patient, where that patient lacks mental capacity to be involved in the decision.

13.3 Any valid and applicable ADRT is legally binding and must be respected unless a patient has subsequently made a Health and Welfare LPA giving the attorney authority to make decisions regarding the provision of life-sustaining treatment.

13.4 Where the patient lacks capacity to be involved in the decisions, and the patient has not made a Health and Welfare LPA giving an attorney appropriate authority, the healthcare professional must consult the patient's relatives, friends, or carers and other professionals involved in their care when making a best interests decision about the withholding or withdrawal of life-sustaining treatment. If there is no-one other than paid staff to consult with, an IMCA must be instructed. Where an urgent decision is required and a patient's representatives cannot be contacted, the reasons for this must be carefully recorded in the patient's medical notes. See paragraphs 8.34 – 8.40 above.

13.5 There is an important distinction between withdrawing or withholding treatment which is of no clinical benefit to the patient or is not in the patient's best interests, and taking a deliberate action to end the patient's life. A deliberate action which is intended to cause death is unlawful. Equally, there is no lawful justification for continuing treatment which is not in a patient's best interests.

13.6 Once a decision has been reached to withhold or withdraw life-prolonging treatment, the basis of the decision and the details of any discussions with the patient and/or their representatives must be recorded in the medical notes. Decisions to withhold or withdraw life-prolonging treatment should be reviewed periodically and following any

relevant change in a patient's circumstances.

Prolonged disorder of consciousness (PDOC)

13.7 If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a second independent clinical opinion is available which supports the best interests decision, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. For more detail see paragraphs 8.56 and 8.57.

13.8 Additional information is available from:

- RCP, BMA (2018) Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent
- GMC (2010) Treatment and care towards the end of life: good practice in decision making

14. Medical treatment of patients with a mental disorder

Basic principles

14.1 This chapter provides information regarding consent issues relating to the medical treatment of patients with a mental disorder. It should not be read in isolation from the rest of this policy, since the principles contained throughout this document apply to all patients from whom consent is sought, irrespective of whether or not they have a mental disorder.

14.2 The principle of self-determination and autonomy of the individual, described in chapter 1 of this policy, applies equally to those who are suffering from mental disorder; a key distinction being that, in the circumstances authorised by the Mental Health Act 1983 (referred to as the MHA), treatment for a mental disorder may be given in the absence of the recipient's consent. Nevertheless, consensual treatment should always be sought in line with the principle of provision within the least restrictive context.

14.3 Part 4 of the MHA is concerned with consent to treatment. The reader should also refer to the MHA 1983 Code of Practice for Wales, 2016 generally and particularly chapters 24 and 25 for further information about consent and the Mental Health Act 1983.

14.4 Patients suffering from mental disorder, including those detained under the MHA are not necessarily incapable of giving valid consent and each patient's capacity to consent has to be judged individually in the light of the decision required and the patient's mental state at the time. Lack of capacity can be permanent or temporary and can also vary over time. Assessment of capacity should follow the principles described in the Mental Capacity Act 2005 (see chapter 8 of this policy).

14.5 The approved clinician in charge of the treatment has a duty to ensure that the patient is provided with sufficient information to enable him/her to understand:

- the nature, purpose, likely and intended effects of the treatment
- their right to withdraw consent at any time, and
- how and when treatment can be given without their consent, including the legal authority for the treatment

14.6 A record of the discussion at which consent is obtained or sought must be fully recorded in the health records.

14.7 Inpatients in Wales, whether detained or informal, and those subject to conditional discharge, a community treatment order, or guardianship are eligible for an independent mental health advocate (IMHA). All patients being considered for s57 type treatments (i.e. psychosurgery or implantation of hormones to reduce male sex drive) and children under 16 years being considered for ECT are also eligible. The only exception is a patient detained in a place of safety under s135 or s136 of the MHA. Further information about the role of the IMHA may be found in chapter 6 of the MHA Code of Practice for Wales, 2016.

Medical treatment for mental disorder

14.8 Psychiatric in-patients may be classified into three groups when considering consent to treatment for their mental disorder:

a) patients detained under the Mental Health Act 1983
b) informal patients who possess capacity to consent to treatment, and
c) informal patients who lack capacity to consent to treatment

a. Patients detained under the Mental Health Act 1983

14.9 Where a patient is capable of giving consent and refuses, non-consensual treatment may only be given if it is for a mental disorder and the healthcare professional has the legal authority in accordance with the provisions of the MHA and the necessary certification requirements. Medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation and rehabilitation and care the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.

14.10 Medical treatment for mental disorder (except treatments under s. 57 i.e. psychosurgery and implantation of hormones to reduce male sexual drive) may be lawfully administered without the patient's consent provided:

- the patient is detained under the Mental Health Act 1983 (excluding patients detained under ss. 4(4)(a), 5(2), 5(4), 35, 135, 136, 37(4)), and
- the proposed medical treatment falls within the provisions of
  - s58 (a second opinion is required for patients who are refusing or incapable of consenting after three months of treatment)
  - s62 (urgent treatment), or
  - s63 (treatment for the first three months of detention) of the MHA

b. Informal patients who possess capacity to consent to treatment

14.11 Where informal patients possess the required capacity to give valid consent to medical treatment for mental disorder or to a plan of treatment, then their consent must be obtained. Where appropriate, this should be written consent. Where informal patients with capacity refuse treatment for their mental disorder consideration may be given to detaining the patient under the provisions of the MHA.

c. Informal patients who lack the capacity to consent to treatment

14.12 An assessment of capacity should be undertaken in accordance with the MCA. If a patient is found to lack capacity to consent to treatment then a determination of their best interests must be undertaken before any treatment is provided. In assessing someone's best interests it is essential to consult people who are close to the patient.

14.13 Section 5 of the Mental Capacity Act 2005 (MCA) provides that treatment may be given to a patient who lacks capacity to consent provided that it is in his or her best interests to do so. Section 6 of the MCA provides that a patient may only be restrained to give care or treatment if it is necessary to prevent harm and it is a proportionate response to the likelihood and severity of that harm.

14.14 If a patient who lacks capacity to consent to treatment appears to be objecting to treatment, then consideration should be given to detaining the patient under the MHA.

Patients detained under the Mental Health Act 1983 requiring treatment for a physical disorder

14.15 Part IV of the MHA is concerned with medical treatment for mental disorder. The MHA cannot be used to enforce treatment for a physical disorder, which is unrelated to a mental disorder, where a patient refuses consent. For patients who lack capacity to consent to medical treatment for a physical illness the provisions of the MCA would be engaged.

14.16 The patient's mental disorder may affect their capacity to consent. This should be assessed as a priority in line with the MCA, as treatment for the physical disorder might proceed in the patient's best interests. However, it should not be assumed that the patient lacks capacity simply because they have a mental disorder.

14.17 Section 63 of the MHA may allow for the treatment of a physical disorder, without the patient's consent, where it is 'ancillary to the treatment of the mental disorder' for example:

- Naso-gastric feeding a patient with anorexia nervosa (*Re KB (Adult)* (1994))
- Taking blood for patients on clozapine
- Treating self-inflicted wounds

14.18 The term 'medical treatment' in section 63 of the MHA refers to treatment which, taken as a whole, is calculated to alleviate or prevent a deterioration of the mental disorder from which the patient is suffering. This includes a range of acts ancillary to the core treatment including those which prevent the patient from harming herself or those which alleviate the symptoms of the disorder (B v Croydon HA [1995])

14.19 If uncertainty exists as to a patient's capacity to consent to treatment, or whether the physical disorder may be treated as a symptom of the mental disorder, legal advice should be sought. See appendix C.

15. Consent to research and innovative treatment

Research

15.1 Any research undertaken within the Health Board must be registered with the Health Board's Research & Development Office, from where additional advice can be obtained. All research and development must be approved before it can be commenced. Please visit the Research and Development Department's intranet page

15.2 Consent to clinical trials is covered by the *Medicines for Human Use Regulations* (2004)

15.3 The same legal principles apply when seeking consent from a patient for research purposes. GMC guidance states that patients 'should be told how the proposed treatment differs from usual methods, why it is being offered, and if there are any additional risks or uncertainties'.

15.4 Where the proposed treatment is of an experimental nature, but not part of a research trial, this fact must be clearly outlined to the patient along standard alternatives – including no treatment – during the consent process.

Patients who lack capacity to consent to being involved in research

15.5 There are strict rules within the MCA concerning the involvement of people who lack capacity in research. (See MCA *Code of Practice* and Welsh Government's *Guide to Consent for Examination and Treatment*). In determining whether the patient should participate in the proposed research, the patient's wishes and feelings about being involved in research should be respected. It should be stressed that many research studies are non-therapeutic, i.e. they will not benefit the research participants personally. Carers or other persons who have an interest in the patient's welfare must be consulted. If there is no one who can be consulted, then a person who is unconnected with the research project must be appointed to advise on whether the patient should take part in the research. If at any time during the research it appears that the patient is upset or unhappy, it must cease immediately. Please see the Research, Consent and Capacity: Standard operating procedure

15.6 Where a patient lacks capacity, experimental/innovative treatment cannot be given unless it is in their best interests. Where there is no alternative treatment available, it may be reasonable to consider an experimental treatment, with unknown risks and benefits, where

treatment may benefit the patient.

Consent to research and innovative treatment in children

15.7 The legal approach to consent to therapeutic research in children is similar to any other proposed examination or treatment: the treatment must be in the child's best interests.

15.8 UHB staff should contact the R&D Department for further advice on obtaining consent for children aged under 16 years. The approach will differ depending on whether the study is a clinical trial or not, and whether or not the proposed research will take place in an emergency setting.

16. Training

The following types of training are available to staff:

- Mental Capacity Level 1 (ESR) (covers consent to treatment)
- Mental Capacity Level 2 (ESR)
- Face-to-face training on both MCA and Consent provided by the Mental Capacity Act Manager (both levels)

Mental Capacity Act training is mandatory for all staff who have contact with patients.

Supplementary Guidance

17. Consent in obstetrics and gynaecology

Pregnant women

17.1 A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to herself and/or her foetus(es). Any treatment involving the foetus will require maternal consent. However, it should be stressed that maternal refusal of treatment thought to benefit one or both parties is a rarity.

Caesarean section (including refusal)

17.2 If a caesarean section is required, the standard Consent Form 1 must be used. Women in labour can consent to a caesarean section even if they have received sedation.

17.3 It is important to ensure that all pregnant women have a good understanding of the different ways in which they may give birth and the associated benefits and material risks. This will include information about the circumstances in which a caesarean section will be offered. A pregnant woman with capacity may refuse a caesarean section, even if "the consequence may be the death or serious handicap of the child she bears, or her own death" (Court of Appeal Re MB). In other words a mentally competent woman in labour has the same right under common law to consent to or refuse consent to treatment as any other patient. United Kingdom law does not currently grant the foetus any legal rights, therefore a caesarean section cannot be authorised by a Court against a competent woman's will and action cannot be taken in the best interests of the pregnant woman or the foetus. In this situation all advice given to the woman should be recorded in her notes. Unequivocal assurances should be obtained from the woman (and recorded in writing) that the refusal represents an informed decision: that is, that she understands the nature of and reasons for the proposed treatment and the risks and the likely prognosis involved in the decision to refuse or accept it. It is good practice to ask the woman to sign the written indication of her refusal. It is also good practice to involve another senior colleague to indicate that a body of senior medical opinion considers caesarean section to be the most appropriate course and that the patient has refused consent for a caesarean section.

17.4 If the woman is unwilling to sign a written indication of this refusal, this too should be recorded in the notes. Such a written indication is merely a record for evidential purposes. It should not be confused with or regarded as a disclaimer.

17.5 There have been a number of cases where doubts have arisen, for

various reasons, as to a woman's capacity to make a valid decision about a caesarean section. Temporary factors such as fear, shock, fatigue, pain or drugs may affect capacity. If there is reason to doubt capacity, support should be provided to help the woman make a decision. If that fails, a capacity assessment must be undertaken.

17.6 Where there is any doubt about a woman's capacity and/or where a refusal would lead to serious consequences for the pregnant woman or her unborn child, then legal advice should be obtained. If a pregnant woman refuses a caesarean section (or any other intervention) and it has been demonstrated (in line with the MCA) that she lacks the capacity to make such a decision, an application to the CoP will be required to decide whether or not such treatment can be carried out Please see Appendix C for details of how to obtain legal advice. In the case of Re S, the Court of Appeal laid down general principles that should be applied in future cases. If the mother lacks capacity, avoiding the foetus' death may be seen by the Court as being in the best interests of the mother.

17.7 Where a pregnant woman lacks capacity due to unconsciousness and so is incapable of giving consent, the caesarean section may be carried out if it is in her best interests, unless a valid and applicable advance decision to refuse treatment exists. The most usual form of advance decision used by pregnant women is the birth plan. However, if there is reason to doubt the reliability of the advance decision (e.g. it might sensibly be thought not to apply to the circumstances which have arisen – see chapter 8 of this policy) then legal advice should be sought. See Appendix C.

Sterilisation

17.8 Men and women requesting sterilisation should be given information about alternative long-term reversible methods of contraception. This should include information on the advantages, disadvantages and relative failure rates of each method. Non-operative methods of long-term contraception should have been specifically rejected by the patient before a decision is taken to proceed with sterilisation.

17.9 Both vasectomy and tubal occlusion should be discussed with all men and women requesting sterilisation. Women in particular should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancy and there is less risk related to the procedure when compared with female sterilisation.

17.10 Patients should be told that the procedure is intended to be permanent, but should also be given the success rates of reversal procedures. They should be informed that the reversal operations of in vitro

fertilisation (IVF) and intracytoplasmic sperm injection (ICSI) are rarely provided by the NHS.

17.11 People requesting sterilisation should be informed that tubal occlusion and vasectomy can be unsuccessful and that pregnancies can occur several years after the procedure.

17.12 Written consent must be obtained for vasectomy, and the man should be advised to take other contraceptive precautions until there have been two consecutive negative semen analyses. It is important that the possibility of late failure is explained to the patient and his partner before vasectomy, so they can make informed decision about additional contraceptive methods.

17.13 Whilst the consent of the partner is not needed before sterilisation, or any other procedure, clinicians may, however, wish to discuss the proposed treatment with the spouse or partner, provided the patient agrees.

17.14 Non therapeutic sterilisation of someone who lacks the capacity to give their consent must be referred to the Court of Protection. The individual's capacity and best interests must be thoroughly assessed in line with the Mental Capacity Act and legal advice should be sought at all times. (See chapter 8 and Appendix C).

Fertility

17.15 It is a legal requirement under the HFEA 1990, as amended, that consent to the storage and use of gametes must be given in writing after the patient has received such relevant information as is proper and had an opportunity to receive counselling. Where these requirements are not satisfied, it is unlawful to store or use the patient's gametes. Healthcare professionals should ensure that written consent to storage exists before retrieving gametes.

17.16 Outside specialist infertility practice, these requirements may be relevant to healthcare professionals whose patients are about to undergo treatment which may render them sterile (such as chemotherapy or radiotherapy) where a patient may wish to have gametes, or ovarian or testicular tissue, stored prior to the procedure. Healthcare professionals may also receive requests to remove gametes from a patient unable to give consent.

17.17 The HFEA 1990, as amended, makes provision to address cases where the taking of gametes is in the patient's best interests but the patient is unable to give written consent or lacks capacity to consent to

the storage of the gametes.

17.18 Further guidance is available from the Human Fertilisation and Embryology Authority.

Termination of pregnancy

17.19 The termination of a pregnancy may only take place with the informed consent of the pregnant woman. Prior to obtaining written consent, discussion must take place concerning the type of procedure (medical or surgical) and the risk of complications. Written information should be given to support verbal information. The husband or putative father's authority is not legally required.

17.20 If a woman opts for a medical termination of pregnancy then a realistic description should be given of the process, the number of visits necessary and the need for a health care professional to see products of conception or to perform a subsequent scan to ensure the termination is complete. It should be pointed out that there is a small risk of heavy bleeding at home before returning to hospital for the second part of the procedure, and that there is a high chance of miscarriage if the patient changes her mind between the first and second stages of the procedure.

17.21 If cervical ripening agents are to be used before surgical termination of pregnancy, the patient should understand that there is a high chance of miscarriage if she changes her mind before completing the procedure.

17.22 Prior to taking consent for termination of pregnancy, the senior doctor (Registrar or above) must sign Certificate A (Abortion Act, 1967) to indicate that he is in agreement with the need for the termination. The woman will receive counselling in advance of the procedure and will then be scanned to assess gestational age. If the procedure is to be undertaken, Consent Form 1 must be used.

17.23 Clinicians are advised to seek legal advice (see Appendix C) where:

- a woman lacks the mental capacity to understand and appreciate the nature or consequences of a termination of her pregnancy; or
- a woman is in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy
- a partner wishes to over-rule a decision to terminate a pregnancy

Histological examination and disposal of non-viable foetal products

17.24 Consent should always be obtained with regard to the histological examination and disposal of non-viable foetal products up to the age of 24 weeks gestation.

Appendix A - Link to current consent forms in use in the UHB

Copies of the All-Wales consent forms can be found here –
http://www.wales.nhs.uk/governance-emanual/patient-consent/

The forms must be purchased through the ORACLE system.

The forms are –

Form 1 for patients aged 16 years and over with mental capacity and also for *Gillick* competent children

Form 2 for parental consent for a child who is not competent

Form 4 for patients aged 16 years and over who lack capacity to consent to examination or treatment

Appendix B - Useful contact / link details

Julia Barrell, Mental Capacity Act Manager (for both consent and MCA queries), Tel. 029 2183 6312

Maria Roberts, Head of Patient Safety and Quality, Tel. 029 2183 6316

Stuart Walker, Medical Director, Tel. 029 2183 6001 (Executive Lead)

Out of hours advice/guidance in emergencies, via the on-call Senior Manager rota, including obtaining legal advice

Appendix C – How to obtain legal advice

If you need advice about a consent/capacity issue and/or you think a court application may be required, you should in the first instance contact the Mental Capacity Act Manager/Patient Safety Team who will be able to advise whether you need to access a Solicitor.

If you need urgent legal advice out of hours, access to a Legal and Risk Solicitor can be obtained via the on-call Senior Manager rota.

You should ensure that you have all the relevant information about the case to hand so that you can brief the MCA Manager/Patient Safety Team/ on-call Senior Manager/ Solicitor appropriately.

You should keep a clear record of the legal advice you have been given by the Solicitor and you should follow that advice.

There may be occasions when the situation may be so urgent, and the consequences so desperate, that it is impractical to attempt to comply with these guidelines. Where delay may itself cause serious damage to the patient's health, or put their life at risk, then rigid compliance with these guidelines would be inappropriate.

The Court of Protection deals with serious decisions affecting personal welfare matters, including health care. Cases involving any of the following decisions should be regarded as serious medical treatment, and should be brought to the court:

a) cases involving organ or bone marrow donation by a patient who lacks capacity to consent
b) cases involving non-therapeutic sterilisation of a patient who lacks capacity to consent
c) where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests, or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both persistent vegetative state (PVS) and minimally conscious state (MCS)
d) all other cases where there is dispute about whether a particular treatment will be in a patient's best interests (including cases involving ethical dilemmas in untested areas).

Appendix D - Assessing and documenting *Gillick* Competence in Under 16s

Assessment of *Gillick* competence should document the following[7]:

- The age of the child
- The intervention being offered
- The child's ability to understand that there is a choice and that choices have consequences, both risks and benefits
- The child's understanding of the nature and purpose of the proposed intervention
- The child's understanding of the proposed intervention's risks and side effects, both in the short and long term
- The child's understanding of any alternatives to the proposed intervention, and the risks and benefits attached to them
- The child's ability to weigh the information and arrive at a decision
- The child's willingness to make a choice (including the choice that someone else should make the decision)
- An estimate of the child's freedom from undue pressure

[7] BMA - Children and Young People Toolkit

Appendix E - About the consent form: information for patients

Before a doctor or other healthcare professional examines or treats you, they need your consent – in other words, your agreement. Sometimes you can simply tell them whether you agree with their suggestions. However, sometimes a written record of your decision is helpful – for example, if your treatment involves sedation or general anaesthesia. In this case, you will be asked to sign a consent form. If you later change your mind about having the treatment, you are entitled to withdraw consent – even after signing the form.

What should I know before deciding?

Healthcare professionals must ensure you know enough to enable you to decide about treatment. They will write information on the consent form and offer you a copy to keep (in either Welsh, English or both languages) as well as discussing the choices of treatment with you. Although they may well recommend a particular option, you do not have to accept that option. People's attitudes vary to things like the amount of risk or pain they are prepared to accept. That goes for the amount of information, too. The person who is treating you will encourage you to listen to all of the information about your treatment but if you would rather not know about certain aspects, discuss your worries with them.

Should I ask questions?

Healthcare professionals will encourage you to ask questions and you should always ask anything you want. As a reminder, you can write your questions down. The person you ask should do his or her best to answer, but if they don't know they should find someone else who is able to discuss your concerns. To support you and prompt questions, you might like to bring a friend or relative. Ask if you would like someone independent to speak up for you.

Is there anything I should tell people?

If there is any procedure or treatment you **don't** want, you should tell the people treating you. It is also important for them to know about anything that is particularly important to you and any illnesses or allergies which you may have or have suffered from in the past.

Who is treating me?

Amongst the healthcare professionals treating you may be a "doctor in training" – medically qualified, but now doing more specialist training. They range from recently qualified doctors to doctors almost ready to be consultants. They will only carry out procedures for which they have been

appropriately trained. Someone senior will supervise – either in person accompanying a less experienced doctor in training or available to advise someone more experienced. Other healthcare professionals such as nurses and therapists may also provide you with treatment.

What about anaesthesia?

If your treatment involves general or regional anaesthesia (where more than a small part of your body is being anaesthetised), you will be given general information about it in advance. You will also have an opportunity to talk with the anaesthetist when he or she assesses your state of health shortly before treatment. For some procedures, you will be invited to a pre-assessment clinic which will provide you with the chance to discuss things a few weeks earlier.

Will samples be taken?

Some kinds of operation involve removing a part of the body (such as a gall bladder or a tooth). You would always be told about this in advance. Other operations may mean taking samples as part of your care. These samples may be of blood or small sections of tissue, for example of an unexplained lump. Such samples may be further checked by other healthcare professionals to ensure the best possible standards. Again, you should be told in advance if samples are likely to be taken.

Sometimes samples taken during operations may also be used for teaching, research or public health monitoring in the future interests of all NHS patients. If a healthcare professional wishes to use your samples for research purposes they will ask for your written consent.

Students

One of the ways that student doctors, nurses or other healthcare professionals learn is by watching care or treatment being given. If the healthcare professional treating you would like a student to watch your examination or treatment, then they have to ask your permission first. If you are having sedation or an anaesthetic during your treatment, then they need your written consent for a student to watch your procedure. This is why there is a section on the consent form for you to say whether or not you agree to students being present. If you are happy for the student to be present, they will be supervised by a qualified member of staff at all times. Your care will not be affected in any way if you decide that you prefer not to have students in the room during your procedure.

Advance decision to refuse treatment (ADRT)

Some people chose to make an ADRT refusing certain care or treatment (sometimes referred to as “living wills” or “advance directives”). If you have

made, or wish to make an advance decision refusing a treatment or procedure which may become necessary during the course of your care or treatment, then you must tell the healthcare professional caring for you. This will make sure that your decisions are followed, for example, whilst you are under anaesthetic. This is why there is a section on the consent form for you to say whether or not you have made a relevant advance decision.

Photographs, videos and audio recordings

As part of your treatment it is sometimes helpful for a photographic, video or audio recording to be made – for example, to record changes to a skin lesion. You will always be told if this is going to happen. The use of photographs and recordings is also extremely important for other NHS work, such as teaching or medical research. If the healthcare professional would like to take photographs, video or audio recordings, then you will be asked to sign a consent form giving your permission. The photograph / video / audio recording will be kept with your notes and will be held in confidence as part of your medical record. This means that it will normally be seen only by those involved in providing you with care or those who need to check the quality of care you have received, unless you have given permission for it to be used in other ways e.g. teaching, publication, research. We will not use the photograph / recording in a way that might allow you to be identified or recognised without your express permission.

What if things don’t go as expected?

Amongst the 25,000 operations taking place every day, sometimes things don’t go as they should. Although the doctor involved should inform you and your family, often the patient is the first to notice something amiss. If you are worried – for example, about the after-effects of an operation continuing much longer than you were told to expect – tell a healthcare professional right away. Speak to your GP, or contact your clinic - the phone number should be on your appointment card, letter or consent form copy.

What do I need to know?

You should be made aware of all of the significant risks (including important (material) risks to you), benefits and alternative treatments (including no treatment) of what is being proposed by the healthcare professional, so that you can make an informed decision

What are the key things to remember?

It’s your decision! It is up to you to choose whether or not to consent to what is being proposed. Ask as many questions as you like, and remember to tell the team about anything that concerns you or about any medication, allergies or past history which might affect your general health.

Can I find out more about giving consent?

This Health Board has a policy on patient consent to examination or treatment, which will be made available to you on request. The Welsh Government has also issued a *Guide to Consent for Examination or Treatment* which can be accessed at: http://www.wales.nhs.uk/governance-emanual/patient-consent/

Questions to ask healthcare professionals

As well as giving you information healthcare professionals must listen and do their best to answer your questions. Before your next appointment, you can write some down.

You may want to ask questions about the **treatment itself**, for example:

- What are the main treatment options?
- What are the benefits of each of the options?
- What are the risks, if any, of each option?
- What are the success rates for different options (nationally, for this unit or for the surgeon)?
- Why do you think an operation (if suggested) is necessary?
- What are the risks if I decide to do nothing for the time being?
- How can I expect to feel after the procedure?
- When am I likely to be able to get back to work?

You may also want to ask questions about how the treatment might affect your future state of health or lifestyle, for example:

- Will I need long-term care?
- Will my mobility be affected?
- Will I still be able to drive?
- Will it affect the kind of work I do?
- Will it affect my personal/sexual relationships?
- Will I be able to take part in my favourite sport/exercises?
- Will I be able to follow my usual diet?

Health care professionals should welcome your views and discuss any issues so they can work in partnership with you for the best outcome.

Unacceptable behaviour

Our staff deserve the right to do their jobs without being verbally or physically abused. Most of our patients and visitors respect this right. Thank you for being one of them. We will work with the police to prosecute those who abuse our staff.

Complaints and compliments

We would like to hear your views about your experience of our services. Our aim is to provide you with the highest standards of care at all times, but we recognise that things can sometimes go wrong. If you have any concerns, speak to the senior staff member on duty or the appropriate ward, hospital or community manager, who will be able to assist and, hopefully, resolve matters to your satisfaction. Where this is not successful, ask for our leaflet *Putting Things Right – Raising a concern about the NHS in Wales*. This advises you how to make a formal complaint and the various stages of the procedure.

In making a complaint, advice and assistance is available to you from your local Community Health Council, which represents the interests of patients and the public in the NHS. The Community Health Councils are skilled in handling complaints. Their Complaints Advocates can provide a range of support during the process of your complaint.

South Glamorgan Community Health Council

Pro-Copy Business Centre (Rear)
Parc Ty Glas
Llanishen
CARDIFF
CF14 5DU

Tel. 029 2075 0112

Email. SouthGlam.chiefofficer@waleschc.org.uk

Data Protection Act/General Data Protection Regulations (2016) or any subsequent legislation having the same effect

Under current Data Protection legislation, we are committed to protecting the privacy of patient information. If you require an explanation of why information is needed, or how you can access information or your health records, please contact

Health Records Manager

Legal Services Section
Medical Records Department
University Hospital of Wales
Heath Park
CARDIFF
CF14 4XW

Tel. 029 2074 6500

You are entitled to see your health records but if you wish to receive a copy note that a charge will usually be made. You should also be aware that in certain circumstances your right to see some details in your health records may be limited in your own interest or for other reasons.

APPENDIX 1

Equality & Health Impact Assessment for

CONSENT TO EXAMINATION OR TREATMENT POLICY

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	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Capacity Act Manager, tel. 029 2183 6312 Medical Director's Office
3.	Objectives of strategy/ policy/ plan/ procedure/ service	This policy sets out the legal framework that governs the provision of treatment and care to patients. The legal framework comprises the common law on consent; the Mental Capacity Act 2005; and the Mental Health Act 1983.

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

		There is also some particular legislation for specialist issues – e.g. research and organ donation. The policy applies to all the UHB's patients. Clinicians who do not comply with this policy are likely to be acting unlawfully.
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[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	• This Policy applies to all patients being treated and cared for by the UHB and sets out the law regarding the provision of health care and treatment. If the Policy is not followed, staff will be treating and caring for patients unlawfully. As the Policy applies to all patients, there is no question of the Policy having a negative effect on any of the equalities groups. There are positive impacts which the policy includes – see the impact section below. • The EqIA completed for the previous version of this Policy found there to be no adverse impact on any of the equalities groups. As the law on consent and capacity has not substantially changed since then, it is most unlikely that the effect of this Policy on any of the equalities groups will have changed. There are positive impacts which the policy includes – see the impact section below.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	UHB staff and patients.

[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	In the case of a patient under 16 years of age, consent may be given either by the patient, if they are *Gillick* competent, or by someone with parental responsibility for them. For patients who are 16 years and over, treatment and care may be lawfully provided either with the patient's consent, or through the Mental Capacity Act 2005. Patients of any age may be treated under Mental Health Act 1983. The Policy therefore has a positive impact, because patients of all ages are reflected in the policy.		
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	For patients under 16 years of age who have a disability, consent may be given either by the patient, if they are *Gillick* competent, or by someone with parental responsibility for them. For patients who are 16 years and over, treatment and care may be lawfully provided either with the patient's consent, or through the Mental Capacity Act 2005. Patients of any age may be treated under Mental Health Act 1983. For treatment and care to be provided lawfully, it is		

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
	essential that patients are able to both receive information and communicate in the medium of their choice, as the Consent Policy makes clear. So, for example, it is essential that UHB staff access BSL interpreters, where appropriate. The Mental Capacity Act 2005 has as one of its principles the provision of support to help people make their own decisions. The Consent Policy includes the need to provide information to patients in different languages and media and to comply with the Mental Capacity Act 2005 where appropriate. The Mental Capacity Act 2005 Code of Practice gives examples of the kinds of support that could be provided. The Policy therefore has a positive impact, because it sets out the legal requirements to provide patients with information that they can understand and to support them to make their own decisions.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is	No evidence. All UHB patients must be treated in compliance with the law, regardless of their gender.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	No evidence. All UHB patients must be treated in compliance with the law, regardless of their marriage or civil partnership status.		
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 evidence. All UHB patients must be treated in compliance with the law, regardless of whether or not they are pregnant or have just had a baby, or are breast-feeding.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	All UHB patients must be treated in compliance with the law, regardless of their race. For treatment and care to be provided lawfully, it is essential that patients are able to both receive information and communicate in the language of their choice. If patients cannot understand the information		

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
	about the treatment they are being offered, then any "consent" will be invalid and the treatment will be unlawful. The Policy reflects that patients must be given information and communicate in the language/method of their choice. The Policy may therefore have a positive impact.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Whether patients have a religious faith or not, they cannot be treated without their consent, or outwith the Mental Capacity Act 2005 or the Mental Health Act 1983. The law is clear that people who have the mental capacity to do so, may refuse any treatment on any grounds, including religious beliefs, or for no clear reason. The Policy, in setting out the law, may have a positive impact.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	No evidence. All UHB patients must be treated in compliance with the law, regardless of their sexual orientation.		

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
6.9 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	All UHB patients must be treated in compliance with the law, regardless of their being Welsh speakers or speakers of any other language. If patients are unable to understand the information they are given about possible treatments, because of language differences, then any "consent" gained will be invalid and any treatment may well be unlawful. The policy reflects the requirement to ensure that patients are able to receive information and communicate in the language/manner of their choice. The Policy may therefore have a positive impact.		
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	No evidence. All UHB patients must be treated in compliance with the law, regardless of their income.		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable	No evidence. All UHB patients must be treated in compliance with the law, regardless of where they live.		

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
to access services and facilities			
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	No evidence.		

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		
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	No impact		

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
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 prosperous Wales	No impact		
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	No impact		

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
health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact		

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
7.6 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	No impact		

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	The Policy applies to all of the UHB's patients. It sets out the law regarding consent to treatment and mental capacity. If the Policy is not followed then the patient is at risk of unlawful treatment/care, regardless of whether or not they are protected by equalities legislation. The policy may have a positive impact on the following equalities groups – age; disability; race; religion and Welsh language. There is no evidence that the Consent Policy adversely affects any of the equalities groups and it is neither directly nor indirectly discriminatory under the equalities legislation.

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?	Remind Clinical Boards to report any Consent Policy Equality issues to MCA Manager	MCA Manager	After adoption of Consent Policy	

	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	Submit to Quality, Safety and Experience Committee for approval	Medical Director	By end of 2019.	

Report Title:	**Policy and Procedure for the Management of a Throat Pack**						
Meeting:	Quality, Safety and Experience Committee				**Meeting Date:**	17.12.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Medical Director						
Report Author (Title):	**Perioperative Care Directorate Governance Forum**						

SITUATION

Retained throat packs are considered a preventable occurrence and careful visual and documentary checks can significantly reduce, if not eliminate these incidents.

The Perioperative Care Directorate governance group identified the need for the policy and procedure for the management of a throat pack to be considered for ratification as a UHB policy so that clear guidance can be accessible for all those affected and accountable.

BACKGROUND

Retained throat packs are considered a preventable occurrence and careful visual and documentary checks can significantly reduce, if not eliminate these incidents.

The overriding principle for the policy and procedure is that throat packs must be accounted for at all times during any invasive surgical procedure in any setting, to prevent retention and subsequent injury to the patient.

The overall aim of this policy is to ensure that all throat packs are accounted for at all times to prevent foreign body retention and subsequent injury/harm to the patient.

The UHB is committed to ensuring patient safety and recognises that the peri-operative period poses a high risk to the patient. It is the intention of this policy to identify good clinical practice within the peri-operative environment and to ensure the health and safety of patients throughout their journey within this environment. To reduce the incident of a “never event” and promote engagement in the “WHO” checklist process.

ASSESSMENT

Wide consultation has taken place to ensure that the policy/procedure meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was shared with the Perioperative Care Directorate Quality & Safety Group and Surgery Clinical Board Quality and Safety Group and following discussions both groups approved the content of the document
- The document was presented at the Anaesthetic clinical governance audit session for awareness and discussion
- Comments were invited via individual e-mails from the Perioperative Care Directorate Policy and Procedure Group. Comments received gave approval of the

document.

ASSURANCE is provided by: Perioperative directorate governance forum, quality & safety group and Surgery Clinical board quality and safety group.

RECOMMENDATION

The Board is asked to:

- Approve the policy and procedure for the management of a throat pack
- Ratify the chairs action to approve the policy and procedure for the management of a throat pack
- Approve the full publication of the policy and procedure for the management of a throat pack in accordance with the UHB publication scheme

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 *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Reference Number: *62* Version Number: 2	Date of Next Review: Previous Trust/LHB Reference Number:

MANAGEMENT OF A THROAT PACK – POLICY AND PROCEDURE

Introduction and Aim

To provide anaesthetists, surgeons and theatre personnel with an evidence based clinical practice process for the management of cases involving throat packs.

Throat packs are used in patients undergoing certain surgical procedures under general anaesthesia to:

- Absorb any blood, other bodily fluids or external fluids of other material that may seep into the back of the patients throat and enter the oesophagus or lungs during surgery in the mouth (oral / nasal surgery)
- To seal the area around the tracheal tube during provision of general anaesthesia and the surgical procedure, and thus prevent leakage of gases. This is particularly common to paediatric practice with uncuffed endotracheal tubes.
- Stabilise the tracheal tube or supraglottic airway device and thus prevent it's displacement during the surgical procedure particularly in prone patients.
- To soak up liquid nasal vasoconstrictors.
- Surgical placement for access, haemostasis or protection.

Retained throat packs are considered a 'Never event' and a preventable occurrence. Careful consideration of the requirement for a throat pack, alongside visual and documentary checks can significantly reduce, if not eliminate these incidents.

In January 2018 a systematic review on benefits and harms of routine anaesthetist – inserted throat packs in adults, and an accompanying editorial was published in Anaesthesia. These papers contained an evidence based approach consensus statement on practice recommendations for inserting and counting throat packs. This was the joint statement by the Difficult Airway Socierty (DAS), the British Association of Oral and Maxillofacial surgery (BAOMS) and the British Association of Otorhinolaryngology, Head and Neck Surgery (ENT-UK).

The review found no study that sought to assess the benefits of throat pack use. There were multiple reports of minor or major complications related to throat packs, including one incident in the NAP4. As a result of these findings, the three national organisations no longer recommend the routine insertion of throat packs by anaesthetists but advise caution and careful consideration. Protocols for pack insertion were presented should their use be judged necessary.

These recommendations built upon a safer practice notice from the NPSA in 2009. If a throat pack is used, the use of at least one visual aid and at least one documented piece

of evidence of throat pack placement should continue as per this notice. The WHO checklist which includes throat pack use should be completed in full for every case.

The UHB is committed to ensuring patient safety and recognises that the peri-operative period poses a high risk to the patient. It is the intention of this policy to identify good clinical practice within the peri-operative environment and to ensure the health and safety of patients throughout their journey within this environment.

The overall aim of this policy is to ensure that throat packs are accounted for at all times.

Objectives

- . To prevent the retention of a throat pack.
- To prevent complications related to the use of throat packs.

Scope

The Association of Anaesthetists of Great Britain and Ireland Standards of Practice Guide (2010) state that “in providing care, an anaesthetist must recognise and work within the limits of their competence”.

The Royal College of Surgeons in their Good Surgical Practice (2014) states that you “take prompt action if you think that a patient’s safety, dignity or comfort is being compromised”.

The NMC Code of Conduct (2015) states that “you must maintain your knowledge and skill for safe and effective practice” and “be aware at all times of how your behaviour can affect and influence the behaviour of other people”.

The Health Professions Council (2014) states that as a professional “You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner and that you must communicate properly and effectively with service users and other practitioners.”

Routine use of anaesthetist inserted throat packs is no longer recommended. The decision to sue a throat pack should be justified. If it is judged that a throat pack is essential, then it should usually be decided at the team briefing of who is going to insert and remove it.

The pack must be added to the surgical scrub count. If packs are sited by an anaesthetist and are not sourced from the surgical swabs eg. Ribbon gauze, the anaesthetist must ensure the pack is added to the surgical count. The throat pack must be inserted in theatre so that the scrub practitioner witnesses the pack being inserted.

The final swab count should be completed before awakening the patient. The anaesthetist is responsible for checking a clear airway at the end of surgery before extubation. The procedure involving visual checks must be followed and documentary checks must be formalised and recorded.

Verbal acknowledgement must be received by a two person check upon insertion and removal of the throat pack.

Equality Impact Assessment	An Equality Impact Assessment has been completed. The Equality Impact Assessment completed for the policy found here to be no impact.
Documents to read alongside this Procedure	Waste Management Policy Risk Management Policy Equality and Human Rights Policy Swab, Instrument and Sharps Count Policy and Procedure
Approved by	Quality Safety and Experience Committee

Accountable Executive or Clinical Board Director	Medical Director
Author(s)	Peri-Operative Care Directorate Education Lead

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
UHB 1	15/12/2015	15/12/2015	New Policy and Procedure
UHB 2			Updated to reflect new guidelines

CONTENTS

1. METHOD

All staff are responsible for ensuring at:

- Their practice is in line with this policy and any additional local guidelines
- Staff must comply with the provision of this policy and where requested demonstrate compliance
- Information regarding failure to comply with the policy is reported to their line manager and where appropriate the incident reporting system is used
- Information regarding any changes in practice or legislation that would require a review of this policy is immediately responded to.

2. RESOURCES

No additional resources were identified as a result of approval of this policy and procedure.

3. TRAINING

Cardiff and Vale UHB is a teaching hospital and therefore supports the placement of students in the peri-operative environment, pre-registered nursing students, student operating department practitioners. During their placement in the peri-operative environment they will have supernumerary status until they have been deemed competent to assist with the count by a registered member of the peri-operative team.

During the orientation/induction programme for all new peri-operative staff, including junior and senior medical staff, an introduction and a copy of the UHB Management of Throat Pack Policy and Procedure will be given to individuals.

Additional training and department meetings will be used to refresh peri-operative staff with regards to the principles of best-practice in throat pack checking during quality and safety sessions.

4. AUDIT

Compliance with this Policy and Procedure will be internally audited on an annual basis. Compliance will also be monitored through the external QUAD annual process.

5. DISTRIBUTION

This Policy and procedure will be shared at Clinical Board and Directorate Quality and Safety meetings, will be displayed on departmental notice boards and will be available for viewing via the Cardiff and Vale UHB Intranet. A copy will also be provided to all Clinical Directors, Clinical Board Nurses, Lead Nurses for onward distribution and circulation to staff as necessary

6. REVIEW

This policy and procedure will be reviewed every 3 years or as often as is necessary to ensure continued compliance.

7. FURTHER INFORMATION

REFERENCES FOR SYSTEMATIC REVIEW, EDITORIAL, NAP 4

Have we reached the end for throat packs inserted by anaesthetists?

C. R.Bailey, J. M.Huitink Anaesthesia, 10 January

2018https://doi.org/10.1111/anae.14168

Systematic review of benefits or harms of routine anaesthetist-inserted throat packs in adults: practice recommendations for inserting and counting throat packs

An evidence-based consensus statement by the Difficult Airway Society (DAS), the British Association of Oral and Maxillofacial Surgery (BAOMS) and the British Association of Otorhinolaryngology, Head and Neck Surgery (ENT-UK)

V. Athanassoglou, A. Patel, B. McGuire, A. Higgs ,M. S. Dover, P. A. Brennan, A. Banerjee, B. Bingham, J. J. PanditAnaesthesia , 10 January 2018

4th national audit project: Major complications of airway management in the UK, Royal College of anaesthetists and the Difficult airway society, March 2011

Grandusky and Phippen (2000) Patient Care During Operative and Invasive Procedures. London Harcourt Brace

References

Association for Perioperative Practice (2007) Standards and Recommendations for Safe Perioperative Practice Harrogate, AfPP

Australian College of Operating Room Nurses (2006) Counting of Accountable Items Used During Surgery, Standard S3. In ACORN Standards for Perioperative Nursing ACORN, Australia www.acorn.org.au

Brigden R (1998) Brigdens Operating Department Practice. London Churchill Livingstone

Grandusky and Phippen (2000) *Patient Care During Operative and Invasive Procedures. London Harcourt Brace*

Haken, A. (2003) Poor Swab Management *The Clinical Services Journal* February pp.50-51

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NATN (1997) Universal *Precautions and Infection Control in the Perioperative Setting*. Harrogate, NATN

NATN (1998) The Count *Principles of Safe Practice in the Operating Theatre pp.*79- 82 Harrogate NATN

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NPSA (2009) reducing the risk of retained throat packs after surgery. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59853

Nursing Midwifery Council (NMC) (2015) Code of Professional Conduct, London NMC

Olsen C (1995) Sutures, Needles, and Instruments in Meeker M H (1995) *Alexander's Care of the Patient in Surgery* 10th Edition St Louis Mosby

Royal College of Surgeons (2014) *Good Surgical Practice*, London, RCS Eng

Rothrock J (Ed) (2002) Alexander's Care of the Patient in Surgery 12th Edn p36-37 London, Mosby

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) (2010) The good anaesthetists standards of practice. Available from: http://www.aagbi.org/publications/guidelines/good-anaesthetist-standards-practice-career-grade-anaesthetists

Tingle, J. (1997) Legal problems in the operating theatre: learning from mistakes *British Journal of Nursing* 6 (15) 889-891

Woodhead, K. and Wicker, P. (2005) A Textbook of Perioperative Care Oxford, Churchill Livingstone

8. PROCEDURE FOR THE MANAGEMENT OF A THROAT PACK

1. INTRODUCTION

The overriding principle for the check is that all throat packs must be accounted for at all times during an invasive surgical procedure in any clinical setting, to prevent retention and subsequent injury to the patient. The main areas for consideration are:

- Education/Training – use of throat packs only in specific individual cases.
- Responsibility for removing the pack
- Responsibility for the visual and documentary check

2. EDUCATION AND TRAINING

	ACTION	RATIONALE
2.1	On induction all staff (nurses, operating department practitioners (ODP) and unregistered staff) must have a supernumerary status whilst training.	So that they are supervised prior to working independently. All staff know how to access the policy and its importance in safe peri-operative practice.
2.2	All staff will have their own copy of the Throat Pack policy and have read and, understood it before participating in throat pack checks. Staff will be expected to sign a signatory sheet when issued with the policy which will then be placed in their training file.	New staff are aware of the location of the policies and procedures To provide an audit trail
2.3	All newly appointed staff will be trained and assessed against the standards in the induction booklet before participating in throat pack checks. The booklet will be retained in the staff member's training/personal file on completion of their induction which is kept with the practice education team.	All staff are to be aware of their responsibilities regarding the adherence to departmental policies. To maintain records and ensure evidence of training.

3. PRINCIPLES OF PRACTICE

3.1	The anaesthetist and surgeon should first discuss at the team brief if the use of a throat pack is clinically indicated and if so, discuss the procedures that would be used to prevent the retention (See flowchart, Appendix 1). The person siting and removing the pack must be identified eg. Surgeon or anaesthetist.	To establish the requirement of the throat pack To reduce the risk of a retained throat pack
3.2	The insertion of the throat pack is verbally communicated to the surgical team by the surgeon or anaesthetist responsible for its placement. The throat pack is placed in theatre so that the scrub practitioner responsible for the swab count witnesses the insertion of the throat pack	To ensure that the team know that a throat pack is in situ
3.3	The throat pack must be embedded with a radio opaque material	To provide a mechanism to check for retained throat packs.
3.4	The designated anaesthetic / theatre practitioner will ensure that a knot is tied at each end of the throat pack prior to insertion. This will be visually confirmed by the anaesthetist or surgeon that placed the throat pack.	To provide a mechanism for checking that the entire throat pack has been removed
3.5	At least one visually based procedure listed below must be applied whenever a throat pack is deemed necessary. This will be carried out by the designated	To provide a visual procedure to prevent the retention of the throat pack

	practitioner that assisted during the insertion of the throat pack • Label or mark the patient on the head. The label or mark should clearly identify the word 'throat pack' to distinguish between it and the mark used for correct site surgery • Attach the throat pack securely to the artificial airway • Leave part of the pack protruding It is the anaesthetist / surgeon who inserted the throat pack responsibility to ensure that the above actions have been carried out.	
3.6	Whenever a throat pack is deemed necessary, the designated practitioner that assisted during the insertion of the throat pack must document by: • Formally recording the insertion of the throat pack in the patients care plan • Record the insertion of the throat pack on the swab board	To provide a documentary procedure to prevent the retention of the throat pack
3.7	During the 'time out' section of the World Health Organisation (WHO) Surgical Safety Checklist the insertion of the throat pack should be identified verbally to the whole team by the person who inserted it	To prevent retention of the throat pack To ensure accountability for the removal of the throat pack
3.8	At the end of the procedure the throat pack should be removed by the person responsible for its insertion.	To prevent retention of the throat pack and to ensure accountability for removal
3.9	When the throat pack is removed a VISUAL check of the throat pack will be performed as a 'two person' check by the	To prevent retention of the throat pack

	person responsible for its insertion and the designated practitioner to confirm that the throat pack has a knot at each end	To confirm that the entire throat pack has been removed
3.10	When the throat pack is removed and the visual check has taken place, the designated practitioner that assisted during the removal of the throat pack must document by: • Formally recording the removal of the throat pack in the patients care plan • Record the removal of the throat pack on the swab board	To maintain accurate patient records To maintain an audit trail
3.11	When the throat pack has been removed it is the responsibility of those involved in the 'two person' check to remove the throat pack label / mark from the patient before the patient leaves theatre	To indicate that the throat pack has been removed
3.12	During the 'sign out' section of the World Health Organisation (WHO) Surgical Safety Checklist the removal of the throat pack should be verbally confirmed by the person who removed it and documented on the care plan	To ensure that the entire team know that the throat pack has been removed
3.13	The anaesthetist providing hand over of the patient to the recovery practitioner must confirm the removal of the throat pack.	To ensure effective communication between theatre and recovery

APPENDIX 1

Active decision made to site throat pack

Team decides at team brief who will insert the throat pack

Anaesthetist

Surgeon

Throat pack is added to surgical swab count

The person that inserts the throat pack is responsible for its removal.

The Anaesthetist is responsible for checking clear airway at end of procedure prior to extubation

Equality Impact Assessment

Section A: Assessment	
Name of Policy	**MANAGEMENT OF A THROAT PACK – POLICY AND PROCEDURE**
Person/persons conducting this assessment with Contact Details	Barbara Jones Perioperative Care Directorate Education Lead – 02920 745537
Date	25th September 2019

1. The Procedure
Is this a new or existing procedure? Existing
What is the purpose of the procedure? To provide anaesthetists, surgeons and theatre personnel with an evidence based clinical practice process for the management of cases involving throat packs. The overall aim of this policy is to ensure that throat packs are accounted for at all times.
How do the aims of the procedure fit in with corporate priorities? i.e. Corporate Plan The UHB is committed to ensuring patient safety and recognises that the peri-operative period poses a high risk to the patient. It is the intention of this policy to identify good clinical practice within the peri-operative environment and to ensure the health and safety of patients throughout their journey within this environment. To reduce the incident of a “never event” and promote engagement in the World Health Organisation (WHO) checklist process. This Procedure is linked with the following documents: • Health and Safety Policy • Waste Management Policy • Risk Assessment and Risk Management Procedure • Risk Management Policy • Incident Reporting and Investigation Procedure • Swab, Instrument and Sharps Count Policy and Procedure

Who will benefit from the procedure?

This policy and procedure will benefit all staff and patients in ensuring adequate arrangements are in place to manage the risks associated with management of a throat pack.

What outcomes are wanted from this procedure?

- To prevent foreign body retention and subsequent injury/harm to the patient.

Are there any factors that might prevent outcomes being achieved? (e.g. Training/practice/culture/human or financial resources)

Contributory factors may include

- Adequate training provision
- Safe Systems of working

To address these factors we have put in place the following:

- Cardiff and Vale UHB is a teaching hospital and therefore supports the placement of students in the peri-operative environment, pre-registered nursing students, student operating department practitioners. During their placement in the peri-operative environment they will have supernumerary status until they have been deemed competent to assist with the count by a registered member of the peri-operative team.

- During the orientation/induction programme for all new peri-operative staff, including junior and senior medical staff, an introduction and a copy of the UHB Management of Throat Pack Policy and Procedure will be given to individuals.

- Additional training and department meetings will be used to refresh peri-operative staff with regards to the principles of best-practice in throat pack checking during quality and safety sessions.

The outcome of the policy and procedure can be affected detrimentally by any of the above not being in place.

2. Data Collection

What qualitative data do you have about the policy relating to equalities groups (e.g. monitoring data on proportions of service users compared to proportions in the population)?

There was no specific equalities data available.

What quantitative data do you have on the different groups (e.g. findings from discussion groups, information from comparator authorities)?

Data was collected relating to the ethnicity of our staff.

Please indicate the source of the data gathered? (e.g. Concerns/Service/Department/Team/Other)

Reference was made to the Equality Impact Assessment undertaken for the Recruitment and Selection Policy, which had gathered data from the workforce profile of the Cardiff and Vale UHB and information was obtained from NHS Jobs.

What gaps in data have you identified? (Please put actions to address this in your action plan?)

Not applicable.

The following documents were referenced when undertaking this Equality Impact Assessment.

Cardiff and Vale University Health Board, November 2013, *Recruitment and Selection Policy Equality Impact Assessment*, http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/238805

3. Impact
Please answer the following Consider the information gathered in section 2 above of this assessment form, comparing monitoring information with census data as appropriate (see www.ons.gov.uk Office National Statistics website) and considering any other earlier research or consultation. You should also look at the guidance in Appendix 1 with regard to the protected characteristics **stating the impact and giving the key reasons for your decision.**
Do you think that the policy impacts on people because of their age? (This includes children and young people up to 18 and older people) No
Do you think that the policy impacts on people because of their caring responsibilities? No
Do you think that the policy impacts on people because of their disability? (This includes Visual impairment, hearing impairment, physically disabled, Learning disability, some mental health issues, HIV positive, multiple sclerosis, cancer, diabetes and epilepsy.) No
Do you think that the policy impacts on people because of Gender reassignment? (This includes Trans transgender and transvestites) No
Do you think that the policy impacts on people because of their being

married or in a civil partnership? No
Do you think that the policy impacts on people because of their being pregnant or just having had a baby? No
Do you think that the policy impacts on people because of their race? (This includes colour, nationality and citizenship or ethnic or national origin such as Gypsy and Traveller Communities.) No
Do you think that the policy impacts on people because of their religion, belief or non-belief? (Religious groups cover a wide range of groupings the most of which are Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs. Consider these categories individually and collectively when considering impacts) No
Do you think that the policy impacts on men and woman in different ways? No
Do you think that the policy impacts on people because of their sexual orientation? (This includes Gay men, heterosexuals, lesbians and bisexuals) No
Do you think that the policy impacts on people because of their Welsh language? No
4. Summary.
This policy and procedure aims to implement actions that will minimize the risk of foreign body retention and subsequent injury/harm to the patient.
Impact expected to be **neutral.** The supporting procedure seeks to address any issues regarding language and disability.

5. Report, publication and Review **Please record details of the report or file note which records the outcome of the EQIA together with any** **actions / recommendations being pursued (date, type of report etc)**

Please record details of where and when EQIA results will be published On UHB intranet and internet site			
Please record below when the EQIA will be subject to review. 3 years after approval of procedure, or earlier if required by changes to legislation or best practice			
Name of person completing	Barbara Jones		
Signed	Barbara Jones		
Date	25th September 2019		
Name of Responsible Executive/Clinical Board Director Authorising Assessment and Action Plan for publication	Medical Director Quality Safety and Experience Committee		
Signed		**Date**	

Title:	**Update of Healthy Eating Standards for Hospital Restaurant and Retail Outlets**						
Meeting:	Quality, Safety & Experience Committee				**Meeting Date:**	17.12.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Fiona Kinghorn Executive Director of Public Health						
Report Author (Title):	Rhianon Urquhart Principal Health Promotion Specialist						

SITUATION

Cardiff and Vale University Health Board (UHB) formally adopted the Healthy Eating Standards for Restaurant and Retail Outlets in December 2015. The Standards have been implemented across all UHB-run restaurant and retail food outlets, which are regularly audited to monitor and ensure compliance with the Standards. We are the first Health Board in Wales to adopt this approach, whereby a minimum of 75% of the food and drink on offer in our restaurants and retail outlets are classed as healthier options.

The Working Group has refreshed the documentation and recommends amending the first criteria so that the Standards are also applied to externally-provided retail outlets. This will ensure a consistent approach with the Platinum Corporate Health Standard Award held by the UHB along with any applications to tender from external providers wishing to have a presence in the redeveloped Concourse at UHW.

BACKGROUND

In Cardiff and Vale, less than a third (31%) of adults report eating the recommended 5 portions of fruit and vegetables a day and over half of the adult population (56%) are overweight or obese. We know that being overweight or obese puts us at greater risk of developing chronic health conditions such as type 2 diabetes and coronary heart disease. For those living in more disadvantaged areas in Cardiff and the Vale, access to healthy, affordable food is often difficult.

Cardiff and Vale UHB is committed to caring for people and keeping people well and one way of achieving this is through creating supportive environments which enable healthy choices to be made. A substantial amount of work with colleagues from Catering, Procurement and Public Health Dietetics has been delivered to provide a retail food offer to our staff, visitors and patients that is healthier in terms of low fat, low sugar options. The consumer and retail experience has been greatly improved. Our main aim is to ensure that the healthy food choice is the easy choice on offer across all of our outlets.

Our work has been recognized UK-wide by the Cost Catering Sector Award and the NHS Business Awards and was highly commended by the Corporate Health Standards assessors in December 2018. The Cardiff and Vale UHB work was used as an exemplar for the Welsh Government `Healthy Weight Healthy Wales' strategy, launched this October.

The documentation for the Standards have been refreshed recently (attached at Appendix 1).

ASSESSMENT

Since the introduction of the Restaurant and Retail Standards, compliance with the 75-25% spilt in favour of healthy options has increased and we are currently at a 77% compliance across all of our food retail outlets – this includes both restaurants , Y Gegin and at UHL - and each of the Aroma outlets. We also audit the Spar convenience store at UHL and have recently begun this process with the Royal Voluntary Service Trolleys at UHW and UHL. We have included the vending machines in the criteria, based on guidance from WG for healthy vending.

We have a Working Group which regularly meets to monitor compliance and other issues that might arise. The Working Group membership reflects the partnership approach we have taken to ensure that all aspects of delivering a healthy food offer are accounted for. Colleagues are drawn from Catering, Food Production, Facilities, Procurement, Public Health and Public Health Dietetics and we work together to audit the products and meals on offer for their nutritional content as well as the range of products on offer.

Public Health is represented on the UHW Concourse Redevelopment Group and from the beginning of the process, retailers interested in applying for space in the Concourse were asked to submit their Expressions of Interest outlining how they would conform with the 75-25% split.

In order to ensure consistency and to reinforce our public health messages, it is appropriate to revise the criteria, which requires a 75%, split in favour of healthier options to apply to external providers. They would be subject to the same audit requirements and would allow access to the training and support on offer to our own internal catering / retail staff through `Nutrition Skills for Life' (Level 1 & 2) and 'Making Every Contact Count' training.

ASSURANCE is provided by:
These UHB Healthy Eating Standards for Hospital Restaurant and Retail Outlets have changed the balance of healthier food provision on our sites and are being extended.

RECOMMENDATION
The Committee is asked to:

- APPROVE the revision of the criteria to include external food retail providers
- SUPPORT continued development of this work

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

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

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Healthy Eating Standards for Hospital Restaurant and Retail Outlets

Date of issue: December 2014
Updated: December 2019
Review date: December 2022

Policy steering group members:

Chloe Barrell, Health Promotion Practitioner, Cardiff and Vale Public Health Team

Emma Holmes, Clinical Lead for Public Health Dietetics, Cardiff and Vale University Health Board

Helen Griffith, Senior Health Promotion Specialist, Cardiff and Vale Public Health Team

Joanne Jefford, Dietetic Catering Lead and Nutrition and Dietetic Manager, Cardiff and Vale University Health Board

Karina Mackay, Staff Dietitian, Cardiff and Vale University Health Board

Peter Cockburn, Head of Commercial Services, Cardiff and Vale University Health Board

Rhianon Urquhart, Principal Health Promotion Specialist, Cardiff and Vale Public Health Team

Simon Williams, Commercial Services Manager, Cardiff and Vale University Health Board

Stepfanie Burgess, Restaurant and Retail Manager, Cardiff and Vale University Health Board

Stuart Davies, CFPU Manager, Cardiff and Vale University Health Board

Nia Price, Assistant Procurement Business Officer, Cardiff and Vale University Health Board

CONTENTS

FOREWORD

Cardiff and Vale University Health Board (UHB) is committed to improving the health and wellbeing of our staff as well as our local population. The UHB formally adopted Healthy Eating Standards for Restaurant and Retail Outlets in December 2015 to improve the food offer for staff, visitors and patients attending our hospital sites. The Standards apply to all UHB-run restaurant and retail food outlets, and we audit each outlet to monitor and ensure compliance with them. We are the first Health Board in Wales to adopt this approach, making the healthy choice the easy choice for customers. It's time to take our approach even further.

We are regularly improving the availability, range and affordability of healthy options offered at our UHB-provided hospital restaurants and cafes in order to make the healthy choice the easy choice. We hope that you will help us make Cardiff and Vale UHB a healthier place to work and take the opportunity to role model the way to make positive changes to improve your health.

Fiona Kinghorn

Executive Director Public Heath

BACKGROUND

Being a healthy weight is both good for us and it makes us feel good. It has become one of the most effective ways to reduce the risk of long-term health conditions such as diabetes, heart disease and cancers. However, in our current environment it is difficult to achieve this as our food provision has developed in a way that prioritises convenience over health.

Despite widespread knowledge regarding the benefits of maintaining a healthy balanced diet, increasing urbanisation, a more fast-paced way of life and increased production of processed foods has led to a gradual shift in the dietary habits of the UK population. As a result, we are eating less fruit and vegetables, oily fish and dietary fibre, but instead are consuming a greater proportion of energy-rich foods high in fat, salt and sugar.

In Cardiff and the Vale of Glamorgan, less than a third (31%) of adults report eating the recommended 5 portions of fruit and vegetables a day, and over half (56%) are overweight or obese (National Survey for Wales, 2019) . We know that being overweight or obese puts us at greater risk of developing chronic health conditions such as type 2 diabetes and coronary heart disease. The food and drink we consume impacts on our oral health and can lead to dental decay, so this also remains a public health concern.

VISION

We are committed to caring for people, taking preventative measures to keep people well and influencing healthier food provision. We have a public duty to act now and ensure the wellbeing of future generations, and work hard to be an exemplar in empowering people to make healthier choices.

As outlined in the Cardiff and Vale UHB Shaping our Future Wellbeing Strategy, our lifestyle behaviours are influenced by the environment in which we live and work and how able we feel to make changes. The UHB is one of the largest NHS organisations in the UK, providing healthcare services for nearly 500,000 people living in Cardiff and the Vale of Glamorgan. To improve the future health and wellbeing of our population we will create an environment in which individuals have a sense of personal responsibility for their health and are supported to adopt behaviours that reduce their risk of poor health. The UHB has a responsibility to ensure provision of opportunities to access healthy food and drink within the workplace, to positively contribute towards the health and wellbeing of the 14,500 staff it employs, supporting them to be fit and healthy to offer the best service to patients and reduce staff sickness. As well as

our staff, we welcome approximately 200,000 patients and visitors per year onto our sites. Supporting staff, patients and visitors to make healthier food and drink choices requires strategic co-ordination and the collaboration of Commercial Services, Dietetic Services, Procurement and the Local Public Health Team. A Working Group, established in 2013 to implement the current 'Hospital Restaurants and Retail Catering Outlets Food Standards', continues to find opportunities for improvements in this work.

LARGE SCALE CHANGE

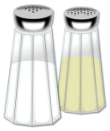
Supporting people to change their dietary habits is a gradual process that requires long-term thinking and a shift in the way we procure, sell and prepare food. We recognise this and continue to work collaboratively with our Health Board colleagues and food industry partners to identify and address changes in the wider system that enable us to make healthier choices more accessible and sustainable. In order to do this we present a policy that requires executive and Board-level commitment to ensure these Standards are implemented.

The Standards drive our ambition to normalise a healthy food environment, changing peoples' expectation of restaurant and retail food provision on hospital sites to one that represents and promotes wellbeing. As part of our commitment to the national `Healthy Weight: Healthy Wales' Strategy, we will continue to implement strict criteria, alongside other initiatives, that supports people to achieve and maintain a healthy weight.

REQUIREMENTS:

The updated Standards require that all outlets providing food and drink items within Cardiff and Vale UHB hospital sites (UHB provided and non-UHB provided) comply with the 75-25% split in favour of healthier options along with the following criteria:

	A minimum of **75%** of the quantity and range of items available for customers to purchase within each product category must be classed as healthier.
	**Only healthier food and drink items can be promoted**, e.g. at till point, in special offers/meal deals, in window displays and via other promotional activities. Products that are not classed as 'healthier' cannot be promoted.

	A **healthier hot meal must be available for purchase as the cheapest** hot meal option available and promoted as such , for example, the 'deal of the day'.
	**Whole fresh fruit must be available** for purchase at all meal times, that is cheaper for the customer to purchase than the majority of confectionary items, and that is included as an option in all meal deals.
	The **nutritional information of all** products to be **displayed to the customer**, as per the Food Standards Agency (FSA) traffic light system.
	Free drinking water is readily available to all restaurant users and location of drinking water highlighted to customers at till point.
	Salt must not be provided at tables – sachets must be available at service counter only.
	**All vending machines** are **100% compliant** with Welsh Government Health Promoting Hospital Vending Guidance (2012) or with subsequent Welsh Government mandates relating to hospital vending.
	**Ensure compliance with the EU Food Information for Consumers Regulation 1169/2011**

The Standards ensure that staff, visitors and patients are encouraged and supported to eat well, with healthy options widely available, and a significant reduction in the quantity of energy-dense, high fat, high sugar and high salt food and drink products.

These Standards will also apply to all new and renewed commercial contracts with non-UHB provided catering and retail outlets on Cardiff and Vale UHB hospital sites as a requirement of their lease. These Standards do not apply to inpatient food provision, which must currently comply with the Welsh Government All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011).

COMPLIANCE WITH THE STANDARDS

In order for food and drinks to be included within the 75% range they must not have high levels of fat, sat fat and/or sugar as defined by the FSA. The audit process will measure compliance within the following categories

Table 1: Criteria for 'healthier' food and drink products by category

Restaurant and Café Outlets	**Product Category**	**Examples**	**Criteria**
	Hot food	Hot meals, cooked puddings, microwaveable ready meals	Must **NOT** be high in fat, saturated fat or sugar as defined in table 2
	Cold food	Sandwiches, salads, cold pasties/sausage rolls, cereals	
	Snacks and confectionary	Crisps, sweets, nuts/seeds, cereal bars, fresh fruit, fruit pots, cakes, biscuits, ice cream	Must **NOT** be high in fat, saturated fat or sugar as defined in table 2, unless fat or sugar is naturally occurring in the product
	Drinks	Hot chocolate, coffee drinks (e.g. lattes, cappuccinos), flavoured water, carbonated drinks, fruit juice/juice drinks, milk based drinks	1. Must **NOT** be high in fat, saturated fat **or sugar** – as defined in table 3 2. Must **NOT** contain **any** 'added sugars', except for the following products provided there is no more than 5% 'added sugars' and the dairy based drinks are based on skimmed, 1% or semi-skimmed milk: - Flavoured milk - Milk based drinks, e.g. iced coffee drinks - Yoghurt drinks - Dairy smoothies 3. **No carbonated drinks are permitted** except: - Carbonated water - Carbonated pure fruit and vegetable juices - Pure fruit and vegetable juices diluted with

			carbonated water (if contains a minimum 50% fruit or vegetable juice)
Retail outlets / Convenience Store	Groceries	**Chilled/fresh foods:** cheese, spreads, fresh milk, deserts **Ready meals:** fresh/frozen pre-packaged lasagnes, pizzas, burgers etc. **Perishable foods:** bread, eggs, flour, etc. **Non-perishable foods:** pasta, rice, tinned vegetables, tinned/packet soups, jam, pasta/curry sauce	Must **NOT** be high in fat, saturated fat or sugar as defined in table 2

MONITORING THE STANDARDS

Products will be audited based on the Food Standards Agency guidance for determining whether products are low (green), medium (amber) or high (red) using table 2 below. (From *Annex 3 Guidance for nutritional labelling, 2016.)*

The information needed is the amount of fat, saturated fat and total sugar per 100g.

If the portion/serving size of the product is more than 100g or 150 ml, you will also need:

- Amounts of fat, saturates, (total) sugars and salt **per portion** (can be calculated using per 100g/ml information and portion size).
- Criteria for red (HIGH), amber (MEDIUM) and green (LOW) as set out below.

Table 2: Criteria for 100g of food

Colour Code	*Low*	*Medium*	*High per 100g*	*High per portion*
Fat	≤ 3.0g/100g	> 3.0g to ≤ 17.5g/100g	> 17.5g/100g	> 21g/portion
Saturates	≤ 1.5g/100g	> 1.5g to ≤5.0g/100g	>5.0g/100g	> 6.0g/portion
Total Sugars	≤ 5.0g/100g	> 5.0g to ≤ 22.5g /100g	> 22.5g/100g	> 27g/portion
Salt	≤ 0.3g/100g	> 0.3g to ≤ 1.5g/100g	>1.5g/100g	>1.8g/portion

Table 3: Criteria for drinks (per 100ml)

Note: Portion size criteria apply to portions/serving sizes greater than 150ml

Colour Code	*Low*	*Medium*	*High per 100g*	*High per portion*
Fat	≤ 1.5g/100ml	> 1.5g to ≤ 8.75g/100ml	> 8.75g/100ml	>10.5
Saturates	≤ 0.75g/100ml	> 0.75g to ≤ 2.5g/100ml	> 2.5g/100ml	> 3g/portion
Total Sugars	≤ 2.5g/100ml	> 2.5g to ≤ 11.25g/100ml	> 11.25g/100ml	> 13.5g/portion
Salt	≤ 0.3g/100ml	>0.3g to ≤0.75g/100ml	> 0.75g/100ml	> 0.9g/portion

Exceptions

As outlined in the Corporate Health Standard Award Vending Machine Food Guidance (2015), processed products containing natural fats or sugars, directly pertaining from foods known to have health benefits, including fruit, vegetables, nuts and seeds are exempt unless they have added sugar or fat.

Added sugars: sugars from fruit will not be taken into account when assessing sugar levels, unless the product has added sugar (or a sugar derivative including honey and glucose syrup) as an ingredient. For example, a product containing dried fruit may exceed the bought-in product specification for sugar, however if they have no added sugar then the product is acceptable. Acceptability will be determined by the ingredients' list, which will reference any "added sugar".

Added sugars: fats from nuts and seeds are not taken into account when assessing fat content, unless the product has added fat from an additional ingredient. For instance, if a cereal bar contains nuts and seeds and no additional vegetable oil or other fat source it will be acceptable.

Vending guidance: all products sold in vending machines must also comply with Welsh Government Health Promoting Hospital Vending Guidance, (2012).

- All food and drink supplied/sold in vending machines must be the healthier option, 100% compliant.

- Food and drinks supplied/sold from vending machines must not be damaging to dental health.
- Branding on vending machines must support health promoting messages
- All existing and new vending contracts must agree to the above as outlined in contractual agreements

EVALUATION AND GOVERNANCE

- The Working Group oversees the implementation of the Standards and monitors compliance. The Working Group reports into the UHB Nutrition and Catering Steering Group, 3 times per year
- In addition to audit data, we collect feedback from customers using customer surveys
- Sales data is reviewed by the Working Group and used to inform healthier product selection and monitor sales
- Nutrition training and regular updates on the Standards are provided for catering staff to increase knowledge of the importance of healthier food provision and support implementation of the Standards
- All outlets (restaurants, cafes, retail outlets, trolleys and vending machines) across the UHB will be audited on a rolling 12-month cycle by representatives from Catering, Public Health and Public Health Dietetics. Regular spot checks will also be carried out throughout the year to support the audit process and maintain the requirements of the Standards
- Audit results will be calculated and fed back to:
    - Restaurant and Retail Hospital Food Standards Working Group
    - Nutrition and Catering Steering Group
    - Cardiff and Vale Public Health Team monthly performance management meetings
    - Capital and Estates performance meetings.

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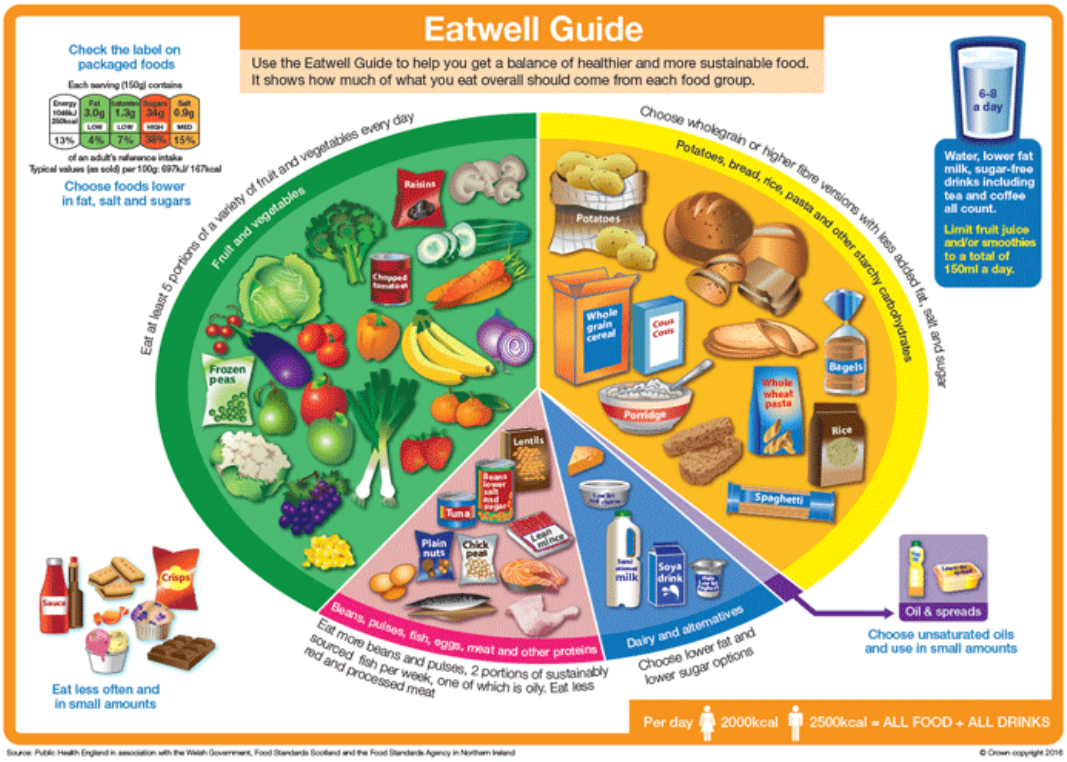


REPORT TITLE:	**NICE GUIDANCE**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**17.12.19**	
STATUS:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Medical Director								
REPORT AUTHOR:	Head of Patient Safety and Quality Assurance								

PURPOSE OF REPORT:

SITUATION: The paper

REPORT:

BACKGROUND:

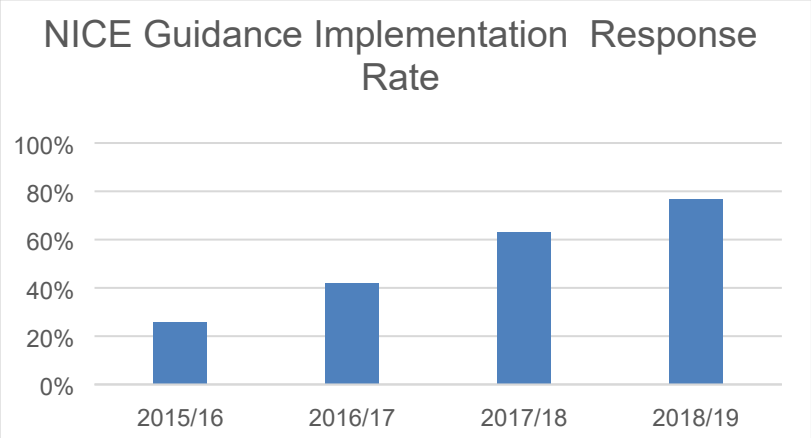
The National Institute for Health and Care Excellence is an independent arm of the NHS that is responsible for providing guidance on treatments and care for people in the NHS in England and Wales. NICE guidance other than Technology Appraisals (TA) are currently disseminated by the Patient Safety and Quality Team to identified Clinical Leads and Clinical Board Directors on a monthly basis.

Implementation of NICE guidance other than TAs is not mandated, however it represents independent and objective evidenced based advice about health care provision and implementation is therefore carefully considered. Compliance with medicines related Technology Appraisals (TA) has been mandated since the launch of the New Treatment Fund at the beginning of 2017 and has been recorded since this time. There is a requirement to include medications on the formulary within two months of the publication of the TA and this process is overseen by Pharmacy.

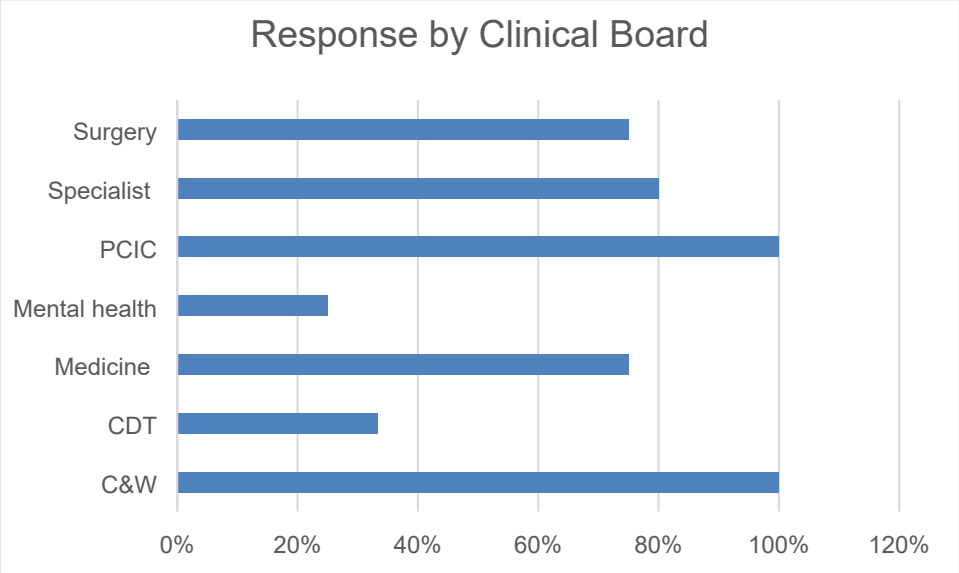
ASSESSMENT:

NICE guidance is disseminated to Clinical Boards for action or for information only. NICE guidance circulated “for action” is sent to the Clinical Board Director and the Clinical Lead to consider implementing. Clinical Boards are asked to respond detailing their levels of implementation. Partial or non-implementation should be discussed in Clinical Board Quality Safety and Experience (QSE) Committee meeting to mitigate any risk associated with non-implementation and where necessary should be included on the Clinical Board Risk Register. Clinical Boards are cited on all NICE Guidance sent to their directorates to consider.

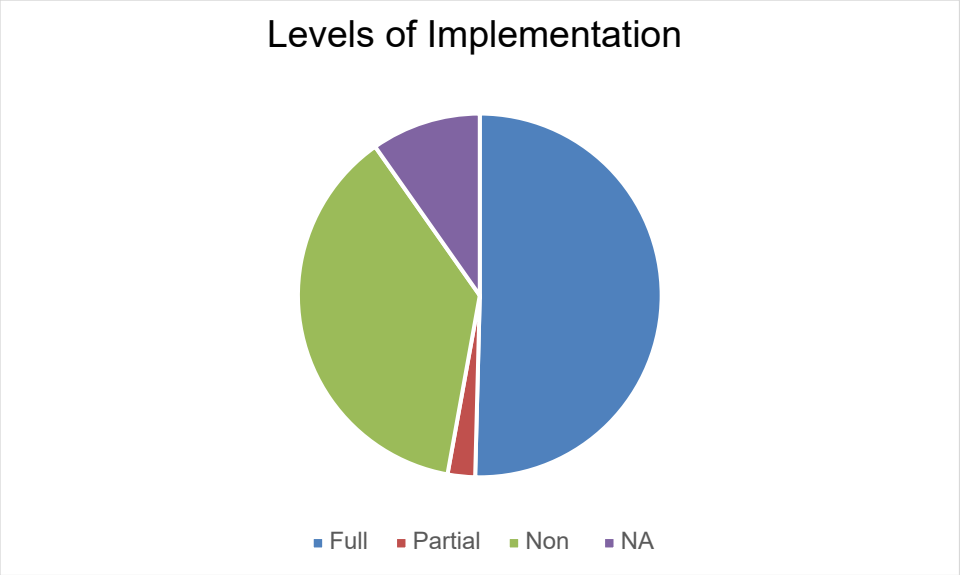
In 2018 /19 Clinical Boards gave details around the levels of implementation for 77% of guidance disseminated for action. This represents a significant and sustained improvement since 2015/16.



Response Rate by Clinical Board 2017 / 2018

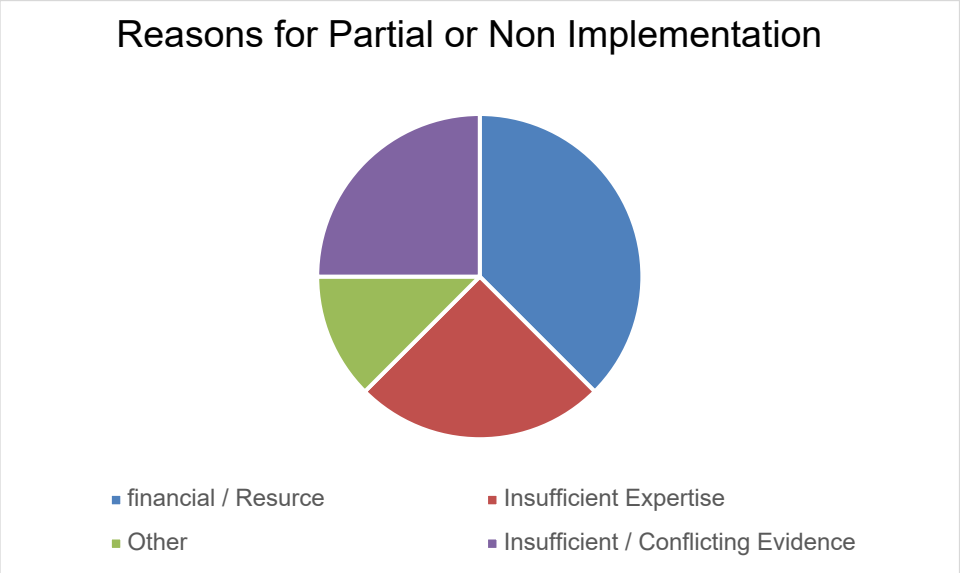


Between April 2018 and March 20119 Clinical Boards were sent 116 pieces of NICE guidance to review. Of the responses received relating to levels of implementation, 62 % of guidance was implemented in full and a further 3% were implemented in part.



In 2017/18 the reasons for non-implementation were varied and in many cases there was work underway to implement guidance.

In 2018/19 financial or funding implications were the most commonly cited reason, in addition poor or conflicting evidence base was noted to be the reason for non-implementation in a number of cases.



Current areas of outstanding non-implementation are:

NG80 Asthma: diagnosis, monitoring and chronic asthma management
At the point of reviewing the guidance the expertise and funding was not available for FeNo diagnostic testing to be made available in primary care and the process was not incorporated in the Quality Outcomes Framework (QOF).

The treatment element of NG80 differs from the British Thoracic Society guidance and this is

being discussed nationally.

IPG611 – Prostate artery embolisation for lower urinary tract symptoms caused by benign prostatic hyperplasia

This is not a funded service within the health board and there is not the necessary skill to implement.

IPG614 – Endoscopic Bipolar Radiofrequency ablation (RFA) for treating biliary obstruction caused by cancer

No Radiofrequency Ablation currently available in the UHB. This is currently under review by WHSSC

CG192 – Antenatal and postnatal mental health: clinical management and service guidance

While the majority of the guidance is implemented there is no Mother and Baby Unit in Wales. A transformational bid has been submitted to fund additional psychology support.

MTG17 – The Debrisoft monofilament debridement pad for use in acute or chronic wounds

This product is used with guidance and prescription from a specialist wound healing team but is not currently included on a local formulary**.**

NG106 – Chronic heart failure in adults: diagnosis and management

The Cardiac Rehabilitation team are not currently resourced to allow exercise based rehabilitation to all patients. A business case is currently under development for a hospital based heart failure cardiac rehabilitation programme and a hospital and community based heart failure cardiac rehabilitation programme.

NG99- Brain Tumors and Brain Metastases in Adults

The Current MRI capacity is not adequate to allow post-operative scanning following specific guided resections or intra operative MRI or Diffusion Tensor Imaging MRI.

MTG41 – Senza spinal cord stimulation systems for delivering HF10 therapy to treat chronic neuropathic pain

There is weak evidence to support the implementation of this guidance. The health board uses an alternative system that incorporates high frequency stimulation

MTG16 – E−vita open plus for treating complex aneurysms and dissections of the thoracic aorta

Since 2017, our patients have accessed this procedure in England.

IPG612 – Microinvasive subconjunctival insertion of a trans-scleral gelatin stent for

primary open-angle glaucoma.

Weak evidence base. Feedback from national groups is that this method is not effective

IPG625 – Transurethral water vapour ablation for lower urinary tract symptoms caused by benign prostatic hyperplasia

There is not currently the expertise in the department to be able support this procedure over existing procedures

NG98 – Hearing loss in adults: assessment and management

There is weak evidence to support the change to MRI of the internal auditory meati for adults with sensorineural hearing loss and no localising signs if there is an asymmetry on pure tone audiometry of 15 dB or more at any 2 adjacent test frequencies, using test frequencies of 0.5, 1, 2, 4 and 8 kHz. Instead the criteria for asymmetry on PTA of 20 dBHL or more at any 2 adjacent frequencies of 0.5, 1, 2, and 4 kHz in used.

IPG639 - Laparoscopic cerclage for cervical incompetence to prevent late miscarriage or preterm birth.

Financial constraints prevent the implementation of this guidance. It would require complete antenatal screening to identify appropriate women and a range of therapies including laprascopic cerclage would be required.

RECOMMENDATION:

The committee is asked to **note** the processes in place to consider NICE Guidance and the levels of implementation.

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	✓	9. Reduce harm, waste and variation sustainably making best use of the	✓

entitled to expect		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:**	**17-12-19**	
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

In the last report to Committee, we advised that a National review of Maternity Services was underway, involving a series of unannounced visits to maternity units across Wales. The UHB had already submitted a self-assessment and the necessary required evidence. An unannounced inspection took place from Monday November 18th. The inspectors spent considerable time reviewing governance, culture, safety and multi professional working as well as looking at systems and processes; they also spoke to a number of staff during their visit.

The HIW inspectorate team shared that this was a very positive review and that the Maternity Service being delivered was one of the best units for multi professional working and evidence based care that they have reviewed across the country.

There was an immediate assurance issue identified in relation to resuscitative checks and emergency resuscitation trolley checks as well as availability of and access to equipment. All of these were completed and actioned at the time of the review and a robust improvement plan has been submitted to HIW since the inspection. The draft report is awaited.

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. An inspection is expected in the near future.

Announced visits

None have taken place since the last report to Committee.

Unannounced inspections

Since the last report to Committee in September 2019 the following unannounced visits have taken place.

Stroke Rehabilitation Centre

This unannounced visit took place on September 17th 2019. There was an immediate assurance

issue which related to the checking of the resuscitation trolley. This was addressed immediately and an Internal Safety Notice and Safe Practice Notice (**Appendix 1**) was distributed widely across the organization to remind UHB staff of their role and responsibilities in relation to this issue.

Feedback on the day was positive. The final report commented that:

The ward provided a good environment to support the rehabilitation for stroke patients. It was well-equipped and spacious with a range of social activities available for patients ….. care was planned in a way to promote patient independence, and was delivered by a multidisciplinary team of relevant specialisms. A new initiative was being developed to amalgamate patient goals across the multidisciplinary team, to make care plans more patient centred.

Staff on the ward were professional and committed to working collaboratively to provide patient care …. there was strong leadership on the ward. However, many staff felt there were not enough staff available, which could affect the standard of care. The demanding role of nursing on the ward was highlighted by staff.

Patients generally reported a positive experience on the ward and were treated with dignity and respect. However there were concerns relating to some staff working night shifts.

There was evidence that the health board was not fully compliant with all Health and Care Standards in all areas. This included a weakness with information governance on the ward, and improvements were needed in infection prevention and control.

A robust improvement plan has been submitted to HIW and they have confirmed that this has provided them with the necessary assurance.(Appendix 2). At the time of writing, the UHB is awaiting publication in December 2019.

Rookwood Hospital (The Welsh Spinal Cord Injury Rehabilitation Centre) – Wards 4 and 5

An unannounced visit took place on 1st and 2nd October. Feedback on the day was very positive. HIW commented that overall they had found there was a dedicated and committed team of staff providing a high standard of care to patients. They found care to be person centered and delivered on an individualized basis.

While, they had identified some areas for improvement, these were predominantly related to the environment and the impact on infection, prevention and control standards. The Committee should be advised that there are few incidents of hospital acquired infection control or outbreaks of infection in this area which has a very good record in relation to IP&C

They commented that was the service did well was that:

- Patients told them they were happy with the care they had received
- Effective multidisciplinary team working was demonstrated
- Care was provided in a personal and dignified manner
- Effective care was demonstrated in relation to preventing pressure ulcers, falls and infections
- Supportive management and leadership was given to the unit team

Recommendations for improvement included:

- Accessibility to patient information
- The need to provide specialist equipment in a timely way to uphold patient dignity
- Access to call bells
- A review of staffing to include nurses, occupational therapists and the urology service, to ensure patients receive timely care
- a review and risk assessment of the storage of equipment on the unit
- Infection control
- Some aspects of medicines management
- Staff access to training and appraisals

At the time of writing, the UHB is developing an improvement plan to address the recommendations

Primary Care Contractors

The outcomes of visits to Primary care contractors is described in a separate report to Committee.
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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			
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.									

SAFETY NOTICE

Immediate action	
Action	✓
Update	
Information Request	

ATTENTION

All staff in areas that possess a Resuscitation Trolley.

SITUATION

It has become apparent during formal inspections of Clinical Areas that the formal checking of the contents and operational functionality of Resuscitation Trolleys is not being undertaken within the correct timescales as specified within the Cardiff and Vale UHB Resuscitation Procedure.

BACKGROUND

The Resuscitation Procedure stipulates the contents of the UHB Resuscitation Trolleys, and also the checking procedure. This procedure is in line with the Quality Standards for Resuscitation Equipment as defined by the Resuscitation Council (UK) guidelines 2016

The Cardiff and Vale UHB Resuscitation Procedure section 10 states

"10.0 RESUSCITATION EQUIPMENT
All departments within Cardiff and Vale UHB will ensure that they have a Resuscitation Trolley with the appropriate equipment as designated by the Resuscitation Committee.
10.1 Acute Hospital Resuscitation Equipment

- Pocket masks should be easily accessible throughout clinical areas as well as with the resuscitation equipment. These are used to prevent direct person-to-person contact, and may reduce the risk of cross infection between patient and rescuer (*Quality Standards for cardiopulmonary resuscitation practice and training, 2016)*

- Adult and paediatric resuscitation equipment should follow the standardised equipment list, which has been based on current

UK Resuscitation Council guidelines and ratified by the UHB's Resuscitation Committee.

- Trolleys should be located on each ward or appropriate clinical area with additional portable oxygen and suction equipment distributed so that it is rapidly available to all other areas of the hospital.

- Portable oxygen and suction devices should always be available on or adjacent to all resuscitation trolleys. Where piped or wall oxygen and suction are available, these should always be used in preference.

- Each ward or department should have access to a manual or automated external defibrillator, so those patients who require defibrillation do so within three minutes of collapse as recommended by RC (UK).

- All resuscitation equipment on the acute hospital sites, including portable suction devices, wall suction and defibrillators must be checked daily.

- Community hospitals must check their resuscitation equipment and defibrillators on a weekly basis.

- If the Resuscitation trolley is wrapped, then a sticker with the earliest expiry date must be displayed on the trolley. A member of staff must still sign daily to confirm that the expiry dates have not been exceeded and that the cling film is still intact. Monthly, the cling film should be removed, all equipment thoroughly checked and then the trolley should be re-cling filmed with the expiry sticker as before.

ASSESSMENT

There appears to be significant variance in the frequency of checking of Resuscitation Equipment within Cardiff and Vale UHB. This does not comply with the Cardiff and Vale UHB Resuscitation Procedure as explained above. As such, this represents a clear risk to patient safety, as during a Resuscitation attempt, equipment may not have been checked and/or available for use.

RECOMMENDATIONS

1. Clinical Boards and directorates are asked to disseminate this Internal Safety Notice to their clinical staff. Please confirm dissemination to the Patient Safety Team by **16th October 2019**

2. The Patient Safety Team will circulate this notice via the CAV You Heard newsletter process.

3. All staff within areas that possess a Resuscitation Trolley are asked to familiarise themselves with the relevant section(s) of the Resuscitation Procedure.

4. Checking of Resuscitation Equipment should comply with the standards set within the Cardiff and Vale UHB Resuscitation Procedure as detailed within the Background of this Safety Notice.

5. It should be Registered Practitioners who check the Resuscitation Trolleys (GMC, NMC, HCPC, GDC)

6. Staff that check the Resuscitation should be rotated, so that the Resuscitation Equipment is not checked by the same staff each day/month.

7. The checklists attached to this Safety Notice are to be used for recording the checking process.

8. Ward areas may wish to appoint Resuscitation Trolley Champions to ensure compliance with Quality Standards.

9. The Resuscitation Service will audit compliance of Resuscitation Trolley checks during audit processes and report any issues in the most appropriate manner.

10. Staff checking the Resuscitation Trolley should use the checklists attached to this Safety Notice.

11. For further information or advice on Resuscitation Equipment, or the procedures surrounding Resuscitation, please contact the Resuscitation Service

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

Daily Resuscitation Trolley Checklist

Month: Year:

Day	Clingfilm Intact	Defibrillator Operational	Comments	Print Name
1				
2				
3				
4				
5				
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Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Monthly Resuscitation Trolley Checklist

Year:

	Contents Checked and Present Y/N	Contents all working? Y/N	Trolley Clingfilmed Y/N	Comments	Print and Sign	Date
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						

Safe practice reminder

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

October 2019

For all areas with a resuscitation trolley

This safe practice reminder has been published as part of Internal Safety Notice 2019/003. Formal inspections of clinical areas have found that checks of resuscitation trolleys are not being carried out correctly.

If the correct equipment is not available during a resuscitation event, patient safety could be compromised.

What do I need to know?

The guideline for checking resuscitation equipment is available on the Resuscitation Services intranet page.

Only registered practitioners should check the resuscitation trolley.

Staff should rotate the responsibility for checking resuscitation equipment so that it is not checked by the same individual each time.

At acute hospital sites, resuscitation equipment must be checked daily.

At community hospital sites, resuscitation equipment must be checked weekly.

For resuscitation trolleys that are clingfilm wrapped, this must be removed and the trolley contents checked monthly.

For further information, please contact the Resuscitation Service

Improvement plan

Hospital: University Hospital Llandough

Ward/department: Stroke Rehabilitation Centre

Date of inspection: 17 and 18 September 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board is required to ensure that: • Clear signage is displayed throughout the hospital, and the site plan is updated to inform visitors how to find the ward • The placement of noticeboards is reviewed to ensure patients, carers, relatives and staff all see the necessary information	4.2 Patient Information	• The Clinical Board will undertake a review of signage in conjunction with media resources • The ward sister in partnership with the therapy teams will review the information board and its placement to ensure they provide appropriate information for patients, relatives, carers and staff. • The responsibility for the update of the clinical audits on the	David Pitchforth, Senior Nurse for Integrated Medicine Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre.	23nd November 2019 23rd November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
• The designated noticeboard for clinical audits is kept up to date • Display Putting Things Right posters within the ward and other areas of the hospital.		noticeboard has been delegated to one of the deputy ward sisters. • Putting Things Right posters have been ordered and will be displayed in the relevant areas of the ward.	Ward sister Ward sister	8th November 2019
The health board is required to ensure that patients are kept up to date regarding their discharge date and plan.	3.2 Communicating effectively	• The issue will be monitored through the ward service improvement group. • All staff will be reminded of their responsibility to ensure that patients are kept up to date regarding their discharge plan and date. • There is a planned roll out of new MDT documentation which will improve communication between and patients. • Spot checks will take place to monitor compliance and this will also be monitored through patient feedback.	David Pitchforth, Senior Nurse for Integrated Medicine. Ward sister Ward sister Therapy lead Ward sister	15th January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• The Consultants and Clinical Psychologist are leading on an initiative to improve engagement with patients, relatives and carers by the formulation of an expert patient group.	Consultant Psychologist	15th January 2020
The health board is required to ensure that: • All staff on the ward are aware of the process in place to collect patient feedback, and that information is fed back to them on how it is used to promote service improvement • There is a systematic process in place to capture patient feedback from all patients	6.3 Listening and Learning from feedback	• Staff education regarding patient feedback and its importance will be given at ward meetings and through other channels of communication such as private social media groups, newsletters, and 1:1's. • The nursing and therapy team are in the process of devising a patient feedback questionnaire which will be specific to stroke patients. This will be reviewed by the patient experience team to ensure it is fit for purpose. • Patients will receive a feedback questionnaire prior to discharge and results collected and collated in conjunction with the patient	Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre Ward sister	22nd November 2019 12th November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		experience team. The feedback gained will be shared with staff via ward meetings, 1:1's,and ward communications. • A notice board will be displayed in a prominent place to display patient feedback, and compliments. • Ward sister is liaising with patient experience team to ensure feedback is received from the 2 minutes of your time survey and shared with staff through afore mentioned methods. .		12th November 2019 22nd November 2019

Delivery of safe and effective care				
The health board is required to ensure that: • All lockable doors on the ward are securely locked at all times, to minimise the risk of patients accessing restricted areas • All hazardous solutions for example disinfectant and bleach is securely stored in locked cupboards on the ward • The bathroom that contains the blocked drain is either rectified, or the shower is decommissioned • All fire extinguishers are serviced within the required timescales.	2.1 Managing risk and promoting health and safety	• All locks were reviewed at the time of the inspection and are in working order. Spot checks are now taking place to confirm that appropriate doors are secure. • Staff have been reminded of their responsibility to ensure that doors are secure and this is being raised through the daily safety briefing. • All hazardous solutions were locked away at the time of the inspection. Spot checks are now taking place to confirm compliance. • Staff have been reminded of their responsibility to ensure that hazardous solutions are safely stored and this is being raised through the daily safety briefing • The bathroom issue has been escalated to the Estates and Facilities department and if it cannot be repaired will be decommissioned. The bathroom is not currently used for patient	Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre David Pitchforth, Senior Nurse for Integrated Medicine.	20th September 2019 20th September 2019 20th September 2019 20th September 2019

		care and spot checks are in place to monitor cleanliness • Ward Sister is liaising with the fire officer regarding servicing of the fire extinguishers.		20th September 2019
The health board is required to ensure that staff knowledge and skills in falls prevention is updated and assessed, which includes the provision of any relevant training.	2.3 Falls Prevention	• Ward sister is reviewing falls education in conjunction with the Consultant Nurse for Vulnerable Adults with the aim of refresher training for all staff • 1000 lives Safety crosses have been introduced to raise falls awareness • Spot checks are in place of all falls assessment and care planning documentation.	Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre	29th November 2019
The health board is required to ensure that: • Staff on the ward place any used tissues promptly in waste bins • High dusting is regularly completed that includes light canopies above patient beds	2.4 Infection Prevention and Control (IPC) and Decontamination	• Staff have been reminded of their responsibility to ensure that tissue waste from patients is disposed of in accordance with IP and C guidelines • Ward sister is reviewing the cleaning schedule with the housekeeping supervisors to tackle high dusting issues.	Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre	16th October 2019

• Shared equipment, such as hoists are always cleaned between each patient • The relatives room and bathroom are cleaned regularly to minimise the risk of cross contamination of infection to others and to patients • All disposable privacy curtains are documented to show the date they were last changed, and are replaced at least once every six months, or sooner if clinically required.		• Staff have been reminded of the need to clean equipment between patients. Clean tags are now applied to hoists. • Joint walk arounds with Ward sister and Housekeepers have been introduced to review standards of cleanliness in all areas including the relatives room. • Ward sister is reviewing curtain provision with the Infection Prevention and Control team. A curtain change schedule and inspection sheet are now in place		22nd November 2019 22nd November 2019
The health board is required to ensure that: • DOLS documentation is well organised and held in a designated section within the patient records • Registered clinical staff complete level two safeguarding training	2.7 Safeguarding children and adults at risk	• Ward sister and nursing team have reviewed the DOLs documentation and organised a specific section in the notes where it can be found easily and efficiently. • Ward sister will review safeguarding mandatory training with the aim of increasing compliance with level 2 safeguarding training from 50% to >80% by January 2020 and	Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre	29th November 2019 29th November 2019]

		supported by the Practice Educator • Letters have been sent to all registered staff outlining the expectation that they will undertake level 2 training. Within the timeframe specified.		15th November 2019
The health board is required to ensure that documentation which contains patient identifiable information, such as care records are stored securely when not in use.	3.4 Information Governance and Communications Technology	• Staff have been reminded of their responsibility to ensure all computer screens are locked when not in use and that patient addressographs are not attached to any computers. • Daily spot checks are in place to monitor compliance • This issue has been raised at Directorate level at the Quality and Safety meeting. • All patient end of bed notes are no longer stored outside of the cubicles and have been relocated to the end of the bed.	Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre	23rd October 2019 [Completed

The health board is required to ensure that patient care records are well organised to ensure paperwork can be easily found.	3.5 Record keeping	• Ward Sister will review patient notes with the MDT as part of the MDT working group to ensure that there is structured order to the patient care records to improve organisation.	Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre	06th December 2019

Quality of management and leadership				
The health board is required to ensure there is a consistent process in place to inform staff regarding changes made in response to reported errors, near misses and incidents.	Governance, Leadership and Accountability	• Themes and learning from incidents will be shared with staff through ward meetings, 1:1's, and newsletters. Where appropriate to do so, this learning will also be shared via notice boards and updated monthly.	Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre David Pitchforth, Senior Nurse for Integrated Medicine.	15th November 2019
The health board is required to ensure that: • Working patterns are equitable for all staff and flexible to meet the needs of the service • The level of service provision is maintained by staff on the night shift and temporary staff • There are sufficient number of staff on the ward to maintain patient safety and staff health and wellbeing • Nursing staff have sufficient time to attend in service training and multidisciplinary meetings	7.1 Workforce	• In conjunction with HR and the trade unions, the ward sister has commenced work life balance reviews to improve flexibility in the ward roster. • Ward sister and Senior nurse are reviewing how senior nurses can be rostered by night and are reviewing the responsibilities of the nurse in charge by night. • All registered nurse vacancies have been filled via the UHB ongoing recruitment campaign.	Kathryn Leader, Ward Sister, Stroke Rehabilitation Centre David Pitchforth, Senior Nurse for Integrated Medicine.	31st December 2019 21st October 2019 January 2020

• Nursing staff complete all aspects of mandatory training relevant to their role and area of work.		• Establishment reviews take place twice a year in line with the Nurse Staffing Act 2016. • Medicine clinical board have an active recruitment and retention plan. • Where there are gaps in the nursing rota due to sickness, other clinical areas provide cross cover or shifts are covered bank and agency. • Staff have been reminded to escalate any concerns regarding staffing constraints, and encourage incident reporting in relation to short staffing to support analysis and improvement work. • Daily hospital safety huddles are already in existence in medicine clinical board to review hospital wide staffing and ensure that all areas risks are balanced. • Ward Sister is prioritising mandatory training needs of staff in the context of the clinical workload.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Rebecca Aylward**

Job role: **Director of Nursing Medicine Clinical Board**

Date: **30/10/2019**

REPORT TITLE:	**PRIMARY CARE GENERAL MEDICAL SERVICES AND DENTAL GOVERNANCE HIW PRACTICE INSPECTION UPDATE REPORT**						
MEETING:	Quality, Safety and Experience Committee				**MEETING DATE:**	**17-12-2019**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
LEAD EXECUTIVE:	Executive Nurse Director						
REPORT AUTHOR (TITLE):	Primary Care Support Manager						

PURPOSE OF REPORT:

SITUATION:

The routine Welsh Government practice and performer inspection programme has been commissioned from Healthcare Inspectorate Wales (HIW) from August 2014. The UHB Primary Care Team is required to provide assurance to the PCIC Quality and Safety Group and Executive Team that Inspection Reports have been received, reviewed and acted upon.

REPORT:

BACKGROUND:
All General Practices and General Dental Services / Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local CHC. The HIW inspections produce an Action Plan which is assessed and followed up on by HIW. The UHB then ensures ongoing compliance with the outcomes of the inspection.

ASSESSMENT:

HIW review each report and produce the action plan for the visit. Any responses from the practice which do not provide sufficient assurances are escalated within HIW and a more detailed response and actions requested from the practice. This communication is copied to the UHB. The outcome of the action plan is assessed by HIW and satisfaction with steps taken or proposed by the practice are included in the final report.

The Primary Care Team undertakes a review of each practice report and any potential actions for follow-up required. These steps are in addition to any satisfaction HIW have with the outcome and so are managed with sensitivity.

Actions contained within the HIW reports and immediate assurance letters are routinely followed

up.

The review and summary of reports are attached **(GP Appendix 1, Dental Appendix 2).**

General Medical Services:
Since the last report to the Committee in September 2019 , there have been no General Medical Services inspectorate visits and one report has been received by the Primary Care Team. One practice visit, for Llanishen Court Surgery, was rescheduled from the 4th of November until the 10th of December. A visit for the Llanrumney branch of Llan Healthcare was also cancelled, but a new date has been planned.

The following report was received:

- Birchgrove Surgery

The Primary Care Team awaits the full report for the Waterfront Medical Centre visit of the 12th of August 2019.

Since the last update report HIW has not issued any immediate assurance letters, or raised any immediate concerns relating to any practices.

An immediate assurance letters was raised regarding the Birchgrove visit, which was included in the previous report. The actions contained within this letter have been completed.

The CD for Clinical Governance has reviewed this report and has recommended that it be rated Amber. Due to the completed actions of the practice it is now rated Green.

General Dental Services:
The following General Dental Services inspectorate reports have been completed during the period since the last report:

- Penarth Dental Healthcare
- Restore Dental Group (Whitchurch Road)
- Restore Dental Group (St Mellons)

These 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.

Since the last update report, HIW issued two Immediate Assurance Letters to Bupa Dental Care (Cowbridge Road East) and Newport Road Dental Practice.

With regards to BUPA Dental Care, healthcare waste was not being stored securely or in line with best practice guidelines. There were also concerns raised in relation to dental record keeping. The primary care team have been in correspondence with the Practice to ensure that appropriate action has been taken.

At Newport Road Dental Practice – HIW identified that autoclave checks were not being carried out regularly so there was insufficient evidence that they were working effectively. In addition the service was not carrying out checks of emergency drugs and emergency resuscitation

equipment. Routine autoclave checks are now in place and records of these are now being maintained. In addition weekly checks of resuscitation equipment and drugs has also been put in place.

One concerns raised remains on the Appendix to highlight that all actions are now complete.

Since the last update report, two Amber practices have been downgraded to Green. There are currently 7 Amber practices and 3 Green practices.

Fire Safety Matters

The Committee should also be advised that HIW have raised an issue following a South Wales Fire and Rescue Service inspection of Meddygfa Canna Surgery on 31st October 2019. An Informal Notice was issued with a programmed return visit for 3 months' time to check compliance with fire safety legislation. The practice is progressing the necessary improvements.

RECOMMENDATION:

*T*he Quality, Safety and Experience Committee is asked to:

- Note the contents of this report and the inspections undertaken by HIW to GMS and GDS contractors
- Be assured that appropriate remedial actions are being taken by practices in relation to immediate assurance notifications
- Note that there is a robust process in place within the Primary Care Team to manage the receipt of inspection reports and ensure review and follow up by the practice

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.								

APPENDIX 1

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions/Update*
Waterfront Medical Centre	12th August 2019	Report has not been published		
Birchgrove Surgery	10th July 2019	1. The practice must implement a process of ensuring staff have a DBS check appropriate for their role 2. The practice must urgently undertake DBS checks for current staff 3. The practice will consider arrangements in the front reception area to ensure confidentiality 4. The practice is to ensure all staff are able to operate the relevant equipment including the hearing loop 5. The practice must consider how to feedback to patients with any actions as a result of suggestions 6. The practice must complete regular surveys of patients to obtain views on the practice 7. The practice must ensure that patient records record the link between medications and diagnosis 8. The practice is to put in place a system to ensure there is evidence, on file, that staff have seen and agreed new policies and changes to policies	G	Originally categorised as Amber. 1. All checks are routinely taken for all clinical staff. The practice will utilise NHS tool to check what levels are required for other staff 2. The practice have ensured that all checks are complete based on requirements 3. The practice have taken steps to ensure confidentiality including relocation of phones, playing ambient music, and promoting the ability to discuss problems away from the waiting room 4. Staff have been provided training on the use of hearing loops 5. The practice will contact patients to discuss outcomes of feedback 6. The practice will undertake an annual survey 7. Current system does not allow for this. *Health Board have queried this requirement with HIW, no response received to date.* 8. Copy of minutes to be signed following any policy change

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

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 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	G	All actions complete
Pontprennau Medical Centre	5th November 2018	1. The practice must promote and provide information regarding the availability of a chaperone 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	G	All actions complete

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

		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		
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	G	All actions complete

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

		11.The practice must comply with all aspects of health and safety legislation		
HIW Immediate Assurance Letters (received since last SBAR update)				
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*	
N/A	N/A	N/A	N/A	
HIW Immediate Concerns raised (received since last SBAR update)				
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*	
N/A	N/A	N/A	N/A	

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to August 2019) - TABLE OF INSPECTIONS

Total 10	*Practice Name*	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
59	Restore Dental Group (St Mellons)	13/08/19 Final draft report received 25/09/19	Overall this is a very positive report with only a few improvements recommended. • Patient feedback mechanism and implementation of changes • Environment risk assessment • IPC training of all staff • All risk assessments documented and evidence conclusions actioned • MH's completed correctly and recorded appropriately		• Dental Practice Adviser (DPA) summary complete	
58	Restore dental Group (Whitchurch Road)	30/07/2019 Final report received 20/09/19	Minimal recommendations and an overall positive and complimentary report • Regular fire drills • IPC training for all staff and first floor rear surgery decluttered • patient records are completed in line with professional standards		• DPA summary complete	• Improvement plan submitted to HIW 17/09/19 • HIW satisfied with Improvement plan 20/09/19
57	High Street Dental Practice Barry (Close, R)	23/07/19 Non compliance 25/07/19 Final Report received 11/09/19	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. An overall good report with some recommendations and an immediate action regarding clinical waste storage which was rectified immediately • Record keeping including clinical notes and medical history • Repair to surgery door • Accured clinical waste storage		• Immediate assurance issues resolved. • Final report summary completed • DPA Letter sent 04/10/19 • Unsatisfactory response email correspondence ongoing.	• Email sent to practice • Response received 29/07/19 confirming action • Non-compliance response accepted 05/08/19.

			• Provision for those patients wishing to use the welsh language • Feminine hygiene bin • Secure dental supplies store • Suitable position of emergency medical equipment • All staff trained in safeguarding of children and POVA • Ongoing audit • Offsite storage of secure data • Whistleblowing policy updated			
56	Penarth Dental Healthcare	01/07/19 Final report received 04/09/19	A number of improvements have been recommended, many of which have been confirmed and should not detract from an overall positive report • Patient information leaflets on OH • Surgery doors glass covered • Patient information and statement of purpose on website • New patient policy • Fire safety training by expert • Business continuity policy • Surface protein tests • Rinsing of instruments in surgery stopped • Baby nappy bin • Secure dental supplies cupboard • Move razor to med emergency kit, move med emergency kit to accessible location • Resuscitation guidelines 2015 in med emergency policy • Staff training in safeguarding of children, Protection of Vulnerable Adults and familiarise		• DPA summary completed.	

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to August 2019) - TABLE OF INSPECTIONS

			with protection procedures 2008 • Consider use of safety syringes or employ a risk assessment • Quality Improvement and audit • Tooth wear to be recorded in notes			
55	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. • Response received 09/08/19	• Email response received 09/08/19 • HIW email response 12/08/19 • Awaiting HIW response
54	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 General Dental Council 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 emergencies drugs dates checked and policies read • Prescriptions locked centrally overnight • Temperature controlled fridge for medicines checked regularly • Safeguarding contact details and staff training required • To complete Health Education and Improvement		• DPA Letter 16/08/19 requesting confirmation of action. • Visit 3/12 (October 19) • Visit booked 27/11/19 @1pm	• HIW Satisfied with improvement plan submitted 18/07/19 • Awaiting response

			Wales (WEIW) QI tool for ionising radiation • Regular audit and peer review including record keeping • General Data Protection Regulation training all staff • System to review, update and staff read all relevant policies • Ensure Continuous Personal Development up to date, staff appraisals, appoint leads, regular meetings and 2 references for new staff			
53	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 algorithms stored safe environment • Remove out of date syringes from emergency kit and put in place appropriate system to check drugs		• DPA: Dental summary complete, no action required	• HIW Satisfied with improvement plan submitted 24/06/19
52	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 HIW • HTM01-05 guidance to be followed including dirty to clean workflow and clearly marked transport boxes		• Letter sent to practice 28/6/2019 requesting confirmation / evidence of completed improvement plan • DPA letter resent 10/10/19 requesting evidence. • Response received 21/10/19	• HIW satisfied with improvement plan submitted 29th April 2019

			• System to check use by dates for emergency drugs and equipment • Review adequacy of private consent forms • Performers require annual documented appraisal • Emergency drugs and emergency flow charts kept in clear folders		unsatisfactory, more evidence requested 25/10/19	
51	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 • Complete evidence submitted 15/10/19	• HIW satisfied with improvement plan submitted 24th May 2019 • Response received 12/06/19
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.)		• 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	~~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.

			- Recording and audit trails • System for recording views of patients • Five yearly electrical testing certificate • Fire risk assessment review • Review access to stock room and decontamination room • Decontamination training required for relevant staff. • Review resuscitation policy for both premises • Review stock control processes: - Materials - Anaesthetics • 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		issues outlined in Action Plan with a request to follow up the process with a meeting within six months. • Response received 19/09/17 • Re-categorised as Amber • Re-categorised as Green	Awaiting response. Practice re visited by HIW 30/07/19. None of the issues were raised in new report.

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to August 2019) - TABLE OF INSPECTIONS

20	Ellen Davies Dental Practice New owner: Owain Joynson	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 - Medical histories are updated - Soft tissue examinations • Justification for x-rays • Review of all staff training needs required and courses • Policies and procedures need to be consistent with version and review dates		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	No Updates Practice under new ownership – Letter to be sent 9th November 2018 • Email correspondence ongoing.

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*
4	Newport Road Dental Practice, (321 Newport Road)	02/10/19	04/10/19	Autoclave Checks not being carried out regularly so insufficient evidence that they are working effectively.	• DPA Letter sent 11/10/19 • Response received 15/10/19
3	Bupa Dental Care	02/09/19 Final	04/09/19	Immediate improvement plan issued - The service must ensure healthcare waste is being stored	• DPA – Phone call and email from practice manage to confirm action has

	(Cowbridge Rd East)	report 23/10/19	Non-compliance response accepted 11/09/19	appropriately and securely outside the dental practice in line with best practice guidelines. Medical history forms completed by patients must be countersigned by the relevant dentist to evidence the dentist has taken into account the patient's medical history when planning dental care and treatment. An audit must be undertaken to provide assurance that medical history information is being transferred accurately from paper forms onto patient's electronic dental records. Medical history checks undertaken with patients need to be recorded on the patient's electronic dental record at each follow up appointment. The practice must provide assurance to HIW that Basic Periodontal Examinations (BPE) undertaken on patients accurately reflect the true periodontal status of the patient. The practice must provide assurance that Full Periodontal Examinations are undertaken for patients with BPE scores of 3 and 4. The practice must provide assurance that clear and justified treatment plans are in place, and documented on patient's electronic patient records, to improve or stabilise the condition for patients with BPE scores of 3 or 4. The practice must provide assurance that intraoral periapical radiographs are being undertaken to aid preoperative planning for patients needing restorative dental treatment.	been taken to address the issues raised in the non-compliance notice.

HIW Concerns Raised (received since last update)					
	Practice Name	*Contact*	*Follow Up*	*Summary of Concerns*	*Summary of UHB Actions*

		from HIW			
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 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	• 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 plans for commissioning of decontamination room & update of changes made to date. • Issues resolved (re-categorised Green)

				the compressor below, and was not conducive to an environment for sterilising equipment. These will prohibit effective cleaning and as a result could pose an infection control risk to patients and staff. **The service is non-compliant with Regulation 20(1)(a) regarding Records** This is because we could not be assured on the day that the dentist was keeping comprehensive, succinct and contemporaneous records for the consultations and treatments of patients. During an examination of patient records it was found there were significant shortcomings in the patient records kept for one of the dentists at the practice. Some of the missing sections included, but are not exclusive to: o Previous dental history o Social history, oral and diet advice, and smoking cessation advice o Symptoms o Signed medical histories for both initial checks and updated at each appointment o Full base and updated charting o Baseline BPE o Examinations including extra oral, intra-oral and cancer screening; o Treatment plans, options discussions o Informed consent o Referrals information	

				○ Radiographs justification, frequency and clinical findings; and ○ Antibiotic prescribing. For both Private and NHS treatments, patient records should include contemporaneous and accurate notes of all assessment, treatment planning and treatment provided to patients. A lack of comprehensive, accurate and contemporaneous records can have serious patient safety implications for any ongoing or future care and treatment decisions. Care, treatment and decision making must be supported by structured, accurate and accessible clinical records, to ensure that people receive effective and safe care.	

KEY

Issues	Status
Minor issue e .g : Price list not displayed - Translation services not present - Patient Feedback	**GREEN**
Issue requiring remediation, but not likely to pose patient safety issue. E. g - QA arrangements - Policies updating and signing - Complaints Processes	**YELLOW**
Serious Issue requiring remediation due to **potential** patient safety concern. e.g: - Safeguarding procedures - IR(Me)R Issues - Record Keeping Issues - Staff Training Records - Access to staff areas - HTM 01-05 issue : Minor	**AMBER**

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to August 2019) - TABLE OF INSPECTIONS

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**

MINUTES
CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 28th May 2019, 8.30am, Meeting Room, Clinical Board offices, Lakeside UHW

Preliminaries		**ACTION**
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing Sandra Dredge, Senior Nurse, Community Child Health Cheryl Evans, Directorate Manager, Obstetrics & Gynaecology Annie Burrin, Clinical Supervisor for Midwives Matt McCarthy, Patient Safety Advisor, Patient Safety Team Pina Amin, ACD, Obstetrics & Gynaecology Laura McLaughlin, Risk Manager, Obstetrics & Gynaecology Louise Dowler, Women's Experience Midwife Anthony Lewis, Clinical Board Pharmacist Mary Glover, Lead Nurse, Acute Child Health **In Attendance** Kirsty Hook, Board Secretary Marie Davies, Assistant Director of Planning	
1.2	**Apologies for absence** Suzanne Hardacre, Alicia Williams, Meriel Jenney, Angela Jones, Paula Davies, Raj Krishnan, Bev Thomas	
1.3	**To receive the Minutes of the previous meeting 23rd April 2019** The minutes of the meeting were agreed to be an accurate record.	
1.4	**To note and update the action log of the meeting of 23rd April 2019** **Adolescent CAS Card and Pathway** Safeguarding Midwife will attend Directorate DMT Meeting in order to understand the requirements and ensure robust pathways. **Lessons Learnt – Hearing Loop** Contact has been made with the patient however no further contact from the patient has been received.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story** LD provided the background to the patient story which relays the events of a patient's recent experience of catastrophic haemorrhage following an emergency caesarean in May this year. The surgery was complex, the mother sustained a bladder injury and had to undergo a hysterectomy with multiple transfusions in theatre. She received high dependency care on delivery suite in the immediate recovery period. It was agreed that the patient story account would be circulated with the minutes for information.	

	Discussion ensued where it was noted that there was very positive feedback and patient felt very well looked after, however it was noted that some lessons learnt have been highlighted with regards to "Hello My Name Is" for visiting consultants from other specialties and it was agreed that this would be fedback to share lessons. With regards to the lack of home visit, this followed routine procedure as the patient was discharged later than would be normal given the complications, however it was acknowledged that given the case, additional visit may have been helpful and this would be considered for future cases where appropriate.	
2.6	**To note the C&V UHB Response to Recommendations of RCOG Report - Cwm Taf Morgannwg HB Maternity Service** AB provided an update on the Cardiff & Vale UHB response to the RCM/RCOG Report into Cwm Taf Morgannwg HB Maternity Services. The reports produced as part of this review have been shared for information. Within the overview, it was noted that the assessors found a number of issues including: • Services working under extreme pressure • Sub optimal clinical and managerial leadership • Under-reporting of Serious Incidents with basic governance processes not properly in place • Merger of two sites planned with no evidence that clinical teams were engaged and supportive of the decision and process • Shortfall of midwifery establishment, significant use of locum medical staff • Lack of established standards of practice The report outlines over 70 recommendations that required a response as to the position and self assessment of Cardiff & Vale UHB against the recommendations and this has been submitted to Welsh Government. It was acknowledged that within Cardiff & Vale the governance processes is very robust and very transparent. The service is also Birthrate Plus compliant. A presentation will also be provided to the UHB Committee Meeting on Thursday 30th April 2019. It was noted that the timeline outlines concerns within Cwm Taf HB noted from 2012 – 2018 of lack of assurance and governance mechanisms and processes within the service. Discussion ensued and it was noted that whilst the concerns were outlined, there is a clear lack of action undertaken which is very concerning. From 9th March 2019 Prince Charles Hospital became the main obstetric unit, with Royal Glamorgan becoming a freestanding maternity unit. As a result of these changes, there has been a significant impact on the activity flow into Cardiff & Vale UHB over and above anticipated expected flow as part of the original South Wales Alliance workflow. There is uncertainty at present as to whether this immediate influx of flow will continue and the required support to manage this activity. A paper is being drafted in order to outline and highlight the pressures and concerns being experienced as part of this activity flow in order to escalate the pressures to the Executive team. It was agreed that the presentation would be shared for information following the meeting.	
	To note – Due to ongoing discussions being required with regards to Cwm Taf Morgannwg Health Board Maternity Services and no exceptions to note, it was agreed that the rest of the agenda would be deferred in order for the discussions to continue with key members in attendance.	

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 25th June, Room 1.13, 1st Floor, Ty Dewi Sant, UHW (H&S FOCUS)**

<u>2019 Meeting Dates</u> (4th Tuesday of the Month, between 8.30 – 10.30am unless otherwise stated)

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)

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE (H&S FOCUS)
Tuesday 25th June
8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		
	Welcome & Introductions Cath Heath, Director of Nursing Paula Davies, Lead Nurse, Community Child Health Rachael Sykes, Health & Safety Advisor Beverly Thomas, Asst Directorate Manager, Community Child Health Alicia Williams, Cancer Services Manager Mary Glover, Lead Nurse Acute Child Health Heather Hancock, Interim Deputy Directorate Manager, Acute Child Health Suzanne Hardacre, Head of Midwifery, Obstetrics & Gynaecology Sarah Spencer, Senior Midwife, Obstetrics & Gynaecology Laura McLaughlin, Risk Manager, Obstetrics & Gynaecology Anthony Lewis, Clinical Board Pharmacist Cheryl Evans, Directorate Manager, Obstetrics & Gynaecology Jennifer Lewis, Infection Prevention Control Yvonne Hyde, Infection Prevention Control Nia John, Consultant in Community Child Health **In Attendance** Kirsty Hook, Board Secretary Kirsty Morgan, Asst Directorate Manager, Acute Child Health Alison Oliver, Clinical Services Lead	
	Apologies for absence Meriel Jenney, Rachel Burton, Matthew McCarthy, Louise Young, Raj Krishnan	
PART 1: HEALTH & SAFETY		
1.2	**Feedback from UHB Health & Safety Operational Group Meeting** • Future meetings will be chaired by Martin Driscoll, Executive Director for Workforce & OD. • HSE Audit will be undertaken in Quarter 3 this year. Focus will be on Manual Handling, V&A and • Fire Service Policy was noted and the changes within the policy. If a real fire is discovered, contact will need to be made via Switchboard. • H&S Priority Improvement Plan – C&W Clinical Board will need to submit a report in September 2019 • Contractor Control was highlighted and reiterated that there is a requirement to notify Capital Estates to ensure that appropriate guidelines and requirements are met. Jonathan Davies in H&S is the point of contract for any contracts confirmed outside of Capital Estates. • Stress Management programme of training has been implemented, however it was noted that currently all training is full and further work is being undertaken to provide further sessions. • ARJO replacement equipment programme • Contract for the Lone Worker Devices has been renewed and a replacement programme is being rolled out.	

1.3	**To note the latest Health & Safety Report** Noted for information. 1 RIDDOR reported in the March – May 2019 period which has now been completed. Chemical incident within Gynaecology has been finalised where it was noted that no issues found with manufacturing records or processes. The bung beneath the removable cap should prevent leaking when transported and stored correctly. Concluded that bottles may have been inadvertently transported or stored incorrectly (upside down) causing bottles to leak. Gloves to be worn when handling bottles of NanoNebulant. Refresher training to be considered in order to highlight requirements. Thanks were expressed to all with regards to the significant work undertaken to ensure that all incidents are reviewed and actioned appropriately. Discussion ensued with regards to the forthcoming HSE Audit that is being undertaken, it was noted that there are some issues with regards to Nitros Oxide within Maternity which is currently being worked through. It was noted that there is an importance to ensure for all areas that all Manual Handling associated risk assessments are complete and all training is robust. Concerns were raised with regards to a potential review of current classroom based training provided and ensure that there is a robust plan in place for relevant training to be commissioned if required. There was discussion with regards to V&A competencies assigned on ESR. It was noted that guidance has been issued on the intranet with regards to the training requirements for individual staff. Work is progressing on the risk registers and correspondence will be circulated in order to highlight and reiterate the importance of ensuring that all risk assessments are completed and risks added to the register as appropriate.	
1.4	**C&W Clinical Board Health & Safety action plan** Work is ongoing in order to update the action plan and it was agreed that liaison would be undertaken directly with the Directorate leads for Health & Safety outside of the meeting. The action plan will be shared at a future H&S Meeting. The group were asked to forward copies of the Directorate Risk Registers to AW in order to review current actions and add any additional actions as required.	**ALL/AW**
1.5	**To note the latest COSSH Report** Noted for information.	
1.6	**To note the latest Fire Safety Report** Not yet received, and it was agreed that once received this will be circulated for information.	
1.7	**Workplace Inspections Update** **O&G** There is a new H&S representative being trained within O&G, once complete workplace inspections will be completed. **ACH** All workplace inspections have been completed. There is nothing specific to note for this meeting. **CCH** Inspections continue. There is some work being undertaken with regards to signage within Community Child Health at St David's Children's Centre.	

1.8	**Feedback from H&S Staff Side** There is currently no representative who attends and it was agreed that CH would contact Stuart Egan for advice/update.	CH
1.9	**Exception Reports and Escalation of key H&S issues from Directorates** Covered as part of agenda item 2.3	
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.2	**To approve the minutes & action log of the meeting held on Tuesday 28th May 2019 and note any matters arising** The minutes of the meeting were agreed to be an accurate record. It was noted that the main focus of the meeting was in relation to the CTM Maternity Services Report. The response has been completed and a presentation was provided to the UHB Board. A meeting has been undertaken with Welsh Government and other Health Boards and the themes for the Vision for Maternity Services in Wales was discussed. A further self assessment has been requested by HIW and unannounced visits are anticipated. Work is being undertaken to complete an improvement action plan against the recommendations which will continue to be a focus over coming months.	
2.3	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues or for consideration for Clinical Board Risk Register)** **ACH Directorate Report** • Rhian Mannings from 2wish upon a Star attended Staff Forum • X2 ongoing RCA's and one concluded which is being shared as part of the meeting (JW). There are x2 notes reviews ongoing. • Hand Hygiene and BBE Audits continue. UV cleaning audits will be implemented later in the year which will run alongside HPV audits. • Posters highlighting learning from Ten Fold Errors have now been displayed throughout the CHFW • CYARU have put forward a research bid to Welsh Government for consideration and hopeful that this will be successful which will allow further research projects to be taken forward. • Recruitment continues and there have been a number of appointments made within Nursing. Within medical staffing, recruitment is ongoing with a number of posts being appointed across a number of specialties. • Significant leak on Rocket Ward following heavy rainfall which impacted on the ward being closed for 2 days and x2 patients were relocated. Concern was raised that this is likely to happen again and is part of a planned maintenance programme to be reviewed. • V&A aggression training is planned for August and September 2019. **CCH Directorate Report** • SBAR for Health Visiting was shared for information. It was noted that there has been increased pressure as a result of an increase in Maternity leave which is likely to further increase through the summer months. Also, with 4wte being unable to practice clinically this has further impacted on the position. Work is being taken forward with Finance to review the proportion of maternity leave that can be covered. Further work is being undertaken to move caseloads, which is being taken forward in conjunction with Human Resources in order to ensure delivery of the Healthy Child Programme. X3 band 5 posts have been appointed to Health Visiting which is being piloted in order to review the impact and look to future proof the service.	

	It was noted that there are x3 areas within the HCP that are currently not being achieved, and an action plan has been produced in order to look to improve the position within these areas and tighten processes which includes data input. Currently the backlog is cleared and it is hoped that this will continue to be managed. • Loss to Follow Up issues has been reviewed. There has been a significant piece of work that has been undertaken within Neurodevelopment and it was agreed that this would be presented at the next meeting for information. • X1 unexpected death RCA is almost complete, which it was noted that there is a lot of learning that will be shared from this investigation at a future meeting. • X1 new legal claim that has been received with regards to self harming patient in Ty Gwyn Special School. A meeting has been arranged to review the recommendations and the actions that have been undertaken in order to ensure that there is no additional learning to note, and that all actions have been embedded into practice. • Key risks highlighted in relation to ongoing capacity issues within the CAMHS service. Recruitment is continuing with some appointments made, however it was noted that bank and agency is also being used at present in order to manage the caseload. • X2 serious incidents within CAMHS of which information has been requested from CTM Health Board in order to review by the external expert. Work is progressing on this and further updates will be provided as necessary. • Jane Imperato, Flu Lead is unable to continue this year. It was requested that all consider options for a new lead to be identified and agreed. **O&G Directorate Report** • X6 RCAs ongoing, one of which is awaiting coroner response and another with further involvement with Legal & Risk. • 6month review of the Quad Audit Action Plan is being undertaken following the external audit undertaken in November 2018. • T2 plans continue to be developed and an interim operational lead in post. There are some environmental issues that require resolving e.g. leaking showers. Flushing is currently delayed whilst this is being worked through. • The recent report by the RCOG into CTUHB has been received. The All Wales assurance document has been sent. Internal actions from the assurance document will be monitored through the directorate spotlight report. • X3 pressure area incidents reported. The common theme was in relation to risk assessments not being completed prior to transfer to the ward. An audit has been undertaken, and further communication has been added to the safety briefing to highlight the importance of undertaking. • X5 Medicines Management incidents have been reported. Investigations have been undertaken and no harm was caused. • Ongoing discussions with regards to blood glucose machines. Plans to upgrade gas machines and therefore this will also allow glucose testing. SBAR will be submitted to clinical board regarding the costing implications associated. • Terms of Reference for closed facebook page is being reviewed and page has been temporarily closed whilst this is completed. • Work continues with regards to recruitment and gaps within the medical rotas. It is anticipated that this will improve from August 2019.	PD ALL
2.4	**RTT Update – Long Waiting Patients (36 weeks and 52 weeks)** **O&G** • Patients continue to wait in excess of 36 weeks for joint Gynaecology/bowel procedures. Colorectal consultants have now been given additional capacity in their job plans to undertake this work. Currently 2 sessions a month allocated from RTT funding agreed 17/18. Planning for 2 sessions a week to include Gynaecology oncology joint operating. Theatre capacity issues continue due to the length of these complex cases.	

	• The outpatient position has deteriorated from 20-24 weeks to up to 36 weeks due to a lack of day time medical cover. • 2 x 36 week breaches unplanned in May, cancelled by theatre due to non-availability of anaesthetists. Work continued and the target for June is zero. **Acute Child Health** • As at the end of May there were zero patients waiting over 36 weeks for inpatients and day cases and outpatient activity to 26 weeks. • Paediatric diagnostics – zero patients waiting over 8 weeks for cystoscopy, bronchoscopy and Endoscopy. • Waiting lists for outpatient therapy services at the CHFW is 11 weeks **Community Child Health** • Primary Mental Health compliance remains very challenging. Work is continuing in order to improve the current position, with agency support also being explored. A trajectory compliance has been completed with improvements envisaged over coming months. • S&LT at 12 weeks with no breaches • Physiotherapy at 10 weeks with no breaches • Occupational Therapy will be at 12 weeks by end of June • Neurodevelopment currently at 36 weeks with significant work undertaken in relation to follow up appointments • Community Paediatrics at 28weeks	
2.5	**Directorate Business Continuity plans** **Update from Acute Child Health** AO was welcomed to the group to provide an update on the business continuity plans within ACH. It was noted that all Business Continuity Plans have to be finalised and signed off by September 2019. Details of the plan was described including the required actions should the plan need to be implemented as a result of any incidents. Work is ongoing with Estates in relation to provision of any urgent hospital accommodation, plant rooms etc if needed. There are a number of interdependencies with other Clinical Boards and departments and work continues to agree on areas such as theatres, radiology, outpatients etc. The plan is discussed regularly at DMT and now needs to be circulated for comment. Discussion ensued and it was noted that this is a significant piece of work which is continuing across all areas. Within CCH it was noted that the plan is almost complete, however there are discussions needed with other Clinical Boards with regards to the interdependencies. For Cancer Services, the Directorate is not a bed holding area and this can be completed quite quickly. Within O&G, the plan is almost complete also. It was agreed that the ACH plan would be shared with the group for information. Concern was raised with regards to the interdependencies with other Boards and the need for discussions to take place as soon as possible in order to ensure that plans are agreed and robust, to ensure that assumptions are not being made.	AO
2.6	**University Hospital of Wales patient and relative experience walk through 30th April 2019 report** The report was noted for information. It was noted that the report should be reviewed and reflect on the services and support being provided for relatives of bereavement.	ALL
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients/Staff** No specific items to note for this meeting.	

SAFE CARE		
4.1	Update on Serious Incidents & Update on CB E-datix performance The report was noted for information. Since the last meeting the issues with regards to the ESSURE devices has been reported as an SI and work is underway to complete and close. Discussion ensued with regards to SI reporting and triggers and it was noted that discussions have taken place with Welsh Government where it was highlighted that a No Surprises Incident can be de-escalated once it has been reported if deemed necessary. There has been significant work undertaken with regards to incidents and thanks were expressed to all for the work in ensuring that all incidents are reviewed and actions undertaken in a timely manner.	
4.2	**RCA's/SBAR's for noting and agreeing actions** **RCA and Action Plan – JW** KM provided an update on the recent investigation undertaken. A patient from Princess of Wales Hospital presented with a large soft swelling involving the right neck in November 2016. The patient was reviewed and treatment plan discussed however there was a breakdown in communication resulting in both hospitals assuming the patient's care was being managed by the other. The root causes identified as part of the investigation included: • Lack of Consultant follow up in Princess of Wales Paediatric Department • Lack of communication between the two centres resulting in the MDT outcome not being relayed in a timely manner. Following the investigation, POW were responsible for chasing an outcome from UHW as they had a duty of care for their patient. However, UHW were responsible for relaying the outcome and recommendations in a timely manner which the evidence shows was not completed. • Confusion with the perceived responsibility of care with both teams thinking that the other was responsible for follow up. Recommendations identified: • A new MDT proforma which has been used since March 2019 in Paediatric Oncology. Progress is being made to roll out the proforma to other specialties within Paediatrics in the children's hospital as this incident could occur within another speciality. • For POW when seeking advice from another hospital, it must be clear that the care of the patient has not been handed over until a referral has been received by the specialty be referred to. This ensures POW systems and practices can track the care of the patient as they can be added to the POW pathways. Feedback has been provided to the family and it was noted that the lessons learnt will be shared widely across all areas to ensure that appropriate actions are embedded into practice to reduce the risk of this type of incident occurring in the future.	

4.3	**Infection Prevention Control Update** It was noted that as a Clinical Board, there is a change to the Tier 1 target for E Coli. It was noted that the target for C&W is zero and at present x1 case has been reported which is being investigated and actions undertaken accordingly. Discussion ensued with regards to ANTT and it was noted that a working group is being progressed for CVC bundles which will also include PICS and a formal education package is being developed to ensure that staff are appropriately trained across the Health Board for management of lines. It was noted that significant work has been undertaken within C&W and will also be part of the annual programme going forward. 2018 C Section report has been received, it was noted that whilst the rates look to have increased, reporting has significantly improved. A new chair has been appointed to the Antimicrobial Group. X4 areas are currently closed with Norovirus and all were asked to be aware. It was noted that Flu Season is bad within Australia at present and it is anticipated that is likely to impact in Wales. All were asked to ensure that robust processes are in place for the coming season.	
4.4	**Safeguarding** No items to note for this meeting.	
4.5	**Patient Safety / MDA Alerts (internal/external)/WHC** • Message from Welsh Government - Disruption to supply of Epanutin® (phenytoin) 30mg/5ml oral suspension 500ml bottle. • Welsh Health Circular 2019 018 - Augmentative and Alternative Communication (AAC) Pathway • Patient Safety Alert – Fracture Fixation Plates The notices were noted for information. It was noted that all notices have been shared widely. There were no specific exceptions to note.	
DIGNIFIED CARE		
5.1	**Latest Cleaning Scores Report** The latest cleaning scores report was noted for information. Currently the Clinical Board is reporting a 98% compliance rate. It was noted that Bumblebee is currently lower than previous months and all were asked to review to ensure that there are no specific issues.	ACH DMT
INDIVIDUAL CARE		
6.2	**Update on latest 2 minutes of your Time feedback** No items to note for this meeting.	
STAFF AND RESOURCES		
7.1	**To note any exceptions/issues relating to staff/resources** No specific items to note for this meeting.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
8.1	**HCAI reduction expectation figures for 2019 to 2020** Noted for information.	
8.2	**Summer 2019 Newsletter Patient Safety and Quality Team** Noted for information.	

8.3	**Medicines Safety Briefing – June 2019** Noted for information.	
ANY OTHER BUSINESS		
	No items to note.	
DATE AND TIME OF NEXT MEETING		

The next meeting is scheduled for **Tuesday 23rd July, Meeting Room, Clinical Board Offices, Lakeside**

Future 2019 Dates
Tuesday 27th August, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 24th September, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)
Tuesday 22nd October, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 26th November, Meeting Room, Clinical Board Offices, Lakeside (IP&C FOCUS)
Tuesday 17th December, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)
Tuesday 28th January 2020, Venue to be confirmed
Tuesday 25th February 2020, Venue to be confirmed
Tuesday 24th March 2020, Venue to be confirmed (H&S FOCUS)

MINUTES
CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE (H&S FOCUS)
Tuesday 24th September 2019
8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		Action
	Welcome & Introductions Cath Heath, Director of Nursing Scott McLean, Interim Director of Operations Avril Gowman, Senior Nurse Acute Child Health Directorate (on behalf of Mary Glover) David Cox, Fire Safety Officer Paula Davies, Lead Nurse Community Child Health Directorate Suzanne Hardacre, Head of Midwifery, Obstetrics & Gynaecology Directorate Matt McCarthy, Patient Safety Advisor, Patient Safety Team Alicia Williams, Cancer Services Lead Manager Alyn Coles, Service Manager, Cancer Services Meriel Jenney, Clinical Board Director Raj Krishnan, Deputy Clinical Director, Acute Child Health Directorate Cheryl Evans, Directorate Manager, Obstetrics & Gynaecology Directorate Rachael Sykes, Health & Safety Advisor Laura McLaughlin, Risk Manager, Obstetrics & Gynaecology Directorate Angharad Oyler, Clinical Supervisor for Midwives, Obstetrics & Gynaecology Directorate Janice Aspinall, Staff Side H&S Representative. **In Attendance** Kirsty Hook, Board Secretary (minute taker) David Tuthill, Consultant Paediatrician (Item 2.1 only)	
	Apologies for absence Linda Hughes-Jones, Anthony Lewis, Nia John, Mary Glover	
PART 1: HEALTH & SAFETY		
1.2	**Feedback from UHB Health & Safety Operational Group Meeting** Minutes from the meeting will be circulated as soon as received for information. The main areas discussed at the meeting were: • Annual report presented with a number of red areas highlighted for C&W including statutory and mandatory training which will require an action plan to be completed • HSE Audit will take place between October – December with a date to be confirmed. Notice will be given and request for specific data will need to be provided prior to the visit, with specific key areas that that they will visit. 4-6 inspectors over a period of a week. Review of risk assessments will be undertaken and will also discuss with staff as to how these mitigation's are being undertaken, that relevant training has been undertaken and staff are compliant. Discussion ensued with regards to statutory and mandatory training compliance and the need to look to improve this across all areas. There was further discussion with regards to the requirements of violence and aggression and the need to review the competency requirements to ensure that they are appropriate for specific staff. Any changes will need to be reported to LED for amendment. RS agreed to circulate the guidance and training dates following the meeting. The DMT's were	

	asked to review and ensure that the appropriate changes are made with LED for all medical and nursing staff. • Priority Improvement Plan schedule has been postponed and will be circulated as soon as this is received. A workshop is being arranged in order to discuss the priority improvement plan and expectations of the group going forward.	
1.3	To note the latest Health & Safety Report The H&S report was shared for information. Follow up actions on the reported incidents will also be reviewed as part of the HSE Audit. The breakdown of the types of incidents that are reported were noted for information, maternity care being the highest reported incidents in the period, along with V&A remaining high. X2 Staff RIDDOR incidents reported to the HSE between June – August. 293447 04.07.19 C1 - nurse injured back when turning patient in bed. Investigation has been received and it was noted that this was an unpredictable event during manual handling task, when patient jerked backwards. All training was up to date and there were no other contributory factors to note. 294637 21.07.19, NNU - nurse slipped on floor in milk kitchen, attended A&E. Investigation has been received - there was no moisture or debris on the floor. Appropriate footwear was being worn. Accident of unknown cause. X1 investigation is outstanding in Maternity (incident reference 286292) which will need to be reviewed and updates provided accordingly. 3 RIDDORS reported during 2018/19, with 3 RIDDORS being reported for 2019/20 to date. Mandatory Training Compliance was noted and it was reiterated that there is a need to ensure that the competency is correct and once this has been completed, there is a need to ensure that staff are attending and able to attend appropriate training. A plan/trajectory will need to be produced to outline when all Directorates will be compliant.	
1.4	C&W Clinical Board Health & Safety action plan No specific update to note for this meeting. All DMT's were asked to ensure that any updates are provided.	DMT's
1.5	To note the latest COSSH Report Noted for information.	
1.6	To note the latest Fire Safety Report Noted for information. It was noted that any staff that are front facing should be completing face to face training. It was agreed that this should be added to the joint audit sessions. Concerns were raised with regards to vertical evacuation equipment and the need to ensure that this is stored and used correctly. It was noted that cascade training should be rolled out to all staff, however it was noted that this is not available through UHB and would be at a cost to departments. A request was made for detail of the trainers to be provided, with a view of potential update training to be reviewed. It was agreed that this is an issue that is across the UHB, and should be raised as a corporate risk. This will also be added to the Clinical Board Risk Register of the inability for training to be provided for vertical evacuation training.	KH/CH
1.7	Workplace Inspections Update • O&G – a number of areas are out of date, and work is being undertaken in order for these to be arranged as soon as possible. • ACH – all clinical areas are up to date and non-clinical areas are being progressed.	

	• CCH – there are a number of areas across community bases that require an up to date workplace inspection and are in the process of being arranged. It was agreed that JA would provide support to the Directorates in order for the workplace inspections to be completed.	JA
1.8	**Feedback from H&S Staff Side** No items to be noted for this meeting.	
1.9	**Health & Safety Executive 'Well at Work' audit** The paper was noted for information and discussed in detail as part of item 1.2	
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Presentation on Ten Fold Medication Errors Study** David Tuthill was welcomed to the group to provide an update on the work that has been undertaken on tenfold or greater medication errors in children across Wales. It was agreed that the presentation would be shared for information following the meeting. Significant work has been undertaken across ACH with regards to medication errors. It was noted that this is a standing item for discussion at Directorate medicines management meetings and awareness continues to be raised across all areas. Further discussion ensued and it was noted that work is being undertaken on an All Wales basis on a Prescription Pathway/Passport. Concerns were raised with regards to the COPs system and potential errors that would not be picked up routinely until the child is seen again in hospital. It was agreed that this should be added to the risk register in order to continue to highlight and monitor going forward.	ACH DMT
2.2	**To approve the minutes of the meeting held on Tuesday 23rd July 2019 and note any matters arising from the last H&S Meeting held on 25th June 2019** The minutes of the meeting held on Tuesday 23rd July were agreed to be an accurate record. There were no matters arising from the last H&S meeting held on 23rd July.	
2.3	**Health and Care Standards – key areas from Directorate QSE Reports** **Acute Child Health** • Risk register is being regularly reviewed. • X3 current RCA's with work progressing • 56 new starters have been appointed and will commence in post through October/November **Obstetrics & Gynaecology** • Plans to restart Yoga sessions for staff in the near future • External QUAD audit undertaken in November 2018. Action plan has been developed and a 6month review is now required. • Gap & Grow – business case was submitted outlining the needs of the service in order to meet recommended criteria. • T2 Obstetric Unit to open on 3rd October 2019. • X2 Medication Errors reported in August 2019. There was no harm to patients. • Blood Glucose machines upgrade is progressing with procurement. • Virtual tours being developed following the successful bid approved by the Health Charity • Post Mortem consent training session has been undertaken as part of recent Audit session for those who required training. • Level of final numbers of anticipated flow from Cwm Taf Health is awaited. Activity continues to be monitored.	

	• Recruitment is ongoing across a number of areas within the directorate. • Sickness on delivery suite has been a significant issue and is being managed on a shift by shift basis, however it was noted that this is starting to improve. • There are currently a number of RCA's ongoing at present and it was agreed that an extra ordinary meeting will be arranged to discuss outside of the meeting. Community Child Health • School Fluenz programme commences on 8th October 2019 with extensive support being provided by school nursing. • CHAT Health Online App being launched on 30th September and will commence on 1st October 2019. • Wellbeing support being provided by School Nursing • Sessions booked for staff wellbeing sessions to take place over the next few months • HCWP compliance remains an issue however work is continuing to improve across all areas. All families that are not receiving standard input at present have been informed of a point of contact. • A session being provided on risk assessments at the next Community Forum in order to provide support for medical staff. • Butetown HC. Additional car parking spaces have been allocated and this is being monitored. • Rover Way site access has been reviewed and individual risk assessments are undertaken for all on site visits, and a buddy system is in place. • Safeguarding – asking question • Safeguarding risks identified with regards to marks from equipment for children that have received through non referral via multi-agency process • DBS checks for youth board members and reviewing processes around recruitment • There are a few RCA's ongoing with some cases almost at completion. • PRUDIC case reported. Work is being undertaken to look at how to support staff post incident as there are significant delays with getting wellbeing support for staff. It was agreed that further discussions will take place outside of this meeting. • Respite provision is a significant concern at present and options are being reviewed • CAMHS recruitment has continued and are now almost at full compliment. • Recruitment pressure continues in Health Visiting and work is being undertaken to look at options of recruiting Band 5 • Move to Woodland House is progressing and there remain issues with regards to confidential areas for some groups of staff. • Business Continuity plan is completed, with further input from CAMHS. It was agreed that this would be noted at the next meeting. Cancer Work is being taken forward on the cancer risk register noting that the risks are owned by individual areas.	LM PD
2.4	RTT Update – Long Waiting Patients (over 36 weeks and 52 weeks) Gynaecology X3 36 week breaches reported in August. There is potentially a further 3 lists going down and work is being undertaken in order to further plan and manage. Acute Child Health X12 36 week Inpatient and Daycase breaches being reported. Lack of anaesthetic cover is a significant issue. Working closely to review the breaches and rebook as soon as possible. Breaches of 26 weeks within Outpatients for Paeds Surgery, General Paeds and Endocrine. Work continues to improve position. X1 diagnostic 8 week breach reported for endoscopy.	
2.5	Directorate Business Continuity plans To note the final business continuity plan for O&G Directorate	

	This has now been completed and agreed/ratified by the Clinical Board. It was agreed that the plans for Community Child Health and Cancer Services would be brought to the next meeting for noting.	AC/PD
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	Initiatives to promote health and wellbeing of Patients/Staff Discussed as part of Item 2.3	
SAFE CARE		
4.1	Update on Serious Incidents & Update on CB E-datix performance X1 new SI reported. Investigation has commenced and a meeting has been set to agree the TOR. There are currently 9 SI's open at present and work is ongoing with a view to close over the next month.	

4.2	RCA's/SBAR's for noting and agreeing actions
	SBAR Patient BN
	This case relates to an incorrect dose of oramorph given to patient. The prescription was undertaken by the paediatric registrar as surgical registrar did not feel confident in prescribing the drug, it was also very busy shift on the unit. Lessons learnt were noted that prescribing needs to be done in an area that is non clinical, where the prescriber can take time to do it correctly.
	
	The recommendations were:
	• When prescribing responsibilities are delegated, both doctors/teams must clearly agree the plan. The doctor requesting the prescription must ensure the prescriber understands their instructions. The prescriber must be happy with the responsibility and ensure they carefully check any drugs they are unfamiliar with. Ideally, the doctor requesting the medication should write this up themselves and not ask another doctor to do it for them.
	• The surgical team should write a guideline that outlines the steps for a baby/child hernia reduction and includes clear dosing advice and dosing warnings.
	• Enforce the "zero tolerance" approach to prescribing. Prescriptions should be written
	  o In an area as quiet and free from interruption as possible.
	  o No prescribing by the bedside
	• Patients who are assessed as having a probable hernia should be admitted to Gwdihw (surgical ward). Any medication and reduction of the hernia would be done there by trained staff in this procedure.
	• Electronic prescribing would be a safer option
	
	All actions have been completed and feedback provided to all staff involved. There was no harm caused to the patient.
	
	SBAR Baby S
	This case relates to a delay in delay in recognition and identification of clinical jaundice and high bilirubin result during initial clinical encounters, leading to missed opportunities and subsequent delay in initiation of corrective treatment, for a potentially very significant medical condition with long term adverse outcomes. Once identified, the practice that was followed was exemplary, with regular updates provided to parents throughout.
	
	Lessons learned
	• To review and record all the parameters on the blood gas analysis
	• To defer routine tasks like baby checks during the daylight hours when conditions are optimal for such examination
	• Adequate documentation of procedures in notes
	• Timely initiation of infusions in the central lines ones inserted
	• Ensure communication is improved and any concerns raised by any staff member are addressed to in timely fashion.	

	Incidental learning • Documentation can be improved, record keeping and filing of paper needs improvement, date and time of events need to recorded The action plan is being completed following further discussions taking place from the recommendations. Once this is complete, the closure form can then be completed for submission to Welsh Government. Coroners Case – BH Deferred to extra ordinary meeting. Pre-inquest date has been set for 8th October 2019, with further dates to be set for staff to attend.	
4.3	To note the Partly upheld PSOW report – Patient SM Noted for information. There were no specific exceptions to note for this meeting.	
4.4	Infection Prevention Control Update Concerns were raised with regards to the lack of IP&C lead for the Clinical Board which has been raised with the IP&C team and also the Executive lead. CH agreed to discuss further outside of the meeting.	CH
4.5	Safeguarding • Child Abduction Policy • Domestic Abuse in Pregnancy Guidelines • Safeguarding Annual Report Noted for information.	
4.6	Patient Safety / MDA Alerts (internal/external)/WHC • MDA 2019/027 - Automated external defibrillators: All Telefunken HR1 & FA1 – no valid CE certificate • MDA/2019/028 - Microneedling pens: Dermapen 3 and Dermapen Cryo • Public Health Wales briefing: Update on listeriosis incidents in the UK • Public Health Wales Briefing: Middle East Respiratory Syndrome and the Hajj The above alerts were noted for information and have been circulated widely across all areas within the Clinical Board. There were no specific exceptions to note as a Clinical Board.	
DIGNIFIED CARE		
5.1	Latest Cleaning Scores Report The latest cleaning scores report was noted for information. Assurance was requested that clinical leaders are attending walkabouts and having input and signing off the audit reports.	ALL
INDIVIDUAL CARE		
6.2	Update on latest 2 minutes of your Time feedback Work continues, there were no exceptions to note for this meeting.	
STAFF AND RESOURCES		
7.1	To note any exceptions/issues relating to staff/resources Discussed as part of item 2.3.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
8.1	Medication Safety Metric Data Summary – August 2019 Noted for information.	
8.2	Terms of Reference – Health Foundation Research Project Noted for information. This project will be undertaken over the next 18months and feedback will be provided as the work progresses.	

8.3	**New H&S risk assessment procedure** Noted for information. This is also available on the intranet and is a practical guide for completing and undertaking risk assessments. Discussion ensued with regards to risk assessment training and training dates. RS agreed to circulate the dates for information. http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/UHB%20467%20%20Health%20%20Safety%20Risk%20Assessment%20Procedure%20Draft%201.pdf	
8.4	**Enforcement Agencies report** Noted for information.	
8.5	**National Maternity & Perinatal Audit** Noted for information.	
8.6	**Newborn Bloodspot Poor Quality Sample Feedback - August 2019** Noted for information.	
ANY OTHER BUSINESS		
	T2 Update The risk assessment was shared for information. Inductions will be opened on Monday 30th September with the official opening taking place on 3rd October 2019. Work is continuing with regards to recruitment in order to fully open the unit for theatres, recovery etc. There will be a need to have a trained recovery nurse in order to comply with standards. There is a pathway in place to manage these patients at present, however there will be a need to address this in the longer term when the activity flow is confirmed from Cwm Taf Morgannwg Health Board. **Bladder Service Update** Concerns were raised with regards to required nursing support for this service. Admin support is being reviewed in order to provide support for arrangement of clinics and meetings are taking place in order to look at robust plans for the patients and what can be provided from a service perspective. Discussion ensued and it was noted that this is also a significant concern within the community. It was noted that there is a need to determine what is tertiary and secondary care in order to ensure that the health board are receiving patients appropriately. It was agreed that notice should be provided to local DGH's in order to outline the pathways and provision of support for these patients. It was agreed that a meeting would be arranged in order to discuss and agree actions going forward.	AG
DATE AND TIME OF NEXT MEETING		

The next meeting is scheduled for **Tuesday 22nd October, Meeting Room, Clinical Board Offices, Lakeside**

Future 2019 Dates
Tuesday 26th November, Meeting Room, Clinical Board Offices, Lakeside (IP&C FOCUS)
Tuesday 17th December, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)
Tuesday 28th January 2020, Venue to be confirmed
Tuesday 25th February 2020, Venue to be confirmed
Tuesday 24th March 2020, Venue to be confirmed (H&S FOCUS)

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

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

MINUTES OF THE MEETING HELD ON 14TH AUGUST 2019

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Alun Morgan	Assistant Director of Therapies and Health Sciences
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Nigel Roberts	Laboratory Service Manager, Biochemistry
Robert Bracchi	Consultant, AWTTC
Rachael Daniel	Health and Safety Adviser
Suzie Cheesman	Patient Safety Facilitator
Lesley Harris	Professional Head of Radiography UHL
Judyth Jenkins	Head of Dietetics
Bolette Jones	Head of Media Resources
Maria Jones	Senior Nurse, Outpatients
Sarah Jones	Quality Lead, Pharmacy

Apologies:

Matthew Temby	Clinical Board Director of Operations
Mathew King	Head of Podiatry
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Lisa Griffiths	Quality Manager, Laboratory Medicine
Paul Williams	Clinical Scientist, Medical Physics
Anthony Powell	Medical Devices Officer
Alison Bax	Professional Head of Radiography UHW
Rhodri John	Operational Support Service Manager
Emma Cooke	Head of Physiotherapy
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/301 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 19/302 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 19/303 Approval of the Minutes of the Last Meeting

The minutes of the meeting held on 10th July 2019 were **APPROVED.**

CDTQSE 19/304 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

Physiotherapy and Podiatry risk registers are outstanding. Alun Morgan will follow this up.

Action: Alun Morgan

CDTQSE 19/196 Business Continuity Plans

Business Continuity Plans are still to be submitted from Physiotherapy. Alun Morgan will follow this up.

Action: Alun Morgan

CDTQSE 19/217 Patient Story from Cellular Pathology

Scott Gable to advise Helen Jenkins of a date of a future meeting when Cellular Pathology will present its patient story.

Action: Scott Gable

CDTQSE 19/259 Patient Stories

Sue Bailey to share the patient stories that were presented in the July meeting with the other Clinical Boards.

Action: Sue Bailey

CDTQSE 19/283 Excessive Heat in Antenatal UHL

An SBAR has been produced to highlight the issues. A temporary mobile air conditioning unit is in use. Alun Morgan will escalate the issue to Ian Fitsall. Lesley Harris to send the email trail of her communications with Estates to Alun Morgan.

Action: Alun Morgan

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/305 Patient Story

Nigel Roberts presented on the lessons to be learned from a Serious Incident involving Ethylene Glycol.

A 12 year old child with autistic learning difficulties visited his GP. He was dehydrated and had a history of weight loss. He had increasing lethargy and vomiting. The child was taken to UHW.

Advice from the Biochemistry Duty Biochemiist was to test his blood for toxins including ethylene glycol. Sample A was retrieved and tested and was reported as a significant result.

The patient received the antidote Fomepizole. The on-call paediatric consultant was concerned and contacted the Child Protection Unit and clinical staff met with the child's parents accompanied by police officers to explain that anti-freeze had been detected.

A second sample was received and assayed by a different member of staff and the same result was returned. 5 days later the Toxicology Biochemist was concerned that on day 4 the ethylene glycol should have been undetectable and asked for the test to be repeated.

Repeats of both samples gave results that raised a suspicion of a false positive. PCCUs clinicians were notified that there had been an error. The samples were sent to an external laboratory for verification and the samples were negative for ethylene glycol from the referral laboratory.

The impact resulted in the patient being treated inappropriately. The family were only allowed supervised visits and the patient awoke from sedation and his family were not there. Police took 43 bags of family possessions from their house as evidence, interviewed their family, friends and neighbours and considered charging the parents with attempted murder. The family have been the subject of local gossip.

The patient has continuing health problems and the parents have lost faith in the NHS.

It was noted that a problem with carryover was identified 1 year previously. Changes to the procedure were made to account for the carryover problem however the Standard Operating Procedure was not changed to reflect this. A culture and practice of passing on changes to SOPs by word of mouth was identified.

Ethylene Glycol is a complex technique. The highly significant results were not double checked before reporting, despite some staff being aware of the problem with carryover.

In terms of learning:

SOPs must be accurate and updated as required.

Laboratory assay procedures must not be changed without full documented validation of the assay.

Staff taking tests should be suitably trained and familiar with problems that might occur such as false positive results due to carryover.

Staff undertaking a very complex technique should be suitably supervised.

Results that are highly significant should be double checked.

Where there is a clinical need for an urgent test and trained staff are not available to perform it contingency plans should be available and implemented if need be.

Staff reporting results and liaising with clinicians should be suitably trained and not give advice and interpretation beyond their competency.

This incident has been presented with all staff in the department. It was mandatory for staff to attend this presentation. A meeting has been held with the family to apologise and they are very distressed. The learning has also been shared with the police. There are also safeguarding lessons to be learned for staff working in laboratories who are not patient facing.

The department has since has reduced its number of assays available to those that are safe and reliable.

CDTQSE 19/306 Feedback from UHB QSE Committee 18th June 2019

The minutes of the UHB QSE Committee held on 18th June 2019 are not yet available.

CDTQSE 19/307 Health and Care Standards

The Annual Quality Statement has been circulated.

CDTQSE 19/308 Risk Register

Directorate Risk Registers have received from Occupational Therapy, Laboratory Medicine, Radiology and Medical Physics/Clinical Engineering and AWTTC.

The Clinical Board has received correspondence from Nicola Foreman that the Board Assurance Framework has been updated. The UHB is now undertaking further work on the Clinical Boards Assurance Framework and a template to ensure all Clinical Boards to have a consistent process in place.

CDTQSE 19/309 Exception Reports

There were no issues to escalate.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/310 Initiatives to promote Health and Wellbeing

The Clinical Board Formal Board meeting reviewed sickness absence figures for the Clinical Board and it was identified that the top reason reported for sickness relates to stress, anxiety and depression. The Workforce and OD team have been tasked to consider measures that can be put in place to help support staff.

Rachael Daniel advised that Occupational Health and Employee Wellbeing teams are looking at mechanisms for raising awareness of health and wellbeing. The stress risk assessment has been revised.

The UHB Flu Campaign will be commencing end of September. To date the Clinical Board has identified 10 flu champions. A request for further flu champions will be circulated.

Action: Maria Jones

CDTQSE 19/311 Falls Prevention

Alun Morgan reported that a workshop is being held in September.

A bid has been submitted for transformation work in the CRTs.

He noted that there is good engagement from Therapies on the Falls Group.

SAFE CARE

CDT QSE 19/312 Concerns and Compliments Report

In July 2019, the Clinical Board received 10 formal concerns, with early resolution for 3 concerns. There were 0 breaches in response times and 10 compliments were received.

There were no directorates reporting poor compliance this month.

Good performance was noted in Radiology where 2 formal concerns were received, with early resolution for 1 concern. There were no breaches in response times and 4 compliments were received.

CDTQSE 19/313 Ombudsman Reports

Nothing to report.

CDTQSE 19/314 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 19/315 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. Sue Bailey will close this incident and re-open it again if required.

Action: Sue Bailey

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. The closure form has been submitted to Welsh Government.

In92069 relates to a paediatric overdose and the investigation is completed and the action plan is being finalised.

In90956 Troponin incident has been closed by Welsh Government but an investigation is underway.

The cluster of IRMER incidents are being reviewed. This issue is on the UHB risk register.

CDTQSE 19/316 New SI's

A new SI in PCIC has been reported relating to patient who had a PSA result which was life threatening, where the GP did not review the correct result and the patient was informed the result was stable.

CDTQSE 19/317 RCA/Improvement Plans

Nothing to report.

CDTQSE 19/318 WG Closure Forms – Sign Off

In88890

The incident relates to a patient who died as a result of a ruptured cerebral aneurysm which is a known but rare complication of a flow diverter insertion procedure. A meeting has been held with the family.

There was learning from the incident that regular, inclusive mortality and morbidity reviews for neurosurgical and neuroradiological interventions should be established so that all involved can understand and learn from experiences. The post-operative pathway should be reviewed to ensure the environment and care plan is fit for purpose. Consideration must be given to mechanisms for improving communication with families in these situations.

CDTQSE 19/319 Regulation 28 Reports

Nothing to report.

CDTQSE 19/320 Patient Safety Alerts

WHC (2019) 024 Pertussis – occupational vaccination of healthcare workers

Healthcare workers in NHS Wales who have received a pertussis-containing vaccine in the last 5 years and who have regular contact with pregnant women and/or young infants will be eligible for a pertussis-containing vaccine as part of their occupational health care.

CDTQSE 19/321 Addressing Compliance Issues with Historical Alerts

There are no issues to be addressed.

CDTQSE 19/322 Medical Device Risks/Equipment and Diagnostic Systems

The safety notices and important documents management procedure was **RECEIVED.**

An urgent Field Safety Notice relating to Phillips EPIQ and Affiniti Ultrasound Systems was **RECEIVED** and **NOTED.**

MDA 2019/026 Professional use capillary blood specimen collection: BD Microtainer tubes – risk of blood leakage and/or incorrect test results due to defective tubes.

The medical device alert was **RECEIVED.** It was noted that Becton Dickinson is not the supplier in Biochemistry.

CDTQSE 19/323 IP&C/Decontamination Issues

A meeting is being held next week to review the Clinical Board IP&C governance structure.

CDTQSE 19/324 Point of Care Testing

Nothing to report.

CDTQSE 19/325 Key Patient Safety Risks

Safeguarding

The White Ribbon Campaign 'Walking a Mile in her Shoes' has been circulated across the Clinical Board. It was noted that the White Ribbon Campaign is seeking ambassadors.

Safeguarding Week will be held in November.

Gareth Edgell will be attending in September to discuss safeguarding issues.

Details of a Mencap conference has been circulated across the Clinical Board.

MCA Act

Nothing to report.

CDTQSE 19/326 Health and Safety Issues

Rachael Daniel reported that the HSE inspected Hywel Dda in July and extended the criteria to include asbestos management. Feedback from the audit was that interest was taken in the transport of medical records between sites and manual handling techniques in the mortuary.

There is no set date yet for the inspection of this Health Board but it will take place between October and December. This will be a 4 day audit with 4 inspectors. The inspectors will be auditing A&E, Mental Health and theatres.

Rachael Daniel offered to visit Medical Records and the Mortuary. It was noted that manual handling of bariatric patients in the mortuary will be a challenge. Rachael Daniel to contact Scott Gable and Sion O'Keefe.

Action: Rachael Daniel

CDTQSE 19/327 Regulatory Compliance and Accreditation

Haematology has cleared its non-conformances and their accreditation has been maintained.

Biochemistry has extension to scopes in progress.

The MHRA has inspected the Production Unit in Pharmacy UHL and the Radiopharmacy in UHW. The main findings related to inadequate resources for the pharmacy quality system and the design facilities of the current Radiopharmacy do not meet standards. A Gold Command structure has been put in place to address the actions required in the Radiopharmacy facility.

CDTQSE 19/328 Policies, Procedures and Guidance

The following documents are out to consultation and have been circulated to the Clinical Board Health and Safety Group for comments:

Contractor Control Policy
Health and Safety risk assessment procedure

Helen Jenkins will circulate the documents to the Group.

Action: Helen Jenkins

EFFECTIVE CARE

CDTQSE 19/329 Clinical Audit

Nothing to report

CDTQSE 19/330 Research and Development

The next meeting of the Clinical Board R&D Group will be in September.

CDTQSE 19/331 Service Improvement Initiatives

A number of CD&T staff were invited to participate in Amplify. Each individual that attended has been asked to undertake a service improvement project. The next stage will be a showcase event in October. Participants are invited to bring 10 colleagues with them which will be linked to the next initiative, Accelerate. This is linked to the key elements of the UHB Strategy.

CDTQSE 19/332 NICE Guidance

Nothing to report.

CDTQSE 19/333 Information Governance/Data Quality

Sion O'Keefe is working with the Information Governance team on providing a detailed submission to the ICO relating to the loss of a set of health records. The importance of individuals tracking health records was emphasised.

SAU keep notes in their department separate from Health Records, for patients that were not admitted. There is an option for scanning then if Surgery Clinical Board wish to fund this. Sion O'Keefe and Mike Bourne will discuss outside of the meeting.

DIGNIFIED CARE

CDTQSE 19/334 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 19/335 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

CDTQSE 19/336 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/337 Equality and Diversity

Pride Cymru is being held on 24th August. This has been promoted across the Clinical Board.

TIMELY CARE

CDTQSE 19/338 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/339 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Sion O'Keefe reported that options are being explored to address possible breaches in Radiology in August.

Therapies are seeking locum support to assist with their performance position.

CDTQSE 19/340 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 19/341 National User Experience Framework

A paper was presented relating to a Patient and Relative Experience Walk Through held on 30th April 2019. The 'Walk Through' considered the experience of the patient and their family as they walked from the car park to clinical areas and considered the provision and processes for care of families after a patient's death by visiting the bereavement office and mortuary.

The report described the walk to the mortuary as bleak however on entering the mortuary, the visiting waiting area was described as comfortable and the decor pleasant.

The User Experience Report for July 2019 was **RECEIVED.** Overall excellent comments were received on the care received. There were 10 complaints related to parking. Some concerns were raised that the Park and Ride is not well advertised and the Clinical Board will review patient letters to ensure this service is being promoted.

STAFF AND RESOURCES

CDTQSE 19/342 Staff Awards and Recognition

Allied Health Awards have a call out for posters.

Nominations are encouraged for the Clinical Board Staff Recognition Scheme. The category for August is An Individual Making an Outstanding Contribution.

CDTQSE 19/343 Monitoring of Mandatory Training and PADRs

Concerns have been raised by the Clinical Board in relation to the Attendance at Work Policy that managers and staff delegated to manage absence have not undergone the training. Measures are being put in place to ensure the appropriate staff in the Clinical Board receive the training.

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

The following minutes were **RECEIVED:**

Biochemistry Quality Group Minutes July 2019
Clinical Board Regulatory Compliance Group Minutes July 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.

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

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

MINUTES OF THE MEETING HELD ON 11TH SEPTEMBER 2019

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Robert Bracchi	Medical Advisor to AWTTC
Lesley Harris	Professional Head of Radiography UHL
Bolette Jones	Head of Media Resources
Maria Jones	Senior Nurse, Outpatients
Keeley Baker	Head of Health Records
Mathew King	Head of Podiatry
Emma Cooke	Head of Physiotherapy
Scott Gable	Laboratory Service Manager, Cellular Pathology
Rhys Morris	Medical Physics (shadowing Matt Temby)

Apologies:

Rachael Daniel	Health and Safety Adviser
Suzie Cheesman	Patient Safety Facilitator
Alun Morgan	Assistant Director of Therapies and Health Sciences
Nigel Roberts	Laboratory Service Manager, Biochemistry
Carol Evans	Laboratory Director, Biochemistry
Judyth Jenkins	Head of Dietetics
Sarah Jones	Quality Lead, Pharmacy
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Matthew Williams	QA Technologist, Medical Physics
Paul Williams	Clinical Scientist, Medical Physics
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/344 Welcome and Introductions

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

CDTQSE 19/345 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 19/346 Approval of the Minutes of the Last Meeting

The minutes of the meeting held on 14th August 2019 were **APPROVED.**

CDTQSE 19/347 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

Podiatry Risk Register will be submitted next week. Physiotherapy is in progress.

Action: Mathew King/Emma Cooke

CDTQSE 19/196 Business Continuity Plan

Physiotherapy Business Continuity Plan has not yet been submitted. It was suggested that Emma Cooke replicates the OT plan.

Action: Emma Cooke

CDTQSE 19/217 Patient Story Cellular Pathology

Scott Gable will contact Helen Jenkins for a slot to present a patient story.

Action: Scott Gable

CDTQSE 19/283 Over Heating issues in Antenatal UHL

Lesley Harris reported that attempts to resolve the issues with Estates are ongoing.

CDTQSE 19/310 Flu Champions

Nominations have been received. It was clarified that Flu Champions do not have to be nurses.

It was noted that there will be no cash prizes this year linked to the flu campaign. The UHB is considering alternative strategies this year to increase uptake.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/348 Patient Story

The Health Records department produced and delivered a presentation based on the health records service.

Sion O'Keefe explained that the Health Records service manages over 1 million records. 400,000 are stored at UHW in a limited number of libraries.

In 2017 there were numerous service complaints and issues relating to health and safety. There were trip hazards and constraints to locating records timely and higher levels of missing records. Clinicians need the timely provision of medical records for decision-making and treatment of patients. However staff external to the department can take away notes which significantly increases the risk of notes not being properly tracked.

A workplace inspection was undertaken by Partnership colleagues who were concerned with the manual handling issues for staff.

At this same period in time, the admin bank closed and the department was heavily reliant on this service which resulted in staffing issues.

It was recognised that the sign up to doing something different was needed understanding that this would involve hard work and great physical effort. Work started by creating space by moving 2000 boxes to an offsite facility. This made a significant difference.

Support was given by the UHB for the department to bring in new permanent staff. The workforce felt more equal and valued and more inclined to take pride and responsibility in their work.

Support was also given to send 12,000 boxes off site and permission was given to recruit temporary staff to provide assistance.

The department was further compounded by issues when the Whitchurch Hospital was decommissioned and the estimate of 500 boxes of case notes to be removed from the site turned into greater than 10,000. Staff working on the site to remove the case notes were working in a poor environment, dealing with pigeon excrement, intruders and theft issues. A storage unit was allocated at Treforest but the department were required to set this up with no additional resource.

Health Records staff in UHL also had to deal with the transfer to Hafan Y Coed.

In terms of the present situation a tidy space has now been created. There is order in the libraries and staff are now enjoying their work. Capital funding was secured for a reception area to be created in the department and there is now partial closure of the libraries. Location based filing has been implemented and the number of missing files has significantly reduced.

There has been a successful trial in library 3 of restricted access libraries and a click and collect service. This has saved time which has been reinvested into better stock management. It avoids pinch points and is keeping the floors and bays tidy. Positive feedback has been received from directorates and users.

Looking forward the aim would be to restrict access to all libraries. Room 1 will commence from September. Also for the future a mobile tracking app is being developed by IM&T and there will be further expansion of digital records resulting in

less paper. The department is also aiming to move from click and collect to click and drop.

The department are now very proud of the libraries and patient notes are getting to where they need to be more efficiently.

Emma Cooke asked if the tracking of walking aids could be used with the same technology. Sion O'Keefe stated that this could be an option to be explored and developed.

Matt Temby worked in Health Records in the past and has noted the huge cultural shift within the department and the pride that staff have in their work.

CDTQSE 19/349 Feedback from UHB QSE Committee 18th June 2019

The minutes of the UHB QSE Committee held on 18th June 2019 are not yet available.

CDTQSE 19/350 Health and Care Standards

Nothing to report.

CDTQSE 19/351 Risk Register

Discussions are being held corporately on the development of a new risk register template.

CDTQSE 19/352 Exception Reports

Sue Bailey reported that bacterial growth from finger dabs was identified in the Radiopharmacy Unit and production has been suspended whilst the cause is being identified and remedial work is undertaken.

The parenteral nutrition issue with Calea is still ongoing and business continuity arrangements are in place in SMPU and Dietetics.

A cluster review has been undertaken on the cluster of IRMER incidents in Radiology. There are a number of actions to be reviewed.

Biochemistry is experiencing an impact on service and quality delivery due to staffing issues relating to long term sickness and retention. There are also ongoing issues with the analysers.

There is a general concern around staffing within the Clinical Board. There are 3 services in particular, where there is concern around sustainability. All the business critical vacancies have been reviewed and with the agreement of the finance team will be approved. The decision has now been taken that the vacancy panels will now be reinstated. The Clinical Board will need to receive detail around vacancies and whilst not all posts will be approved, the aim is to bring stability to the system. The same process will be implemented however services must be aware that posts will be scrutinised and challenged.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/353 Initiatives to Promote Health and Wellbeing

Sue Bailey confirmed that the cash prize received from last year's flu vaccination campaign will be used to promote health and wellbeing of staff.

CDTQSE 19/354 Falls Prevention

Nothing to report.

SAFE CARE

CDT QSE 19/355 Concerns and Compliments Report

The Clinical Board's performance against concerns management deteriorated in August 2019. 7 formal concerns were received with 43% by early resolution. There was 1 breach in response times and 9 compliments.

Outpatients/Patient Administration was the area of concern to highlight. It received 2 concerns, 1 breach in response times, however it did receive 2 compliments.

The area to highlight in terms of good performance is Physiotherapy. The department received 1 formal concern which it responded to within the early resolution timeframe and it also received 1 compliment.

CDTQSE 19/356 Ombudsman Reports

Nothing to report.

CDTQSE 19/357 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 19/358 Patient Safety Incidents

In69239 relates to Cellular Pathology. The closure form was submitted to Welsh Government in October 2018 and the department is awaiting notification of whether this incident can be closed.

In82274 relates to a choking episode of a patient.

In92069 relates to a paediatric overdose. The investigation is completed and the closure form has been completed.

All open HIW incidents have now been submitted for closure.

CDTQSE 19/359 New SI's

Nothing to report.

CDTQSE 19/360 RCA/Improvement Plans

Nothing to report.

CDTQSE 19/361 WG Closure Forms – Sign Off

A 14 month old child with Down's syndrome was admitted to Morriston Hospital in Swansea on 1st May 2019 with loss of weight and floppiness. Prior to this on the 15th April the child had been prescribed Furosemide and Spironolactone for breathlessness, secondary to complete atrioventricular septa defect. He developed a suspected allergic reaction to one of the drugs and both of the drugs were stopped although it was thought that Spironolactone was most likely to be the problematic medicine. The child was seen by a Consultant Neonatalist at Singleton Hospital who recommended that the Furosemide be restarted on the 26th April 2019. The parents administered the medicine dispensed by the UHW Pharmacy on 15th April.

On admission to Morrison Hospital on 1st May, the doctors identified that the child had been receiving too high a dose of Furosemide and Spironolactone. On investigation it was discovered that the original prescription did not specify the strength of either the Furosemide or Spironolactone to be administered and this prescription was endorsed by the Clinical Checking Pharmacist. It was identified that the child had been given an overdose 10 times the dose prescribed.

Morriston Hospital completed all the necessary tests and monitoring and the child was discharged the following day with the correct prescription for Furosemide. The child was seen on 17th June and it was noted that he was actively, lively, pale, warm and well perfused. The parents reported that the child had been gaining weight since discharge.

The investigation highlighted that familiarity with the medications and complacency meant that the pharmacist did not follow best practice that required a calculator to check his own calculation whilst carrying out the clinical check, but did the calculation using mental arithmetic.

It was identified that there were a lack of calculators easily available at all stations in the dispensary.

The assumption was made that the calculation had been carried out by an experienced paediatric pharmacist and was clearly endorsed, led the pharmacy technician to not follow dispensary standards and check the calculation.

The pharmacist carrying out the final check did not follow best practice and did not check the calculation.

Actions implemented following this incident include a review of dispensing standards to include that calculations must be checked at every stage of the dispensing process. To also include that the prescription must be signed when counselling has been performed.

A label is being developed to clearly show that the calculation has been checked at each stage of the dispensing process.

Regular audit of paediatric prescriptions to ensure the label is being used to evidence adherence to dispensary standards.

The staff involved have completed reflective accounts of their involvement in the incident and one of the staff members is taking forward a service improvement project to reduce the numbers of 10 x paediatric dose errors.

CDTQSE 19/362 Regulation 28 Reports

Nothing to report.

CDTQSE 19/363 Patient Safety Alerts

Nothing to report.

CDTQSE 19/364 Addressing Compliance Issues with Historical Alerts

There are no issues to be addressed.

CDTQSE 19/365 Medical Device Risks/Equipment and Diagnostic Systems

It was noted that Lesley Harris has produced an SBAR on Medical Device Regulations for Radiology which require all high risk medical devices to carry a unique identifier. This is being discussed at the Regulatory Compliance Group.

CDTQSE 19/366 IP&C/Decontamination Issues

The Water Safety Group has advised that bottled water coolers must not be placed in clinical areas.

A reminder has also been issued around the need for appropriate flushing regimes.

CDTQSE 19/367 Point of Care Testing

Nothing to report.

CDTQSE 19/368 Key Patient Safety Risks

Safeguarding

Gareth Edgell and Aimee Cox were in attendance to provide an update on safeguarding issues. The Safeguarding team will be based in Woodlands House from October and can provide information on how to make referrals. There are 7 Advisers in the team, Kevin Hogan who was linked to this Clinical Board has now left the UHB and his post will be replaced by a Nursing Adviser. A member of the team, Sarah Richards is the Independent Domestic Violence Advocate. She

provides inpatient case management of patients who make disclosures of domestic abuse and supports staff who have been victims of domestic abuse.

The team receive a lot of queries relating to safeguard training. Level 1 Mandatory training is for all staff and is completed on-line. Level 2 is for all frontline staff and face to face training was mandated this year. The package has been condensed to a 2 hour session. Level 3 is for all staff involved in the potential for safeguarding referral case management and involves face to face training.

Training is also available on modern slavery and human trafficking and a bespoke package on county lines. FGM and RAP training is also provided. Legal aspects of safeguarding training can be provided for complex cases. There are also 2 adult safeguarding courses available incorporating dementia.

The team have links with Cardiff MASH which deals with all child protection referrals.

The UHB is awaiting publication of the All Wales Policies and Procedures for Safeguarding of Adults next month and drop in sessions will be set up.

Adult Practice Reviews are being developed. The first publication was received last month and highlights the importance of multi-agency working and information sharing.

There has been a rise in knife crime and a post is being put in place to work across multi-agencies.

MCA Act

Nothing to report.

CDTQSE 19/369 Health and Safety Issues

The Health and Safety Policy is due for review.

Two RIDDOR issues have been reported where a member staff became caught in automatic doors and in Health Records a member of staff kicked a brick that was being used to prop open a door in St Davids.

It was noted that in preparation for the HSE visit to the UHB, directorates are to ensure that mandatory training for all staff is up to date.

CDTQSE 19/370 Regulatory Compliance and Accreditation

Natural Resources Wales is inspecting Nuclear Medicine UHL next week.

CDTQSE 19/371 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 19/372 Clinical Audit

Nothing to report.

CDTQSE 19/373 Research and Development

The Clinical Board R&D meeting is being held tomorrow. Discussions will focus on directorate's financial allocations.

CDTQSE 19/374 Service Improvement Initiatives

Amplify has been launched in the UHB. This relates to ensuring the Health Board's 10 year strategy is implemented.

Accelerat8 programme is also being implemented. A number of service managers have applied.

CDTQSE 19/375 NICE Guidance

Nothing further to report.

CDTQSE 19/376 Information Governance/Data Quality

The Medical Records Operational Group has been stood down. The Health Records team are meeting the new Medical Director in October and will discuss his thoughts on future arrangements.

DIGNIFIED CARE

CDTQSE 19/377 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 19/378 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

A new Sensory Loss Champion pack has been produced. The pack contains useful information on sensory loss services that are available.

CDTQSE 19/379 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/380 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 19/381 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/382 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Radiology reporting 33 breaches.

Breaches anticipated in dietetics, details to be confirmed.

Sion O'Keefe to meet with Emma Cooke to discuss physiotherapy template issues.

Action: Sion O'Keefe/Emma Cooke

CDTQSE 19/383 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 19/384 National User Experience Framework

The August report has been received this week. Sue Bailey will review this outside of the meeting.

Action: Sue Bailey

STAFF AND RESOURCES

CDTQSE 19/385 Staff Awards and Recognition

The category for the Clinical Board's monthly staff recognition scheme for September is the 'Making an Outstanding Contribution as a Team' award.

CDTQSE 19/386 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting 46% compliance against PADRs.

Mandatory training compliance is 81%.

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

The following minutes were **RECEIVED:**

Biochemistry Quality Group Minutes August 2019

Laboratory Medicine QSE Minutes August 2019

Outpatients/Patient Administration & Medical Illustration QSE Minutes August 2019

ANY OTHER BUSINESS

The Clinical Board Annual QSE Report will soon be due to be submitted to the UHB QSE Committee. Sue Bailey requested for directorates to send her any good news stories, awards or concerns that she can include in the report.

Action: All

DATE AND TIME OF NEXT MEETING

9th October 2019 at 2pm in Room 2.20 2nd floor Ty Dewi Sant UHW

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

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

MINUTES OF THE MEETING HELD ON 9TH OCTOBER 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
Robert Bracchi	Medical Advisor to AWTTC
Lesley Harris	Professional Head of Radiography UHL
Bolette Jones	Head of Media Resources
Maria Jones	Senior Nurse, Outpatients
Mathew King	Head of Podiatry
Suzie Cheesman	Patient Safety Facilitator
Scott Gable	Laboratory Service Manager, Cellular Pathology
Rhys Morris	Medical Physics (shadowing Matt Temby)
Judyth Jenkins	Head of Dietetics
Lisa Griffiths	Quality Manager, Laboratory Medicine
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Cath Marshall	Physiotherapy (for Emma Cooke)
Sarah Jones	Quality Lead, Pharmacy
Paul Williams	Clinical Scientist, Medical Physics

Apologies:

Rachael Daniel	Health and Safety Adviser
Mike Bourne	Clinical Board Director
Emma Cooke	Head of Physiotherapy
Alun Morgan	Assistant Director of Therapies and Health Sciences
Nigel Roberts	Laboratory Service Manager, Biochemistry
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/387 Welcome and Introductions

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

CDTQSE 19/388 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 19/389 Approval of the Minutes of the Last Meeting

The minutes of the meeting held on 11th September 2019 were **APPROVED.**

CDTQSE 19/399 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 Physiotherapy Business Continuity Plan

Physiotherapy to send Bolette Jones a date when this will be ready for submission.

Action: Emma Cooke

CDTQSE 19/399 Annual Report

Sue Bailey will send out the template for the QSE Report to directorates.

Action: Sue Bailey

She is particularly looking to capture any good news stories from within directorates and requested to receive responses by end of October.

Action: All

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/400 Patient Story – What is AWTTC?

Robert Bracchi explained that AWTTC is a directorate in Cardiff and Vale UHB that sits within the Clinical Diagnostics and Therapeutics Clinical Board. It was set up in 2002 to appraise high cost drugs in Wales and this changed in 2010 to encompass all medicines. It is an NHS organisation working to ensure that all people in Wales can access clinically effective and cost effective medicines as quickly as possible.

AWTTC promotes the best use of medicines to help patients in Wales be healthier and better informed by providing understanding of prescribing and toxicology data to decision makers. The service works with healthcare professionals, the general public and the pharmaceutical industry. The team brings together a unique mix of professionals who combine their skills and expertise to provide professional support to Welsh Government. Its work focuses on:

- Assessment of new medicines
- Analysing trends in prescribing and improving the use of medicines in Wales
- Providing guidance on best practices for prescribers
- Improving medicines safety
- Reporting serious suspected side effects of medicines (adverse drug reactions)
- Education and training for healthcare professionals and public/patient groups
- Toxicology services

- Specialist clinical services e.g. management of hypertension and suspected adverse reactions to medicines.

The outputs can be organised into five sections and we also provide patient facing clinical services in partnership with Cardiff and Vale UHB.

PAMS – Patient Access to Medicines Service

Provides professional and administrative support to the All Wales Medicines Strategy Group (AWMSG). It provides a central coordination role to support the IPFR process in Health Boards across Wales.

It provides professional and administrative support to the One Wales Interim Commissioning process to enable access to medicines for patient cohorts where no AWMSG or NICE advice is available.

WAPSU – Welsh Analytical Prescribing Support Unit

Analyses data and reports on medicines usage. It reports on the implementation of medicines from the New Treatment Fund. Due to its success the average time to make medicines available has far exceeded the 60 day target and has made a difference to patient lives. WAPSU also process Wales Patient Access Schemes which allows pharmaceutical companies to provide Wales with a discount price.

WEMeReC – Welsh Medicines Resource Centre

Provides education in therapeutics, prescribing and behavioural change by digital and face to face learning opportunities.

Yellow Card Centre Wales

Encourages patients to report suspected adverse reactions to medicines. Wales has some of the highest reporting rates in the UK, helping to contribute to a shared goal of improving the safe use of medicines.

WNPU - Welsh National Poisons Unit

Provides a 24 hour advice service to healthcare professionals following toxicity of substances. These incidents may be caused by accidental ingestion, errors in the dosing of medicines, recreational drug use, intentional drug overdose, or environmental or occupational exposures.

AWTTC Compliance with Welsh Language Standards

Kelly Wood is the Welsh Language Lead to ensure AWTTC comply with the Welsh Language Standards.
A bilingual AWMSG and AWTTC website is in development.

An English and Welsh language Twitter account has been launched.

Bilingual signage is provided for external meetings.

AWTTC English and Welsh language Twitter account has been launched.

Welsh language computer software has been provided to all staff.

The IPFR and AWMSG annual report is produced in English and Welsh.

A bilingual telephone answer service is in operation and bilingual signatures and out of office notifications have been implemented.

An internal compliance document has been produced to monitor progress against compliance with the Welsh Lang standards**.**

Sue Bailey agreed to ensure that Alun Williams, Welsh Language Officer is appraised of this work.

Action: Sue Bailey

In terms of the future for AWTTC, an external review has been undertaken in Welsh Government followed by an internal review by the Clinical Diagnostics and Therapeutics Clinical Board to consider the future structure.

Mathew King enquired whether the AWTTC can provide support on optimising dressings. Robert Bracchi commented that this would be a project that AWTTC can take forward and this would involve a very robust process. Mathew King will link in with Robert Bracchi.

The Annual QSE Report from AWTTC was **RECEIVED.** Sue Bailey will use this report to help inform the Clinical Board Annual Report.

CDTQSE 19/401 Feedback from UHB QSE Committee 18th June 2019

The UHB QSE Committee minutes 18th June 2019 were circulated.

The HTA CAPA Plan closure letter was received and noted by the Committee.

It was noted that Point of Care Testing is to be considered as an agenda item for QSE.

There should be arrangements in place to ensure that clinical audits are planned and undertaken.

An update was provided on the activity undertaken by the UHB to support and engage with the Infected Blood Enquiry. It was noted that the disposal of records is still on hold.

CDTQSE 19/402 Health and Care Standards

Ruth Walker convened a meeting for the Corporate Standards Leads. Discussion was held around the avoidance of duplication. Support will be provided from the Patient Safety Team to identify linkages as there is a lot of overlap between the standards.

CDTQSE 19/403 Risk Register

Corporate paperwork has been received advising Clinical Boards to prioritise their key risks.

CDTQSE 19/404 Exception Reports

The HSE will be undertaking an inspection of the Health Board between now and December and will provide 4 weeks' notice. It is anticipated that the inspectors will visit Health Records. Departments need to ensure their risk assessments are up to date as the inspectors may visit areas that hold records outside of the central function. Staff need to ensure their mandatory training is up to date, particularly the violence and aggression module.

Lisa Griffiths reported a breakdown of the paediatric fridge in the mortuary. Contingencies have been put in place whilst the fridge is being repaired.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/405 Initiatives to Promote Health and Wellbeing

Flu vaccines are now available to staff. The Health Board is donating to the local food bank for every vaccination undertaken.

My Work, My Health Events are being held in the coming weeks to engage with staff in looking after their own wellbeing. Resources and information will be provided on healthy eating, encouraging more physical activity and advice on wellbeing. Matt Temby requested that managers encourage their staff to attend.

CDTQSE 19/406 Falls Prevention

Alun Morgan has advised that the Community Falls Alliance met last week and have refined the community falls pathway with criteria for each of the sections. The next step is to reach consensus on the style of presenting the pathway and further refine the criteria. Once agreed this will then be submitted to the Health Pathways team for conversion into HP for primary care. There has also been a patient voice engagement session to engage with the public. HIW have also published a 'Review of Integrated Care; A Focus on Falls' which sets out a number of recommendations. Alun Morgan is benchmarking the UHB falls framework against the recommendations.

SAFE CARE

CDT QSE 19/407 Concerns and Compliments Report

In September 2019 the Clinical Board received 16 formal concerns, which is a significant increase compared to its average number of concerns normally received. 25% of these concerns were dealt with within early resolution timeframes. The Clinical Board received 4 compliments.

Areas of concern are Radiology which received 11 formal concerns, however early resolution was reached for 18% of these concerns.

The dietetics position deteriorated this month. The department received 1 formal concern however it also received 1 compliment.

Areas to highlight in terms of good concerns management are Physiotherapy which received 2 formal concerns, with early resolution for 50% of these and 4 compliments. Podiatry whilst reporting an amber status, received 1 formal concern which it resolved by early resolution.

An analysis has been undertaken of themes of concerns from 1st April 2019 to 30th September 2019 and the top 3 reasons are:

- Waiting times for a scan report or test result
- Difficulty arranging or cancelling an appointment
- Concern about treatment received.

In previous years' attitude of staff was a key theme however this year it accounts for 7% of the concerns received to date.

CDTQSE 19/408 Ombudsman Reports

Nothing to report.

CDTQSE 19/409 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 19/410 Patient Safety Incidents

The Clinical Board is reporting 2 SIs

In69239 relates to the incident in Cellular Pathology which was submitted to Welsh Government in October 2018 and is awaiting closure.

In82274 relates to a choking episode involving a speech and language therapy patient which is under investigation.

CDTQSE 19/411 New SI's

A new SI has been reported involving a laptop stolen from the Outpatient department. The Clinical Board is now undertaking an audit within all its directorates on mobile IT equipment e.g. laptops, mobiles, I-pads etc. Directorates are to ensure that all its mobile equipment has been subject to the UHB IT security and is stored securely in departments. Directorates to feedback to the next meeting for a timeframe on when this audit will be completed in their areas.

Action: All

Sion O'Keefe suggested that directorates ensure that mobile equipment is recorded on their information asset registers.

The audit relates to devices acquired through Cardiff and Vale, however anyone using their own devices for work purposes and not protecting patient identification needs to be highlighted. Photography of images also needs to be considered. Patient data held on the hardware of devices and not stored on the network needs to be flagged. Health Records team to undertake spot checks on PCs. Kit provided by managed service contracts in the laboratories will need to be checked as they are not procured through Cardiff and Vale IT.

CDTQSE 19/412 RCA/Improvement Plans

Nothing to report.

CDTQSE 19/413 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 19/414 Regulation 28 Reports

Nothing to report.

CDTQSE 19/415 Patient Safety Alerts

MDA 2019/028 Microneedling Pens

The MDA was **RECEIVED** and **NOTED**. Not relevant to this Clinical Board.

MDA 2019/030 T34 Ambulatory Syringe Pumps

The MDA was **RECEIVED** and **NOTED**. Not relevant to this Clinical Board.

Urgent Field Safety Notice FSCA 006/19

The Compliance Report from Laboratory Medicine was received. The directorate no longer receive cards and is compliant.

CDTQSE 19/416 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 19/417 Medical Device Risks/Equipment and Diagnostic Systems

Tony Powell circulated a report. There are no major equipment issues aside from the rollout out of defibrillators across the Health Board. It was noted that Physiotherapy UHW has been slow on the uptake of the training.

The Medical Device Regulations coming into force are complicated and there is confusion across the UHB as to the implications for various groups. The Medical

Equipment Group has sent out to all areas to respond with their position against the regulations. Some of the issues are as follows:

Unique Device Identification which must be recorded particularly for class 3 devices.

Any software is now regarded as medical devices and this will have an impact for all internally developed software in the future.

CDTQSE 19/418 IP&C/Decontamination Issues

It was noted that no new bacteraemia is reported against the Clinical Board.

Alun Morgan will be meeting with the IPC team to discuss concerns raised around the decontamination of wheelchairs on the wards prior to sending to Clinical Engineering for repair.

CDTQSE 19/419 Point of Care Testing

Nothing to report.

CDTQSE 19/420 Key Patient Safety Risks

Safeguarding

Discussions are being held at the Safeguarding Group around level 3 safeguarding training which is appearing on all staff's ESR records.

A presentation was given from Specialist Services on the affects that follow from nursing staff professional behaviour issues.

Alun Morgan participated in the Walk a Mile in Her Shoes Initiative.

Information will be circulated on National Safeguarding Week 7-15th November. Safeguarding Annual report has been circulated.

The Pressure Damage report has been circulated alongside a revised flow chart.

MCA Act

Nothing to report.

CDTQSE 19/421 Health and Safety Issues

The Clinical Board Health and Safety Group is being held next week.

CDTQSE 19/422 Regulatory Compliance and Accreditation

The regulatory dashboards for Haematology and Phlebotomy reached 100%.

SMPU is experiencing challenges supporting Radiopharmacy and the HPN service.

Microbiological issues in Radiopharmacy required significant remedial estates work to the unit. The building work is now completed and samples are being undertaken.

The UHB BCAG will be discussing the Clinical Board business case to strengthen its quality resource for all its directorates.

CDTQSE 19/423 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 19/424 Clinical Audit

Nothing to report.

CDTQSE 19/425 Research and Development

The key discussion at the Clinical Board R&D Group is around the submissions process and funding for R&D.

CDTQSE 19/426 Service Improvement Initiatives

Sion O'Keefe reported that the Spread and Scale Academy was held last week. Len Richards is the Executive Lead across Wales. There was good attendance from Cardiff and Vale Health Board and this Clinical Board. Projects included:

- Enhancing trachea care
- Get up get dressed – End PJ Paralysis
- Fetal Cardiac Sonography
- Low Fodmap diet
- Stance

CDTQSE 19/427 NICE Guidance

Nothing to report.

CDTQSE 19/428 Information Governance/Data Quality

The Information Governance Sub-Committee is now working as the Digital Health Committee.

Sion O'Keefe noted that a number of health records groups have been stood down however the Health Records Operational Group is still operational.

DIGNIFIED CARE

CDTQSE 19/429 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Sue Bailey reported that the Executives who undertook the Community Nutrition and Dietetics Patient Safety Walkround were highly complimentary of the service and contacted the Clinical Board Management Team following the walkround to convey their feedback. Judyth Jenkins to feedback to the team that the Clinical Board were delighted to receive such positive comments.

Action: Judyth Jenkins

CDTQSE 19/430 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Sue Bailey will be completing the template for the accessible communication standard and requested for directorates to send her any information on specific work being undertaken in their areas.

Action: All

It was noted that the UHB has signed up to the Charter of the British Deaf Association.

Sion O'Keefe commented that it would be helpful if the UHB set up a communications group which focused on the Health Care Standards.

CDTQSE 19/431 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/432 Equality and Diversity

Pride Cymru was a success again this year.

The UHB's assessment for the Stonewall Index has been submitted.

A letter on managers responsibilities for reducing the stigma associated with mental health issues in the workplace will be circulated following the meeting.

A discussion was held that there appears to be a training gap for managers and staff in relation to mental health issues. Matt Temby advised that Steve Gauci is the Mental Health Lead for the Clinical Board and suggested that managers contact him for resources, information and support that can be accessed.

TIMELY CARE

CDTQSE 19/433 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/434 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

September unconfirmed position for Radiology is 28 patients waiting over 8 weeks. 8 patients in Therapies waiting over 14 weeks.

Predicted figure of October is 20 patients waiting over 8 weeks in Radiology. There may be an issue in Speech and Language Therapy.

CDTQSE 19/435 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 19/436 National User Experience Framework

The September Report will be reviewed next month.

STAFF AND RESOURCES

CDTQSE 19/437 Staff Awards and Recognition

The Print Team received the Clinical Board Staff Recognition Award in September for a Team Making an Outstanding Contribution.

Sue Bailey encouraged all directorates to submit nominations.

CDTQSE 19/438 Monitoring of Mandatory Training and PADRs

Nothing to report.

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

The following minutes were **RECEIVED:**

Biochemistry Quality Minutes 9th September 2019

ANY OTHER BUSINESS

Sue Bailey and Lisa Griffiths have undertaken an audit in the mortuary. The audit highlighted the care, attention and dedication of the team. They observed how staff prepared a patient who deceased in traumatic circumstances with dignity and great care for a viewing by the family.

1 member of staff has gone above and beyond to source clothing items from a charity for babies that have passed away under 24 weeks.

The team have also procured a box of luminous stars to be placed with babies so they ‘don’t have to sleep in the dark’.

Paul Williams reported that a carer accompanying a patient to Medical Physics used a commode to transport the patient across the road outside the department which lost control and the patient tipped out. Sue Bailey will escalate to the porters for their awareness.

Action: Sue Bailey

DATE AND TIME OF NEXT MEETING

13th November 2019 at 2pm in Room 2.20 Ty Dewi Sant UHW

MEDICINE CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE MEETING
MINUTES

HEALTH & SAFETY FOCUS

Thursday 21st June 2019
9am – 11.30am
Classroom 2, UGF A Block, Main Hospital, UHW

Attendees:
Rebecca Aylward (chair), MCB Director of Nursing
Kath Prosser, MCB Quality & Governance Lead
Derek King, MCB IP&C Nurse
Fran Wilcox, Integrated Medicine Senior Nurse
Rachael Daniel, Health & Safety Advisor
Suzie Cheesman, Patient Safety Facilitator
Emma Mitchell, Integrated Medicine Senior Nurse
Sue Patchett, C6 Ward Manager
Ian Dovaston, MCB Professional Practice Development Nurse
Sarah Cornes-Payne, Diabetes Senior Nurse
Louise Williams, Medicines Management Advisor
Emma Foley, Case Management Officer
Nicky Croxon, Interim General Manager, Specialised Medicine
Jacquie Westmoreland, Senior Nurse, Emergency Medicine
Angela Jones, Resuscitation
Katja Empson, Clinical Director, Emergency Medicine
Barbara Davies, Lead Nurse, Specialised Medicine

Apologies:
Diane Walker, Lead Nurse, Integrated Medicine

In attendance:
Caroline McArdle

PRELIMINARIES		**Actions**
A1	Welcome and Introductions RA welcomed all present to the quarterly H&S meeting.	
A2	Apologies for Absence Noted as above.	
PART 1: HEALTH & SAFETY		
1.1	Feedback from UHB Health & Safety Operational Group RD had not attended the most recent meeting but noted the meetings were now chaired by Martin Driscoll. RD advised that the existing MCB Priority and Improvement Plan was old and out of date and agreed to meet separately to discuss making the necessary updates.	**RD**

1.2	MCB Health & Safety Report To be circulated in conjunction with the minutes of this meeting. The following points were noted: - EM queried the number of incidents reported in comparison to other Clinical Boards of comparable size. RD advised that the MCB reported more incidents than the Surgery Clinical Board but this variation may be due to the timing of the incident and the report being made. EM suggested that the MCB acted upon larger scale incidents but didn't always close 'minor' incidents that were reviewed quickly.	
1.3	Fire Safety Nothing to discuss and there were no representatives of the fire safety department present. It was noted as part of a later agenda item that the new Fire Officer for the MCB was Mel Perrow.	
1.4	HSE Correspondence BBV & Needle stick Incident RD recounted the following incident that had been reported to the HSE: - A member of staff had sustained a needle stick injury while administering insulin to a patient with a blood borne virus - There were no safety insulin pens available so the staff member had used the patient's own insulin pen but did not use a safety needle, despite there being a full stock available - This incident was attributed to human error as the staff member had not followed advice and was detailed in a robust report by the Ward Manager - On this occasion the HSE were satisfied and closed the investigation but RD warned that they would carry out an internal investigation if there was a repeat occurrence - RD confirmed that all staff on the ward involved had been reminded of the safety advice - ID confirmed that the diabetes team had visited all wards during insulin safety week and circulated information on insulin safety pens and information was being posted to the MCB Facebook page - SCP confirmed that this information was reiterated at every study day and information literature was freely available - SCP also confirmed that while insulin safety pens may not be regularly stocked on a ward as a CSSD item, the patient's own pen could be used with a safety needle Medication Safety Executive – noted	
1.5	Exception Reports and Escalation of key H&S issues from Directorates There had been no further H&S visits since this committee met in March. A fire inspection had been carried out on Sam Davies ward and it had been reported that nobody on the ward knew how to use the EVAC chair in place; this ward was not alone and it was agreed that there were a number of wards with an EVAC chair but nobody trained in its use. RD confirmed that the fire team were aware of this as it was a UHB issue and no refresher training or training for new staff had been provided. A better alternative to the EVAC chairs was being sought and this matter was on the agenda of the Fire Safety Group. RA noted that the MCB did not have a representative on the Fire Safety Group and asked for nominations. RA also asked that Mel Perrow be invited to attend the next MCB H&S meeting.	**RA** **KP**

	There had been no inspections in Specialised Medicine but BD reported that the storage of patient notes in Dermatology had been added to the risk register and the department was working with Coding and Medical Records to identify a solution. This issue dated back to when dermatology specific records were created but it posed a significant risk to staff. A H&S inspection/risk assessment of A1 had been carried out with union representatives to review the condition of the environment, including uneven floor surfaces. The area in Rookwood used for weekly Parkinson's clinics had been closed with immediate effect due to unsafe flooring; accommodation for weekly clinics for 40 patients was being sought.	
1.6	<u>HSE Well at Work Audit</u> The HSE had pulled together a programme to audit UHBs between October and December. At a similar audit in Swansea in 2018, the HSE had issued 9 improvement notices, mainly regarding Manual Handling and Violence & Aggression. Notices issued to Hywel Dda also included asbestos management. It was anticipated that the audit of Cardiff and Vale would focus on Manual Handling and Violence & Aggression. Ahead of the audit, RD planned to visit the Emergency Unit to discuss training compliance and relationships with security and the police and concerns around furniture in the MH room. Areas with the highest number of incidents, the EU and Clinical Gerontology, would definitely be audited but other areas might also be visited so RD advised that the whole UHB should be prepared. BD anticipated SRC to be a hot spot. RD agreed to meet with DW. RA asked that a separate group be established to prepare for this audit. RD advised that compliance with policies and the quality of risk assessments would also be reviewed.	**RD/DW** **RA/KP**
1.7	<u>Staff wellbeing/violence and aggression</u> EF advised that the police and Crown Prosecution were working towards prosecuting individuals who had assaulted staff. The Obligatory Responses to Violence in Healthcare document was to be released in November this year outlining the responsibilities of the CPS, the police and the UHB. EF asked all present to remind staff that support was available to them. It was noted that assessments of a patients' capacity would know be made after they had been arrested and investigated whereas previously this would be assessed before arrest. The Assault on Emergency Workers Act had been released at the end of 2018 to cover all staff. Under this Act individuals would be sentenced to 12months, double the previous sentence of 6 months for ABH. EF asked that all staff are made aware of this act and advised she would be carrying out workshop days for staff to attend for brief updates. Posters to advise patients of these changes and to make staff aware of the act were available from EF. EF noted that violent warning markers could be added to patient records following an incident or on advice from the police so should be factored in to risk assessment but it was not always part of a process to check the workstation for this marker. SC queried if information was shared across Health Boards and was advised that case workers would flag this verbally. BD agreed, saying nursing staff would note this when handing over a patient. BD also noted there was a grey area with some patients with dementia but noted staff were still able to report incidents to police, emphasising that it was always the staff member's decision to report an incident. EF advised that if a member of staff in her department felt an incident that should have been reported wasn't, they would contact the Clinical Board for further discussion.	

	RA asked EF to arrange engagement sessions across all sites. ID noted that compliance with Violence and Aggression training was variable across all areas but some areas with high compliance also reported a high number of incidents. RD reminded all present that the level of training required for staff in each area should be assessed, documented, and training provided.	**EF**
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP & ACCOUNTABILITY		
2.1	Minutes of Previous Meeting The minutes of the last meeting were accepted as an accurate record.	
2.2	Matters Arising **MCB Health & Safety Lead** David Pitchforth had been nominated for this position. **Violence and Aggression training** ID had reviewed V&A training compliance figures and found it to be variable across all areas. ID had reminded all Ward Sisters/Charge Nurses of training requirements. **Specialised Medicine Lead Nurse actions** BD had picked up these actions as follows: - It had been suggested that as one door had been sealed during the rheumatology clinic corridor refurb there was only one escape route. BD had found there to be sufficient escape routes and was checking these alternatives - The capsule room was isolated from other clinical areas and there was no means by which to call for assistance; this room was due to be relocated but the refurb of the new location had been delayed **Workplace Inspection Update** The alarm in the MH room in EU had been repaired.	
2.3	Patient Story – Specialised Medicine EM recounted an incident from winter 2017/18, involving pressure damage, that had been referred to the Ombudsman. A lady with COPD had been admitted with heart valve disease; she also had cardio issues, AF and acid reflux. The cardiology team saw her whilst on T2 regarding her heart valve disease and assessed her as too high risk for surgery. The patient started to report abdominal pain and was given an X ray and a CT scan which indicated faecal loading. NEWS was taken but not scored but nursing staff were monitoring her as required. Over the weekend period the medical team did not review her as frequently as needed. The Ombudsman made a number of recommendations and upheld one complaint with the following comments: - The patient's pain was appropriately noted and appropriate investigations, treatment and pain relief were provided - The patient should have been reviewed by doctors before 4pm on 14th April and again after the X ray - There were gaps in the escalation from the nursing staff to medics due to workload over the weekend period - Failure of nursing staff to complete NEWS did not have any bearing on the time taken to review her - The patient's outcome would not have been different if she had been seen sooner	

	- Bowel surgery would not have been possible and only palliative care would have been offered - If the patient had been seen by doctors sooner, a diagnosis of ischaemic bowel disease could have been given earlier and better explanations given to the family for them to prepare themselves Redress of £1k was awarded to the family due to failings in patient records. The following actions/explanations were noted: - EM noted the teamwork and resilience of the staff on winter wards - An audit of NEWS scoring across the MCB was taking place - The patient's DNAR recording was not clear - Improvements in arrangements for medical staff had been made for winter 2018/19 - It was agreed that poor communication with the family regarding the patient's condition exacerbated existing difficulties with the family	
2.4	<u>Feedback from UHB QSE Committee</u> Noted. KP advised the MCB would be required to present to the UHB committee again in December and asked for suggestions of good work to be presented.	**ALL**
2.5	<u>Directorate QSE Minutes – Exception Reporting</u> Dermatology QSE notes from the meeting held on 10th April noted. The following meetings had taken place but the notes were not yet available: - Integrated Medicine 16th May - Specialised Medicine 14th June - Emergency Medicine w/c 10th June RA asked that the standard agenda format that had been circulated previously be used.	
HEALTH PROMOTION PROTECTION & IMPROVEMENT		
3.1	<u>Flu plan 2019</u> KP had commenced a programme of early myth busting and was looking for more flu champions for winter 2019/20. IT were assisting in producing flu related screensavers. JW noted the recent early outbreaks of a particularly virulent strain of flu in Australia. It was agreed that as Australia had experienced early cases of flu, the UHB should try to obtain and distribute vaccinations as early as possible.	
SAFE CARE		
4.1	<u>Changes to the Medicines Code of Practice</u> LW advised that the NMC had removed the Medical Standards document so as of 2019 staff could no longer refer to these guidelines and no comparable alternative replacement had been identified. The Policy in Medicine Code and the All Wales Policy for Medicines Administration was available but was overarching with little detail. The RPS had introduced the Professional Guidance on Safe and Secure Handling of Medicines, this had been an update on the Duthie report, but it also stated that it was not a replacement for the NMC Standards. An RPS administration document had been identified as a replacement for the NMC document but with 8 pages compared to the	

	NMC document at 100 pages this also did not have the same detail. A group had been established to produce new All Wales standards but it was expected that the completion of this document would take a year. BD queried the governance around meds errors and repeated errors and asked if this could be included in the new document. LW advised caution in this as it would be difficult to prove if an error was due to capability or deliberate. The following medication issues were also discussed: - RA asked if an All Wales Standard on one check for fluid administration was to be agreed; LW confirmed it would as a number of groups shared the same concerns on this matter - It had been noted from Pharmacy students' observations that allergies were being robustly recorded but not acted on. It was agreed that more robust checks were needed - RA queried whether Pharmacy Assistants were to complete drug rounds; LW advised that Betsi Cadwaladr UHB had stopped this practise but the C&VUHB Pharmacy was undergoing significant changes so this was also likely to change - It was agreed that policies around TTHs should be amended as it was current practise for pharmacy staff to make checks then for TTHs to be dismantled on the ward and checked again, creating opportunities for errors or losses - The All Wales Medicines Chart, to include the All Wales Microbial Chart, which had previously been piloted in Betsi Cadwaladr and Swansea UHBs was to be rolled out by 1st August. There were some significant changes, it was now a booklet rather than a fold out chart. The first few pages were dedicated to anti-microbial for acute, prophylactic and prolonged use. There was also one page dedicated to omitted and missed doses. E-learning on the use of this document was available and Pharmacy were due to remove stock of the old forms and replace with the new version. Patients on the existing chart would remain on this chart until it was complete	
4.2	New SIs WG closure forms for discussion and shared learning Integrated Medicine In90086 In65519 In87459 In90239 In80462 KP recounted the following incidents: In65519 A patient had been admitted to ward B7 after experiencing weight loss, a long term cough and collapsing at home with a background history of Sarcoidosis under Respiratory Medicine. The patient was given antibiotics following a diagnosis of possible pneumonia although swabs had indicated flu. This episode coincided with disruptions throughout the hospital caused by heavy snowfall. As a result, the patient saw four different respiratory consultants; one of whom noted a request for AFB but there was no documentation to indicate this was followed up. A positive Influenza result was reported so anti-biotics were discontinued and Tamiflu continued. The patient was of polish origin and spoke little English, and would repeatedly ask that he be discharged. In line with good practice the day the patient was due to be discharged, they scored on their NEWS so was kept in for a further 24 hours. The following day the patients NEWS was incorrectly calculated and	

when reviewed by the Medical Registrar on call was considered appropriate for discharge. The NEWS score was incorrectly calculated as 1 instead of 4 which would have prompted further medical review.
A week later the patient was admitted to ITU and died of multiple organ failure, sepsis and undiagnosed TB. The death was discussed with a Coroner and the cause of death noted as 1a TB. As this was a notifiable disease this was subject to a jury inquest for Her Majesties Coroner which lasted over 3 days.
The outcome of the inquest was that of a narrative conclusion however the jury found the following:

-
- Antibiotics should not have neem withdrawn
- The failure of nursing staff to correctly calculate the NEWS contributed to the patient's death
- A Regulation 28 would have been administered by the Coroner if the patient's discharge plan had not been amended
- Following evidence the death certificate was amended as mult-organ failure as a result of Klebsiella pneumonia on a background of Sarcoidosis. The incorrect calculation of NEWS did not cause the patient's death, but did contribute.

The considerable stress, distress and upset of this case going to the Coroner's Court was not to be underestimated for all staff and the patients family. This case is currently under Redress.

AJ advised widespread concerns around NEWS scoring and suggested UHB wide learning could be taken from this. It was agreed that further work to protect staff calculating NEWS was needed.
With regard to the patient's death certificate that recorded TB on parts 1 and 2, AJ noted that the most junior member of staff usually completed this and it was felt that it recorded in death what was missed in life. On this occasion, a consultant on ITU had completed the death certificate.

IN90086 – avoidable healthcare acquired pressure damage
A patient with pneumonia had been admitted following a fall and experienced deterioration of their skin. This was deemed unavoidable as preventative intervention was in place but was not in line with the individual needs or plan. The patient also spent a great deal of time in a chair with no adequate support.

IN91010 – avoidable healthcare acquired pressure damage
A patient was admitted after collapsing at home and not being found for an unknown length of time. Pressure damage was deemed to be avoidable as despite a care plan being in place, pressure areas were not inspected regularly enough, mattress provision was not up to date and intentional rounding did not increase with the patient's decreasing mobility.

IN80462 – Injurious injury

A patient was admitted to A6S following a stroke. On improvement, the patient was moved to A4 for rehab and experienced an injurious fall resulting in death. The patient had a history of injurious falls and the RCA noted that consideration should have been given for half-length bed rails and not full length. Following a move to another area the patient experienced pain in their knees so stopped mobilising, which resulted in the pain worsening. The patient then attempted to get out of bed and fell from the gap between the end of the bed and bed rail. It was noted that the patient had been moved late at night which may have exacerbated their situation. The move was also a possible contributory

	factor in the patient's decreased mobility. **In87459** Injurious injury Ward West 2 had been approached for information on a patient who had fallen on Heulwen ward. This patient hit their head and was given a CT scan following a fall that had been witnessed and reported on Datix by a physiotherapist.	
4.3	Patient Safety Alerts/MDA's/ISN Medicines Safety Briefing May 2019 Noted.	
EFFECTIVE CARE		
5.1	**Infection Prevention and Control up date** **HCA Compendium** Please see report provided. It was noted that the number of outbreaks across the UHB had fallen and fewer bed days had been lost as a result. **RCAs** There were 3 outstanding RCAs; 2 were within the required timeframe and one was related to A4, were the Ward Sister was on sick leave. DK agreed to forward the RCA request on to the Deputy Ward Sister. **C4C Scores** C4C scores on A block had improved and greater supervisor presence had been noted. RA expressed her congratulations to the CFU for achieving a C4C score of 98%.	
5.2	Point of Care Testing (POCT) Noted.	
	Assessment Unit HIW action plan update Defer to next meeting	
DIGNIFIED CARE		
6.1	Enhanced Care Supervision For noting, published in RCNI magazine.	
TIMELY CARE		
7.1	Delayed Transfer of Care (DTOC) Report Noted.	
7.2	Feedback from Ombudsman report KP reported the feedback on a complaint from a family regarding the care of their mother who had been admitted with ischaemic colitis and the potential failure in the DOLS process. The following points were noted: - The concern regarding a delay in treatment was not upheld - Concerns around the management of the patient's pain were partly upheld with regard to planning for pain assessment and management	

	- There had been an adequate Gastro review - Concerns around dignity and respect were not upheld RA queried whether the All Wales Pain Assessment Tool was being used as well as it could as pain management and assessment were recurring themes in concerns. It was felt that there was confusion and risk around this document and the hard copy and e-copies available. It was noted that in this case, the patient was initially seen on A1L and a paper document was used.	
INDIVIDUAL CARE		
8.1	National User Experience Framework Feedback – 2 Minutes of your Time Noted.	
8.2	Compliments and Trends Noted.	
8.3	Appendix S – Lessons Learnt KP reported on a lady who had undergone a hysterectomy in 2012 and discharged same day of surgery. The patient attended the Emergency Unit a week later complaining of constipation and abdominal pain which was thought to be constipation. Following a further attendance with abdominal pain the patient was diagnosed with Peritonitis. The learning identified from this case was that the Emergency Unit failed to consider complications following the hysterectomy and to refer the patient back to Gynaecology team . The patient was awarded £65k.	
STAFF & RESOURCES		
9.1	Concerns to note Noted	
ANY OTHER BUSINESS		
10.1	Brian Dolan visit RA noted the success of the PJ Paralysis lectures by Brian Dolan on 6th June, saying it had been well attended in person and via live streaming and was now available to download and it was suggested that pertinent sections could be shown at study days. RA advised that Cardiff and Vale were taking part in a global summit on the Last 1000 Days on 11th July to publicise this programme in action in various hospitals and asked for suggestions of success stories to include a 30 minute slot. Suggested ideas included a patient story, a poem written by staff on one ward, dance classes in SRC and work around model wards. RCN awards RA asked for nominations for the Nurse of the Year awards to be submitted, noting the closing date of later the same day. This was to be discussed at the Lead Nurse meeting due to be held later in the day. An incident regarding the a drug box containing used needles that had been to pharmacy was noted; all present were asked to ensure that used needles were returned to a clinical area and disposed of correctly, particularly in the disarray following a resuscitation. Zoll Defibrillators There were some concerns regarding the roll out of new defibrillators while only 80% of staff were trained in their use. This roll out was essential as the batteries in existing defibrillators had run out. EM confirmed that training was progressing well in UHL and suggested a video may be available to provide more training.	

	Changes to Continence Products BD advised of changes to the provision of continence products with patients to be assessed from 1st July as to whether they required wraparound pads. BD was concerned that supplies would not be available quickly enough if patients were found to be in need of these pads and queried the possibility of keeping a small stock for emergencies. It was noted that St David's would be holding a stock that would be locked away but the biggest concern for availability was in UHW. BD noted that a training presentation included a slide that recommends urinalysis and asked that this slide be amended as it was not recommend for patient aged over 65.	
DATE & TIME OF NEXT MEETING		
	18th July 2019 09:00	

MEDICINE CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE MEETING
MINUTES

Thursday 18th July 2019
9am – 11.30am
Classroom 2, UGF A Block, Main Hospital, UHW

Attendees:
Jane Murphy (Chair), MCB Deputy Director of Nursing
Rebecca Aylward, MCB Director of Nursing
Diane Walker, Integrated Medicine Lead Nurse
Wayne Parsons, Emergency & Acute Medicine Lead Nurse
Sam Barrett, Emergency & Acute Medicine Service Manager
Derek King, MCB IP&C Nurse
Suzie Cheesman, Patient Safety Facilitator
Sian Brookes, Integrated Medicine Senior Nurse
Ben Durham, Integrated Medicine Senior Nurse
Emma Mitchell, Integrated Medicine Senior Nurse
Gillian Spinola, Specialised Medicine Senior Nurse
Ian Dovaston, MCB Professional Practice Development Nurse
Gemma Murray, MCB Professional Practice Development Nurse
Sarah Cornes-Payne, Diabetes Senior Nurse

Apologies:

Kath Prosser, MCB Quality & Governance Lead
Aled Roberts, MCB Clinical Board Director
Geraldine Johnston, MCB Director of Operations
Nicky Croxon, Specialised Medicine General Manager
Sarah Follows, Emergency & Acute Medicine General Manager
Barbara Davies, Specialised Medicine Lead Nurse
David Pitchforth, Integrated Medicine Senior Nurse
Fran Wilcox, Integrated Medicine Senior Nurse
Ceri Richards-Taylor, Integrated Medicine Senior Nurse
Hannah Mastafa Clinical Gerontology Service Manager

In attendance:
Roisin Kirby

PRELIMINARIES		**Actions**
A1/ A2	Welcome, Introductions and Apologies for Absence JM welcomed the group to the meeting and advised them of apologies given. JM advised that RA would be in attendance for the latter half of the meeting due to an unavoidable diary clash.	
PART 1: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP & ACCOUNTABILITY		
1.1	To Receive the Minutes of the Previous Meeting DW noted several inaccuracies to be amended. These noted errors will be corrected accordingly.	**CMc/RK**

1.2	Matters Arising None to note.	
1.3	Patient Story GS presented a Specialised Medicine directorate patient story to the group, concerning a female Gastroenterology patient, attending IBD Infusion Room in UHL. Patient advised the nursing team on arrival that she had been poorly over the last few weeks, and suffering from a Crohn's flare up. After being reviewed by IBD CNS, and noting that the patient was having bloody diarrhoea approximately 15 times per day, the decision was made to admit her for further assessment. The lady was assessed by the Gastro SpR based on Ward West 1 who agreed that she was safe to be transferred to UHW, preferably Ward A7 as this is where her IBD consultant is based and the best ward to be able to provide specialist management of her TPN. The Medical SpR in UHW accepted her care and advised for her to be brought to MAU. The Senior Nurse for Specialised Medicine was made aware of the transfer and identified that one of the A7 pilot ring-fenced beds was available for the lady be directly after admission to UHW, so this therefore ensured: ➢ Correct Hospital ➢ Correct Area ➢ Correct Time (for her particular medical needs). JM thanked GS for the story, noting that this was a great example of timely, effective, better care. GS was in agreement that the current A7 pilot ring fenced beds has been very successful so far, and ensures that gastro, liver and ID patients are being treated in the right place at the right time. Group in agreement that this is an excellent example of patient care and it would be a backwards step to discontinue these ring fenced beds in particular.	
1.4	Feedback from UHB QSE Committee For noting. DW advised that the current link takes you to minutes from 2018. JM will feed this back to KP to ensure the correct link is embedded into the agenda going forward.	**JM/KP**
1.5	Directorate QSE – Exception Reporting JM queried the prescribing course mentioned by Julia Evans in the Internal Medicine Q&S meeting 16.05.19 UHL. JM also noted that she was pleased to see that audits are being undertaken within the Integrated Medicine directorate. DW confirmed that the audits were occurring on both UHL and UHW sites	
1.6	Papers for Noting None to note.	
HEALTH PROMOTION PROTECTION & IMPROVEMENT		
2.1	UHL Code Stroke Pathway Sign Off Deferred due to HM's apologies. KP to invite HM to present at the next meeting.	**KP**
2.2	Annual Quality Statement 18/19 JM encouraged the group to read through the booklet, advising that electronic copies are also available. A link to statement will be circulated to the group outside of this meeting.	**RK/KP**
2.3	End PJ Paralysis Video The group were played a video that the C&V Comms team had created, detailing the implementation of the End PJ Paralysis initiative. The group were in agreement that the scheme was beneficial and had been well received throughout the UHB.	
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	Patient Safety Alerts For noting, all circulated prior to the meeting. EM / DW noted that from a governance perspective it would be prudent for the MCB to review who was responsible for circulating these notices, as sometimes they are sent by KP, and sometimes by RK. RK confirmed that she circulates the PSAs at AR's request, but does not liaise with KP when she does. RK and KP will discuss this outside of the meeting and ensure that duplicates are not circulated to the directorates going forward.	**RK/KP**

	DW queried how the Medicines Safety briefing was being circulated throughout directorates. JM advised that circulation of these briefings will be reviewed with KP outside of this meeting.	**KP**
3.2	<u>New SIs</u> In92504: Avoidable healthcare acquired pressure damage: Category 1 evolved to category 3 pressure damage to the sacrum. Reported as avoidable secondary to gaps within the Intentional Rounding Tool which could not clearly evidence that the patient was repositioned as per care plan. Discussion ensued with regards to the impact of poor documentation within the Intentional Rounding Tool, and having to comply with reporting to WG as avoidable. SC noted discrepancies between CBs, noting one in particular has not had any avoidable damages, though they have had several incidents of unavoidable damages. Group in agreement that the scoring questions are open to interpretation and too broad. JM advised these are All Wales approved. In93612: Injurious Injury, fracture to the right hip: The patient was known to be a high risk of falls, and whilst an inpatient they slipped from the bed and lacerated their head. An x-ray was performed the next day and no fractures were identified. 10 days later a CT scan was requested as the patient was complaining of pain, and a fracture to the neck of femur was identified. It transpired that this damage was due to a historic fall at home, with the latest fall exacerbating the injury. The investigation highlighted that the Hover jack was not used in line with NICE 2015 and UHB post falls procedures to safely manoeuvre the patient from the floor back onto the bed. In94582: Injurious Injury, fracture to the right neck of femur. Investigation highlighted that the cause of the fall was secondary to ill-fitting slippers, so lessons learnt by staff in question were to ensure that all patient's footwear is safe. SC to confirm if a typing error could be amended on the WG closure summary. In94679: Avoidable healthcare acquired category 3 pressure damage. The patient was admitted to UHL with a pre-existing category 2 ulcer to the sacrum, which evolved into a category 3 secondary to a deterioration in the patient's condition whilst an inpatient. The pressure damage was reported as avoidable as there were gaps noted within the Intentional Rounding Tool which could not accurately reflect that care was provided as per recommendations. SC advised the group of a recent IRMER incident, in which the wrong patient was taken from AU/EU for the scan, and the radiographer did not undertake a patient ID check prior to the scan. An investigation in underway, and the incident has not yet reported to HIW. JM to liaise with WP regarding this incident outside of the meeting.	**SC** **JM/WP**
3.3	<u>IP&C Update</u> DK advised that this has been a satisfactory month for the MCB. The report will be circulated in conjunction with these minutes. JM asked the Senior Nurses to review how audits are being undertaken in their areas and to feedback at the next meeting in September. Discussion ensued with regards to lower than expected C4C scores, with DW advising that she only receives scores, rather than a breakdown of the scores, which would be beneficial. The Senior Nurses agreed to liaise with Housekeeping supervisors to discuss this issue further. DK advised he was pleased to report that there is only 1 current outstanding RCA, and that he is pleased with the turnaround time at present, with all being dealt with and closed in a timely manner. DK noted that there are some condemned chairs on B7 that are yet to be disposed of. BD advised that he would chase this, and GM is happy to conduct audit if necessary.	**Senior Nurses** **Senior Nurses** **BD**

	DK advised that Australian flu has occurred early and peaked at a fairly low level, with less than a third of the States affected in Australia and severity not as much of a concern compared to previous years. FFP3 Train the Trainer training will be conducted this year. DK will send these dates to ID and GM so that they can circulate widely and maximise attendance. VIPs Audit Update: GM advised the group that the audit was conducted on 12.07.19. It has been established that when nurses cannulate, the VIPs are being done on the day, but when medical staff have cannulated, the patient is not being VIP scored. Increased education and training for medical staff in particular is essential. JM asked GM to present these findings at directorate level Q&S meeting, and advised it would be prudent to also present this to the CDs as well. RK to send GM the next CD Forums date and advise AR for this item to be added to next agenda.	**RK/GM**
3.4	<u>Point of Care Testing Concerns</u> Concerns were raised when Duthie ward was utilised during winter as the blood glucose monitoring machines could not be used. Difficult to train bank and agency staff as 2 days after the training an assessment must occur for sign off. Any further issues will be escalated to Lead Nurses / RA / JM as necessary.	
3.5	<u>Patient Safety Day 17th September</u> JM asked the group for idea as to what topic of focus the MCB should have this year. Discussion ensued with ideas such as VIPs, Read About Me and DOLS. Food for thought. Lead and Senior nurses to discuss further within their directorates and then discuss at Lead Nurse meeting in 3 weeks' time. RK to ensure that this event in RA, JM and KP's diaries.	**RK**
DIGNIFIED CARE		
4.1	<u>HIW Action Plan: Assessment Unit</u> WP provided the group with an update of the HIW AU Plan, advising good progress has been made with regards to implementation of the HIW action plan, with focus now on the movement of the Surgery patients to appropriate areas within the SCB. All MCB actions are now completed or in the process of completion. A fortnightly DMT T&F group has been formed in a minuted environment to review progress and continue robust scrutiny. GJ, Len Richards (Chief Executive) and Steve Curry (COO) met with the AU team on Thursday 04.07.19 and feedback from the meeting has been positive, as the Execs acknowledged that they were aware of the ongoing issues and had not acted quickly enough. This message was also featured in last Friday's 05.07.19 Len Connects circular, which was positively received by staff. LR and Ruth Walker (Executive Nurse Director) attended the EU/AU DMT senior and consultant nurse away day as well to further engagement with the staff. A joint MCB and SCB HIW meeting was held on 09.07.19, in which the teams discussed the three key components that the SCB need to action: Retrieve ambulatory trauma patients: the SCB are looking to utilise an area on Duthie ward for 4 to 6 beds. This is expected to be completed by the end of August, Retrieve ENT patients: this is a medium/long term plan with no current estimated completion date, and SSSU opening to 7 days. From Friday and throughout the weekend the unit will be 24 hours, and will be open until 7pm Mon – Thurs. This change is expected to be implemented by Christmas 2019. WP noted that an increased number of complaints and concerns have been and continue to be submitted following the negative media coverage, which is an added pressure on staff. WP advised this was his most challenging experience as a Lead Nurse so far, but that he is reassured with the organisations long term plan and strongly believes that the unit will be in a much better position when all recommendation are completed. It was terrible at the time, but a good professional experience. EM agreed, reflecting on her HIW inspection of East 4, following which the 'An Inspector Calls' workshops were established. DW queried whether, on the back of damning reports such as this, from a	

	staff H&S perspective, if the UHB Employee Wellbeing Service could be contacted and advised that there will be significant cohort of staff who will be needing extra support. JM and RA to discuss this outside of the meeting.	**JM/RA**
4.2	<u>UHW Patient and Relative Walkthrough 30.04.19</u> JM advised that a team of MCB colleagues put themselves in the perspective of a recently bereaved patient and their family. Will be recirculated in conjunction with these minutes.	
TIMELY CARE		
5.1	<u>Emergency Medicine Performance Report</u> Deferred until next meeting.	
5.2	<u>Waiting List Assurance Update</u> Deferred until next meeting due to NC's apologies.	
INDIVIDUAL CARE		
6.1	<u>National User Experience Framework Feedback – 2 Minutes of your Time</u> For noting. SC-P advised they would like to adopt this initiative in the Diabetes clinic. RK will feed this back to KP to roll this out.	**RK**
6.2	<u>DTOC Report</u> ▪ Total number in June 2019 is 46, compared to 49 in May 2019 ▪ Total aged 25 plus, decreased to 12% ▪ 10% lower than same period last year	
6.3	<u>Compliments</u> Noted.	
6.4	<u>Ombudsman Report 201801440</u> This report was circulated as a shared learning opportunity. Patient was admitted on 29.01.19 and passed away 19.02.19. At the mortality review, there was a query of ischemic colitis, to which the family raised concerns. The family felt there: ▪ Were delays in the diagnosis and treatment of the colitis, this was not upheld. ▪ Was inadequate monitoring and pain relief, this was partially upheld – able to identify this patient received analgesics, but the monitoring was the key concern. ▪ Was failure of nursing staff to escalate, this was not upheld. ▪ Was failure to administer medication effectively, this was not upheld. ▪ Were DOLS concerns, and that staff did not act in the patient's best interest, this was not upheld. ▪ Was a lack of dignity and respect, this was not upheld. The Ombudsman's recommendation was that the UHB takes action to reiterate to staff the importance of accurate assessments. RA queried whether the All Wales Pain Assessment tool was used. It was established that this document was used. Group were advised that from now on it is all MCB staff's responsibility to ensure the tool is being used correctly, as part of the new eDocumentation initiative.	
STAFF & RESOURCES		
7.1	<u>Overseas Recruitment Campaign</u> JM advised that the tender process is now complete, and that the group were meeting later today so a further update would be provide at the next meeting and to the Lead Nurse, via email, as appropriate.	
ANY OTHER BUSINESS		

8.1	Staff Recognition Awards RA/JM reminded the group of the upcoming MCB Staff Recognition Awards, which are being held 2pm – 4pm in Lecture Theatre 3, UHW, on Weds 04.09.19. Nominations forms will be circulated throughout the MCB widely, with nominations to be returned to RK by 05.08.19. RA asked the group to encourage nominations and attendance. Gloves are off Campaign RA described the recent Gloves are off Campaign which saved GOSH £80k upon implementation. RA asked the group to please provide feedback to herself or JM outside of this meeting so further discussion can occur. Incontinence Slip Pads GS advised that her staff have been having trouble ordering incontinence slip pads. As a consequence, UHL are still using wrap around pads. RA/JM noted this and asked BD to update / escalate accordingly outside of this meeting.	
DATE & TIME OF NEXT MEETING		
	Thursday 19th September 2019, 9am – 11.30am, Room 1.13, 1st Floor, Ty Dewi Sant, UHW	

MEDICINE CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE MEETING
MINUTES

Thursday 19th September 2019
9am – 11.30am
Room 1.13, 1st Floor, Ty Dewi Sant, UHW

Attendees:
Rebecca Aylward, MCB Director of Nursing (Chair)
Jane Murphy, MCB Deputy Director of Nursing
Kath Prosser, MCB Quality & Governance Lead
Diane Walker, Integrated Medicine Lead Nurse
Derek King, MCB IP&C Nurse
Suzie Cheesman, Patient Safety Facilitator
Lisa Waters, Emergency & Acute Medicine Senior Nurse
Jacqui Westmoreland, Emergency & Acute Medicine Senior Nurse
Ben Durham, Integrated Medicine Senior Nurse
Emma Mitchell, Integrated Medicine Senior Nurse
Barbara Davies, Specialised Medicine Lead Nurse
Gillian Spinola, Specialised Medicine Senior Nurse
Ian Dovaston, MCB Professional Practice Development Nurse
Ruth Cann, MCB Operations

Apologies:
Aled Roberts, MCB Clinical Board Director
Geraldine Johnston, MCB Director of Operations
Nicky Croxon, Specialised Medicine General Manager
Sarah Follows, Emergency & Acute Medicine General Manager
Wayne Parsons, Emergency & Acute Medicine Lead Nurse
Sam Barrett, Emergency & Acute Medicine Service Manager
David Pitchforth, Integrated Medicine Senior Nurse
Sian Brookes, Integrated Medicine Senior Nurse
Fran Wilcox, Integrated Medicine Senior Nurse
Ceri Richards-Taylor, Integrated Medicine Senior Nurse
Gemma Murray, MCB Professional Practice Development Nurse
Hannah Mastafa, Clinical Gerontology Service Manager

In attendance:
Roisin Kirby, MCB Administrator (Minuting)

PRELIMINARIES		**Actions**
A1/ A2	Welcome, Introductions and Apologies for Absence RA welcomed the group to the meeting and advised them of apologies given.	
PART 1: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP & ACCOUNTABILITY		
1.1	To Receive the Minutes of the Previous Meeting DW noted that under 3.4 (POCT Testing), no outcome to issue raised had been identified. Discussion ensued regarding staff letting colleagues use their ID for POCT, and that staff do not understand the legal ramifications of doing this. RA/KP to invite Aron	**RA/KP**

	White, Professional Regulations Senior Nurse, to the next QSE meeting to advise on adhering to correct POCT procedure.	
1.2	Matters Arising RA asked DK if there was any appetite to adopt the Gloves Are Off initiative. DK advised no-one is as of yet. RA keen to trial this on one ward on each site and would like a nomination by a week Friday, can link this in with 'Five Moments' and encourage this to be led by the HCSWs and Band 5s. LW noted it would be beneficial to adopt this on a ward where hand hygiene scores are overall good, EM advised it may be prudent to conduct on a ward where hand hygiene scores are not satisfactory, in an attempt to improve scores. This also links with The Future Generations Act (plastics ruining the environment) and finance. T&F group to be devised, with reps from each directorate to ensure aligned working.	
1.3	Patient Story LW shared a positive patient story from Emergency Medicine of a female patient expressing their thanks for the care provided in a busy Emergency Department for Anaphylaxis. This story has demonstrated that, on top of the great demand within the service, the staff are ensuring that timely, efficient patient care is still being delivered and maintained. It was a life-threatening experience, but there was a positive conclusion for the patient, who sent a heart-warming thank you card to all of the team after her experience. LW confirmed that all concerns and compliments are scanned and forwarded to the Concerns team to be recorded accordingly.	
1.4	Feedback from UHB QSE Committee The last available minutes from UHB QSE committee were discussed with the following relevant items shared; - Concerns were raised regarding medical cover for Mental Health, and WAST attendance if a 999 call is made for urgent transfer. - CHC Report – 'One Simple Thing' – focusing on the key issues of communication for most feedback reports. - The UHB had been unable to confirm compliance with the following Safety Solutions: ▪ PSA008 – Nasogastric tube misplacement: continuing risk of death and severe harm. ▪ PSN030 – The safe storage of medicines: This Notice is subject to further consideration by Welsh Government. ▪ PSN040 – Confirming removal or flushing of lines and cannulas after procedures. ▪ PSN043 – Supporting the introduction of the Tracheostomy Guidelines for Wales.	
1.5	Directorate QSE – Exception Reporting **Emergency/Acute Medicine QSE** - Redesign of Paeds casualty card has been completed, now has POBS (similar to NEWS but Paeds specific) procedural guidance and is aligned with WAST's card. **Integrated Medicine QSE (UHW & UHL)** - Nothing specific to note. KP noted that some of the UHW minutes' content were potentially inaccurate, and need to be reviewed and amended. DW apologised for the UHW IM minutes, advising that these will be amended before further dissemination. **Specialised Medicine QSE** - Latest Gastro QSE sessions have been run by Amplify. - Discussion ensued with regards to the recent Dermatology walkabout with Executive Nurse Director, Ruth Walker, which included visiting one clinic in W&C and one in Glamorgan house. It is a cause for concern that some Paeds dermatology patients are still being treated in Glamorgan house, which is an adult environment. BD advised that the CHfW do not have the facilities and equipment to accommodate phototherapy, so going forward the Paeds phototherapy clinics will be isolated so only children are seen at that time. - Nurse led consent in diagnostic Endoscopy commencing this week, backup provided by medical staff as necessary.	

1.6	Papers for Noting **Chaperone Policy** For noting. This policy has Colonoscopy, WGS and medical photography implications. This will need to be discussed further at ward sister forums. **Adult Practice Reviews Safeguarding** For noting. **Seven Minute Briefing Safeguarding** For noting.	
HEALTH PROMOTION PROTECTION & IMPROVEMENT		
2.1	UHL Code Stroke Pathway Sign Off Deferred due to HM's apologies. KP to invite HM to present at the next meeting.	**KP**
2.2	Flu Update - KP presented the new Flu Myth-busting poster that should be displayed widely throughout the directorates and ward areas. - Vaccines should be delivered by Tuesday 24.09.19, which will be the quadruple vaccine. - Flu A is the main concern within Southern Hemisphere. - The MCB has 51 flu champions this year, including Dr Aled Roberts and Jane Murphy. - Some changes have been made to monitoring procedure – on the returns form, champions will be asked to monitor their stock, and any loaning or wastage of vaccines. - No large corporate money for extra incentive, each CB will be awarded £3k to spend as they see fit in order to promote staff vaccinations and improve uptake in order to achieve UHB and WG target. In addition each member of staff will be provided with a pin badge and an item of food donated to a food bank. - MCB have decided to implement our local incentive in which the first 500 staff to have their vaccine will receive a voucher for to the value of £2.60 to be spent in Aroma coffee shop. - Target is 65% UHB uptake, with Public Health and WG target is 60%. KP is hopeful that the MCB will achieve 60% this year.	
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	Patient Safety Alerts For noting, all circulated prior to the meeting. KP noted Listeriosis briefing will have implications on the wards during mealtimes (i.e. not to leave sandwiches out at patients bedsides, they must be refrigerated appropriately). It was also noted that Pertussis may have implications on staff working in Paeds EU. LW noted this and advised these alerts would be shared with staff appropriately.	**LW**
3.2	New SIs **Emergency Medicine** In63622 – An 18 year old boy was unwell at home with mum, suffering with nausea, vomiting and diarrhoea and advised by an OOH GP to attend the Emergency Department in February 2018. The patient was triaged and cared for in the Ambulatory Care Unit in the Emergency Unit. At this time the UHB was under extreme pressure reporting Escalation Level 4 across all Clinical Boards/bed holders. The patient was correctly triaged as a Category 2 patient noting a potential Sepsis, however, secondary to the pressures in the department at the time there was no space in the majors area to transfer them. Whilst in the ACU medical staff had difficulty cannulating the patient to obtain bloods, and the patient continued to deteriorate. Once identified the patient was transferred to Resus and a Critical Care opinion requested. The patient was transferred to Critical Care but sadly, despite invasive treatment died in their care. The cause of death was confirmed as Influenza B. It was widely shared that the completion of the investigation and learning identified was challenging. Learning identified that continued engagement and work continues to improve patient flow through the organisation and the	

importance of collaborative working. The recognition and timely treatment of Sepsis; significant work has been conducted in the Emergency Department including a Sepsis Flag on the Clinical Workstation advising of a potential Sepsis patient, regular EU 'huddles' highlight sick and potential Sepsis patients in the department to ensure that they are in the correct environment or actions being undertaken to ensure the patient is moved to a majors/assessment space. The investigation also noted that there was a potential delay in Critical Care review as the treating EU clinician at the time contacted anaesthetics rather than Critical Care for support. This has been discussed and shared at local induction and Consultant meetings. RA and Acute & Emergency Medicine Clinical Director Dr Katja Empson met with the patients parents to share the outcome of the investigation. RA advised that the main lesson she had learnt from this incident is to ensure that families and carers are kept up to date regularly regarding the investigation and early outcomes as the patients family were blaming themselves for not reacting sooner, when it was felt that sadly the outcome would have been the same.
LW advised that adding a caveat to the policy advising that staff should maintain monthly contact with the family would be beneficial.

Integrated Medicine
In98049 – Injurious injury following an unwitnessed fall. The investigation found that x-rays confirmed a sclerotic line fracture to the right femoral head. This is believed to have been a pathological fracture and not as a result of an injurious injury. UHB and NICE 2015 post falls procedures undertaken in line with best practice.

In98403 – Injurious injury following a witnessed fall resulting in a fracture to the left neck of femur. The investigation found that this was a witnessed fall for a patient with a background history of falls, The patient was a new admission to the clinical area and nursing staff had not been able to establish the patients urge incontinence which prompted them to try and stand from the bottom of the bed and bed rails to pass urine. All risk assessments completed in line with best practice. The investigation found that there was a delay in the post falls documentation being updated as this was over the handover period. Immediate post falls procedures were undertaken in line with UHB and NICE 2015 best practice.

In98790 – Avoidable healthcare acquired category 3 pressure damage. Established that the patient developed avoidable category 3 pressure damage from a pre-existing category 2 area to the left heel which was present on admission to the UHB. This was agreed as avoidable secondary to preventative interventions not being consistent with the patients needs and the effectiveness of preventative interventions not reliably monitored.

In98579 – Avoidable healthcare acquired category 3 pressure damage. Established that the patient developed avoidable category 3 pressure damage to the sacrum which evolved from a category 1 healthcare acquired area. This was agreed as avoidable as it could not be identified when a pump was added to the Promat mattress when changes in the patients skin integrity was noted. In addition, a Repose cushion was not used until two days after admission to the ward area despite a high Waterlow Score. There were also gaps within the Intentional Rounding tool, therefore unable to determine if preventative interventions were undertaken.

Common themes continue in relation to the avoidable healthcare acquired pressure damage being reported. Gaps within Intentional Rounding, and lack of individualized patient pressure relief/treatment care plan. The Medicine Clinical Board Pressure Damage Care Plan booklet is well embedded and being constantly re-enforced across all areas. An evaluation of the booklet is currently being conducted by the Practice Development Nurse. All areas have been advised to discuss patients at risk of pressure damage/ or with pre-existing pressure damage at Safety Briefings as a means of ensuring all actions have been undertaken.

	In98451 – Injurious injury following an unwitnessed fall resulting in a fracture to the left Acutabular and profusion of the femoral head which was treated conservatively. This was reported to WG before a decision was made not for surgical intervention. The injurious Assessment noted that all pre and post falls procedures where conducted in line with best practice, with all preventative falls measures in place and reassessed.	
3.3	<u>IP&C Update</u> - 74 days since last MRSA incident. - C4C scores are a cause for concern, C6 and C7 are the only wards doing well. EU/AU is variable, some good areas with some requiring further actions and improvements. DK to forward the C4C scores to senior nurses so that they can investigate further. **MCB Newsletter** Outbreak data for Seasonal Infections – for noting. Australian flu has decreased, not as severe as previously anticipated. Ebola risk is also minimal to the UK. New guidelines for PPI and Ebola are currently being drafted, DK will circulate when they become unavailable. DK noted that EU/AU were well prepared for any potential patient presenting with a suspected Ebola. DW queried whether the 'seasonal infections' can be split to specific types. DK agreed to do this. **UHL Cover** BD noted that the IP&C workforce is currently limited on the UHL site. DK confirmed that the team currently had significant vacancy gaps which are out to advert. As much support is currently being provided by limited on site cover or via a bleep for UHW. **WAST ANTT Procedure** For noting.	**DK** **DK**
3.4	<u>Point of Care Testing Concerns</u> Discussed earlier in the meeting (Matters Arising).	
DIGNIFIED CARE		
4.1	<u>HIW Action Plan: Assessment Unit</u> The group were advised that the AU action plan is being worked through and nearing completion. Recliner chairs have now been purchased, the patient identifiable data issue has now been rectified, and the unit's nutritional and hydration plan has been reviewed and improved. The only outstanding actions on the plan are now the responsibility of the Surgery Clinical Board, including introduction of the new TACU and increasing SAU staffing and opening hours. Meeting every two weeks to ensure that no traction is lost. JW to forward the up to date action plan to KP for reference.	**JW**
TIMELY CARE		
5.1	<u>Management of Endoscopy Surveillance Update</u> Report circulated with the agenda, for reference. BD advised the group that the Gastroenterology team inherited a patient surveillance backlog from several years ago, without having the capacity to review the patients accordingly. As of January 2018 there were over 1000 patients that had not had appropriate surveillance, and as a result, serious incidents were identified. This meant that the UHB had to review weekend insourcing opportunities to alleviate the pressures. With the introduction of insourcing, as at August 2019, the list now has only 101 patients waiting, but recent changes to bowel screening processes, i.e. changing from FOB to 'FIT' testing will have massive implications on our resources. Overall reduction of 91%, and of the 101 patients that are currently on the list, 77% have appointments dates, with plans in place to contact the other 23% imminently. BD advised that she is hopeful that the department will be able to cope with the demand with a once a month insourcing tender. The DMT and SMT have further meetings scheduled to review bids and discuss viable options going forward.	

5.2	NIV Pathway Adopted on the back of reconfiguration of B7 and a High Care NIV Unit to support the flow of Respiratory patients through the Emergency and Acute footprint. JW confirmed that they are seeing a positive impact. Phase two of the business case is to ring fence additional beds. KP advised that she was happy to support with any data needed to bolster the business case.	
INDIVIDUAL CARE		
6.1	National User Experience Framework Feedback – 2 Minutes of your Time Not received at time of meeting. Will be circulated once sent.	
6.2	DTOC Report The report does not specifically relate to Medicine Clinical Board. Overall for August; The total number of DTOC's for August was 38 compared to the 29 reported in July; a decrease in month of 16%. The number is 7% lower than the same time period last year. The total number of DTOC's aged 75+ for August is 26 compared to 29 for July; a decrease of 10%. The number of bed days lost for August is 1,138 compared to 1,177 for July; a decrease in month of 3%. For Medicine this is a decrease of 4 from last month.	
6.3	Compliments **Emergency Medicine** *'I just wanted to say a huge thank you to staff in Children's A&E today. My six year old son came in with an injured shoulder having fallen. He was seen quickly by nurses, sent to x-ray and a fractured clavice was quickly diagnosed. Everyone was so friendly, patient and helpful. We are very grateful.'* **Integrated Medicine** *'We would like to express heartfelt gratitude to all the staff who took such excellent care of our mother, and who showed such care and understanding of her family. You do a fantastic job and everything you did for Mum is very much appreciated. With fondness and heartfelt thanks (which will always be remembered).'* **Specialised Medicine (NETS)** *'I would like to pass on to you all that you are the kindest people I have come across and I'm forever grateful for all of your help and support.'*	
STAFF & RESOURCES		
7.1	Staffing – Winter Ward JM advised that this year's winter beds will be on Heulwen and Ward A4 North, with the MCB being tasked with staffing 50 extra beds in total. JM also advised that the 4 beds currently open on Lansdowne ward will remain open. The main challenge will be to appropriately and safely staff these beds. Five staff will be provided from SpS, but at present Surgery are unable to provide any nurses due to their own pressures. Working corporately active recruitment continues.	
7.2	MCB Staff Recognition Awards JM thanked the group for their involvement and nominations and reflected on what she deemed to be a positive, successful event. External Awards - GS noted that Andrew Brown, A7 Ward Manager, has been nominated for the Mentor award at the RCN Staff Recognition Awards. - DW noted that Sam Davies Ward had become the first service organisation to be awarded the Carer Friendly Silver award, and commended Ward Manager Linda Edwards for her exemplary hard work and commitment.	
ANY OTHER BUSINESS		

8.1	RTT Position KP noted that Caroline Bird has requested that the Board's RTT Position become a quarterly standard agenda item at CB QSE meetings going forward. JM noted this and will advise the new GMs, once appointed (mid to late November), of this. Pressure Damage KP advised that if healthcare acquired pressure damage is reported as avoidable and that staffing may have contributed to not being able to deliver safe and appropriate care for the patient, it is likely that staff will be invited to discuss the Pressure Damage Tool with the Executive Nurse Director as a means of sharing concerns and learning outcomes. Patient Safety Team – Quality Clinics Further information will be circulated by KP to the group accordingly once available. Patient Handover SBAR Feedback JM advised that, off the back of a recent SI, Ruth Cann, Operations Senior Nurse, has been asked to complete an SBAR for handover of patients. The SBAR will soon be circulated widely throughout the MCB for comments, please could the group return any feedback ASAP.	**JM** **All**
DATE & TIME OF NEXT MEETING		
	Wednesday 23rd October 2019, 11.30am – 2pm, Room 1.4, 1st Floor, Ty Dewi Sant, UHW	

MEDICINE CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE MEETING

MINUTES

Wednesday 23rd November 2019
11.30am – 2pm
Room 1.4, 1st Floor, Ty Dewi Sant, UHW

Attendees:
Rebecca Aylward, MCB Director of Nursing (Chair)
Jane Murphy, MCB Deputy Director of Nursing
Aled Roberts, MCB Clinical Board Director
Kath Prosser, MCB Quality & Governance Lead
Diane Walker, Integrated Medicine Lead Nurse
Jacqui Westmoreland, Emergency & Acute Medicine Senior Nurse
Sian Brookes, Integrated Medicine Senior Nurse
Ben Durham, Integrated Medicine Senior Nurse
David Pitchforth, Integrated Medicine Senior Nurse
Gillian Spinola, Specialised Medicine Senior Nurse
Sarah Cornes-Payne, Diabetes Senior Nurse
Ian Dovaston, MCB Professional Practice Development Nurse
Seetal Sall, Point of Care Manager
Linda Hughes-Jones, Head of Safeguarding
Aron White, Regulations and Standards Senior Nurse
Jane Morris, Medical Rapid Response Nurse

Apologies:
Geraldine Johnston, MCB Director of Operations
Nicky Croxon, Specialised Medicine General Manager
Sarah Follows, Emergency & Acute Medicine General Manager
Wayne Parsons, Emergency & Acute Medicine Lead Nurse
Sam Barrett, Emergency & Acute Medicine Service Manager
Barbara Davies, Specialised Medicine Lead Nurse
Jeff Turner, Consultant Gastroenterologist
Sharon Jones, Consultant Rheumatologist
Maitrayee Choudhury, Consultant Diabetologist / Integrated Medicine Quality Lead
Emma Mitchell, Integrated Medicine Senior Nurse
Fran Wilcox, Integrated Medicine Senior Nurse
Ceri Richards-Taylor, Integrated Medicine Senior Nurse
Suzie Cheesman, Patient Safety Facilitator
Gemma Murray, MCB Professional Practice Development Nurse
Derek King, MCB IP&C Nurse

In attendance:
Roisin Kirby, MCB Administrator (Minuting)

PRELIMINARIES		**Actions**
A1/ A2	Welcome, Introductions and Apologies for Absence RA welcomed the group to the meeting and KP advised of apologies given.	

PART 1: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP & ACCOUNTABILITY		
1.1	<u>To Receive the Minutes of the Previous Meeting</u> The minutes were agreed to be an accurate record.	
1.2	<u>Matters Arising</u> None to note.	
1.3	<u>Patient Story – Specialised Medicine</u> GS shared a story relating to the MHRA notification for the restriction on the production of parental feeds by provided by CALEA. It was identified that concerns were raised regarding how the company were administrating nutrients to individual bags of feeds and the potential risk of cross contamination. This resulted in a supply issue across the whole of the UK. As Cardiff & Vale are a tertiary referral centre for patients on parental nutritional a task group was initiated immediately and commended for their swift response. This included a telephone advice service, additional dietetic support, specialist TPN support, and pharmacy to ensure that patients in our care were able to contact staff for advice, and be provided with parental feeds from the UHB instead of CALEA whilst this issue was being resolved. A concern was raised that this may impact on patients being admitted to the speciality ward as a result, however secondary to the measures introduced no patients required admission. This incident has highlighted how important cross Directorate and Clinical Board working can support effective, safe and timely care.	
1.4	<u>Feedback from UHB QSE Committee</u> June's minutes were shared. Particular reference was made to the Stroke Rehabilitation Model and Workforce.	
1.5	<u>Directorate QSE – Exception Reporting</u> Acute and Emergency Medicine directorate's minutes were received, though they were not in the correct UHB QSE template. DW and GS will chase their directorate's minutes and forward to KP asap. RA advised that she has liaised with the Internal Audit team with regards to them undertaking an audit on our current governance structures to ascertain what should be fed up from Directorates to Clinical Board QSE. More information will be provided as the audit commences.	**DW/GS**
1.6	<u>Papers for Noting</u> Cardiff & Vale Safeguarding Children and Adults at Risk Annual Report. Guide to new notification of death regulations. Patient Safety Autumn Newsletter.	
1.7	<u>Safeguarding</u> LH-J tabled the Safeguarding Annual Report and welcomed questions from the group. LH-J then proceeded to give an overview of the Safeguarding team, touching upon the fixed term Welsh Government funded Band 6 nurses role. DP queried whether there would be any training provided with regards to Advocacy, to which LH-J confirmed that she could raise this query with the team and request that they arrange a Health Lead Practitioners Advocacy training session for the MCB for the new year. DW noted that in England there has been an amendment to the DOLs legislation and queried whether this would this be implemented in Wales also. LH-J advised that DW contact Susan Broad, DOLs Coordinator, was the best person to contact to confirm this. <u>Pressure Damage</u> The Safeguarding team undertook an audit regarding avoidable and unavoidable	**LH-J**

	pressure damage and the requirement to submit a VA1 for all healthcare acquired Category three, four or unstageable pressure damage. The audit commenced in December 2018 to March 2019 which included both Medicine and Primary Care Clinical Boards. The aim of the audit was that healthcare acquired pressure damage that had been deemed as unavoidable, would not require a VA1 to be submitted. The findings of the audit were noted to be extremely positive and as a consequence has been introduced throughout the UHB. JM reiterated the importance of the HLP signing off the VA2 to ensure the timely closure of these incidents. DP asked if the VA1 forms could be used on Datix, however LH-J advised that the required documentation would need to be agreed on an all Wales basis for this to happen.	
HEALTH PROMOTION PROTECTION & IMPROVEMENT		
2.1	<u>UHL Code Stroke Pathway Sign Off</u> DP presented the UHL Code Stroke Pathway 1 to the group. DP will recirculate this pathway in conjunction with these minutes. RA will discuss this further with DP outside of the meeting for SMT agreement, but agreed in principle to the pathway.	
2.2	<u>Flu Update</u> Within 3 weeks, the MCB have immunised 594 members of staff, with 528 being members of staff within the MCB. Of those 528, 421 are front line staff (approximately 18% of our front line staff in total). Most ward areas have a Flu Champion which has greatly supported the uptake in individual areas.	
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	<u>Patient Safety Alerts</u> MDA-2019-36 Specific Hudson RCI Sheridan endotracheal tubes and connectors – 15 mm connector may detach. Drug Alert Class 2 – recall of Bisacodyl 10mg suppositories. Medicines Shortage Provera tablet. MDA/2019/029 Deltic Gripper non-coring needles and PORT-A-CATH trays containing Gripper needles – recall due to risk of needle occlusion. MDA-2019-30 All models of T34 ambulatory syringe pumps – updated cleaning advice and maintenance requirements. Medicines Shortage Tiagabine 5mg/10mg/15mg tablets. Capsaicin cream – Zacin 0.025% Axsain 0.075%. Mianserin 10 mg30mg tablets. ISN 2019 003 Resuscitation trolley checks. All staff asked to ensure that Resuscitation trolleys are checked in line with guidance across their specific areas.	
3.2	<u>New SIs</u> **Integrated Medicine** In97859 – Injurious injury resulting in an acute right sided subdural haematoma. Following the completion of an Injurious Assessment investigation it was believed that the patient had an unwitnessed fall whilst trying to mobilize from the bed unsupervised. Post falls procedures were undertaken to rule out any long bone/spinal injury and neurological observations commenced. A medical review	

	was requested immediately and a CT head scan requested. Following a discussion with Neurosurgeons the patient was treated conservatively. Continued education and training of pre and post falls procedures as a means of maintaining best practice is being undertaken. All staff are reminded at Safety Briefings of the importance of updating patients risk assessments when changes to the patients mobility have been noted to reflect safe and effective care. In100752 – Healthcare acquired avoidable category 3 pressure damage. The patient developed avoidable healthcare acquired category 3 pressure damage to the sacrum which evolved from a pre-existing category 2. The investigation identified that this was avoidable secondary to the patients individual pressure risk factors not being updated regularly and in line with UHB best practice. Rolling documentation audits with the emphasis on risk assessments are being undertaken. Continued education and support in relation to pressure damage and treatment. In100738 – Healthcare acquired avoidable category 3 pressure damage. The patient developed avoidable healthcare acquired category 3 pressure damage to the left elbow. The investigation identified that this was avoidable secondary to risk assessments being completed, but unclear of the timeframe of completion. When the pressure damage was noted it was not acted upon promptly which resulted in a delay in preventative measures being initiated. The consideration of upgrading the mattress should have been considered earlier. Off-loading could have been considered sooner with repose products to help protect the elbows. All staff have been formally reminded at safety briefings of the repose products available and to ensure a stock is always readily available. In addition staff have been reminded of the importance of skin inspection and documentation in line with UHB best practice. All staff have been reminded of the correct mattress selection in line with UHB guidance. Continued education and training including the wards pressure damage information board being updated. In99928 – Injurious injury resulting in an acute subarachnoid haemorrhage. Following the completion of an Injurious Assessment investigation it was noted that the patient had an unwitnessed fall resulting in a small subarachnoid haemorrhage which was treated conservatively following a neurosurgical opinion. The mechanism of the fall is unknown but it is believed that the patient attempted to mobilize from the bottom of the bed unsupervised. The patient had a significant history of falls, pre and post falls procedures and interventions completed in line with UHB best practice. Incidental learning identified that there was a delay in the patients post falls documentation being updated by agency staff on duty, but this would not have contributed to the outcome. All staff including bank and agency, have been reminded of the importance of updating all documentation including post falls documentation in a timely manner to support safe, effective and timely care. Falls simulation training is being encouraged within the Clinical Board which covers all pre and post falls procedures and risks in line with UHB best practice. In99386 – Healthcare acquired avoidable category 3 pressure damage. The patient developed avoidable category 3 pressure damage to the sacrum which evolved from a category 1 pressure area. The investigation identified that this was avoidable secondary to the patients individual pressure risk assessments not being regularly reviewed. Care plans were evident but they were not updated	

	appropriately to reflect changes to the patients skin integrity. Intentional rounding was in place, but the frequency was not increased following the deterioration in the patients skin integrity. The importance of timely and accurate documentation including risk assessments and care plans has been re-enforced with staff at safety briefings. Additional spot documentation audits have been introduced and actions taken accordingly as a means of monitoring compliance and improvement.	
3.3	<u>IP&C Update</u> RA shared the MCB IP&C report dated 17th October. 104 days since last MRSA 10 days since last MSSA 37 days since last C Difficile 33 days since last E Coli 48 days since last Pseudomonas 41 days since last Klebsiella Improvements noted in IP&C audits. CF unit UHL for August 92% environmental audit, 3/3 commode, 100% hand hygiene, 100 BBE, 96% equipment, 100% linen,1/2 MRSA. UHL Gwenwyn 89% environment, 1/1 commode, 100% hand hygiene, 100% BBE, 100% equipment, 100% linen. Meeting Tier 1 reduction goals year end for MSSA, Klebsiella and C Difficile.	
3.4	<u>Point of Care Testing</u> SS presented the 'WPOCT' system to the group, and during this presentation she also underlined the key misuses identified with regards to POCT within the MCB, and how this negatively impacts the monthly reports generated. This also raises significant governance concerns. Going forward, SS will circulate the reports directly to the DMTs so that they are able to challenge staff who are not appropriately using the testing equipment, or using other staff ID's. AW also noted that there have been several incidents of discrepancies in MCB, and would like to conduct a spot audit on particular wards in question to ascertain why these instances have occurred. Discussion ensued with regards to bank and agency nurses, and how they access POCT training in order to have their own badge to use the machine. It was confirmed that if a member of staff is permanently banking or agency then the POCT team will not give them access, and though this will pose a clinical risk, there is a quality assurance risk to consider as well. SS advised that this was not to be obstructive, but the patient safety aspect is paramount. ID advised that he can provide ad hoc training at short notice, as necessary.	
DIGNIFIED CARE		
4.1	<u>HIW Action Plan: Assessment Unit</u> JW provided an update on the HIW action plan: - TACU opened beginning of Sept, 7am – 7pm. - SAU extended hours expected to commence first week of December. - Bespoke training on DOLs and Mental Health being undertaken. - Pulse surgery has just commenced and will be running for 3 weeks. JW advised she would contact GS regarding the outstanding pressure damage action outside of this meeting.	**JW/GS**

	HIW Action Plan;SRC DP provided an update on the HIW action plan: - Resuscitation trolley checks continue to be checked and reviewed by the Ward Sister and Senior Nurse. - Spot checks on VDU screens and notes trolleys have shown improvement but there is scope for further improvement. - All bed end notes are no longer stored outside of patients cubicles. - All staff instructed to ensure that when computers are not in use they are to be screen locked. - No patient addressographs attached to any computer screens.	
TIMELY CARE		
5.1	LIPS Project Sepsis This project was conducted by JM, KP, Emergency Medicine Consultant Dr Susan Allen, Acute Medicine Consultant Dr Laurence Gray, MEAU Deputy Ward Manager Grettel Belarmino, and West 1 Deputy Ward Manager Regina Herbert. This project was established to support the Clinical Board in being able to audit the use of the Sepsis Star. In order to achieve small steps of change two wards have had Sepsis Champions trained as a means of identifying, initiating timely treatment and the completion of the Sepsis Star. JM confirmed that in theory the new pathway will be a positive and improve our Sepsis compliance, but at present uptake has been disappointing. Staff have queried why they have to fill in both the Sepsis star form and the Sepsis pathway. A further PDSA review is required to inform where the group is with its objectives, and actions required to continue the implementation of this change.	
INDIVIDUAL CARE		
6.1	National User Experience Framework Feedback – 2 Minutes of your Time Shared with the group.	
6.2	DTOC Report Report circulated to the group prior to meeting, key figures as follows: - Total number of DTOCs for September 2019 is 46 compared to 38 for August 2019 (increase of 21%). - The number is 59% higher than the same period last year (29). It was noted that this report is not MCB specific, it is for all areas across the UHB.	
6.3	Compliments **Emergency Medicine** *'Massive thank you to the A and E staff working yesterday who helped care for my granny Marion after she took a tumble. Everyone treated us with such kindness and care. We are so blessed to have the NHS and the fact we were seen by a number of specialists within only a few hours is such a privilege. I am a midwife in the trust myself and the care that we received yesterday made me very proud to say I also work under the same trust. Big shout out and thank you to the NA Ashley Magill. He was so lovely and kind to granny and provided really excellent care. I hope this gets seen by him!'* **Integrated Medicine** *'From UHW A&E to A4 to ICU and now C7 my mum has had the best care ever from our NHS. Every person involved does their best under extreme pressure, thank you from me and my family.* *After almost two weeks in hospital, mum is back home and feeling much better. She'd like to thank all the wonderful staff, doctors and nurses at Llandough and the University Hospital of Wales for taking good care of her. We are very*	

	grateful.' Derek Brockway **Specialised Medicine (Dermatology)** *'A big thank you to the dermatology team at UHW for taking care of my mother in law yesterday. Lovely team who treated her with respect and made our visit more comfortable. Proud of our NHS.'* **Specialised Medicine (Endoscopy)** *'Dear Dr Dharmaraj, I want to thank you for the advice and support over the past few months as well as the excellent care on Thursday morning. I hadn't been to the endoscopy unit before and was impressed with the way the unit ran and the friendliness and care from all staff.'*	
STAFF & RESOURCES		
7.1	Staffing – Winter Ward JM advised that with Ward C7 based on Heulwen ward at present due to ongoing refurbishments, concerns have been raised with regards to areas of the ward which are not suitable for patient care. JM has made the Patient Access team aware that these areas are not to be utilised for patient care when the Winter ward moves into this space.	
ANY OTHER BUSINESS		
8.1	Relative Cardiac Arrest on Sam Davies ward The group were advised of an incident in which a relative arrested in the corridor of Sam Davies ward after visiting a patient. The staff on the ward acted quickly and successfully resuscitated the patient.	
DATE & TIME OF NEXT MEETING		
	Wednesday 20th November 2019, 11.30am – 1.30pm, Room 2.20, 2nd Floor, Ty Dewi Sant, UHW	

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING

18th July 2019

Seminar Room, Hafan y Coed, Llandough Hospital

Present: Jayne Tottle, Director of Nursing Mental Health (Chair)
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Mark Bates, Night Site Manager
Jayne Bell, Lead Nurse Adult MH
Owen Baglow, Deputy Ward Manager, Oak Ward
Philip Ball, Senior Nurse Manager Vale Locality CMHT
Kate Bonar, OU Student, Gabalfa CMHT
Alison Edmunds, Concerns Co-ordinator
Jess Gibby, Student Oak Ward
Sarah Howell, Lead CMHN, Gabalfa CMHT
Natalie Hulbert, Deputy Senior Nurse Manager MHSOP
John Hyde, Mental Health Lecturer, Cardiff University
Jayne Jennings, Deputy Senior Nurse Manager Adult MH
Deepali Mahajan, Consultant Gabalfa CMHT
Mary Morgan, Senior Nurse Manager Rehab & Recovery
Neil Pugh, Ward Manager Maple Ward
Tara Robinson, Senior Nurse Manager Cardiff CMHT
Darren Shore, Senior Nurse Manager Adult In-patients
Jayne Strong, ANP Rehab & Recovery
Andrea Sullivan, Concerns Co-ordinator
Mark Warren, Senior Nurse Manager Criminal Justice & Forensic
Justin Williams, Team Leader South Crisis Team
Lowri Wyn, Liaison Psychiatry

Apologies: Will Adams, Professional Practice Development Nurse
Des Collins, Ward Manager Pine Ward
Carol Evans, Assistant Director Patient Safety & Quality
Catherine Evans, Patient Safety Facilitator
Annie Procter, Director Mental Health
Tayyeb Tahir, Consultant Liaison Psychiatrist
Sarah Trench, Lead CMHN, Hamadryad CMHT

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

Chair welcomed all to the meeting and introductions were made. Chair gave a background to the meeting:

This MHCB Quality & Safety Closure and Lessons Learned meeting is a sub-committee of the MHCB Quality, Safety & Experience Committee and reports to the Executive Board. The notes are published but patient names are anonymous. The meeting is to discuss good practice as well as incidents where things did not go quite right. It is not a meeting to look at individual practice; it is to look at what we can do better. Attendees are requested to disseminate the findings to their teams.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

No Actions.

PART 3

CLOSURES:

3.1 Mr A (AC)

Mr A is a 39 year old gentleman with no previous contact with mental health services until June 2018 when his GP urgently referred him to the Community Mental Health Team (CMHT). The CMHT saw Mr A within 3 hours. During the assessment at the CMHT, Mr A disclosed that he had taken an overdose of medication that morning prior to a hanging attempt. CMHT advised Mr A to attend A&E for treatment of the overdose; Psychiatric Liaison Service were contacted and informed of Mr A's imminent arrival at A&E.

At A&E, Mr A informed that he had slit his wrists about 5 months ago. He did not inform anyone then and did not seek medical intention but wrapped it up in plaster. About 4 months ago he took an over dose of tablets but again it did not come to attention. Also 4 months ago, he stabbed himself in the abdomen with a knife in an attempt to end his life and attended A&E but reported that he had fallen on a spike. Family said that Mr A appeared confused at times and had been noted to respond to unseen voices asking him to harm himself.

It was concluded that given the risk history, Mr A would benefit from assessment in hospital. Mr A agreed to informal admission in hospital and was admitted to Cedar ward, Hafan y Coed.

On the ward Mr A appeared distracted and paranoid. He was hypervigilent and suspicious of the nursing staff. Mr A was placed on 15 minute observations. Mr A disclosed that he was feeling actively suicidal therefore the decision was made to place Mr A onto close observations.

Background information was obtained, it was recorded that someone ran in front of his car whilst he was driving and they had died. It was recorded that it had a profound effect on him and his confidence had been very much affected. This appears to have been the point when Mr A's mood changed and he had repeated in self harm behaviours since.

Later that afternoon, whilst observing Mr A on close observations using the ROS system staff noted that he was acting in a bizarre manner. On closer inspection, Mr A was self harming, drawing blood to his left wrist using a sharpened tooth brush. Mr A became agitated and staff felt that he required the use of PRN medication, 2mg lorazepam orally offered but declined. Mr A was very suspicious of the water; he needed a few attempts and some encouragement to drink it.

Mr A became increasingly suspicious on the ward and requested to leave. He was assessed by the Ward Junior Doctor and placed on Section 5:2 of the Mental Health Act.

A few days later during a 1:1 it was felt that Mr A had been slightly more engaging. Mr A sighted his children as a protective factor. He indicated that he would approach staff if he felt agitated or his thoughts became inclined towards self harm. The decision was made to reduce Mr A's level of observations from close observation to intermittent observations (15 minute checks). Mr A agreed that he would spend more time in communal areas. The risk assessment was updated accordingly and Mr A's risk of suicide was recorded as Low Risk.

During a review meeting which included the family, discussions were had around Mr A's presentation on the ward. It was felt from all involved that Mr A's low mood had progressed to paranoid thinking and Mr A was now presenting as depressed with psychotic features. The plan was to refer to the

CMHT, initiate Quetiapine and taper up the dose, no leave for the week and to review with family next week.

A couple of days later during the 15 minute checks at 14:30 Mr A was observed to be sat on his bed. On the 14:45 check a student nurse opened Mr A's bedroom door as she had been unable to appropriately locate him via the ROS system but was aware that he had not left his room. Mr A had ligatured from the bedroom door with a shoe lace. The student nurse immediately called for assistance. Cardiopulmonary resuscitation (CPR) was commenced immediately by a Doctor who was on the ward at the time and the Ward Manager. The Resuscitation team were called and arrived approximately 9 minutes later by which time there had been a return of spontaneous respiration. Paramedics arrived at 15.00 hours and the patient was transferred to Intensive Treatment Unit, University Hospital Llandough.

Fortunately, Mr A recovered and is doing well.

Contributory Factors:

- The GP recorded that Mr A felt that his children were a protective factor but the GP did not feel that these were a significant protective factor because of their stressors.

- Mr A's clinical condition of a depressive condition had progressed to paranoid thinking and psychotic features.

- The risk assessment was updated following the review of levels of observations, however, the risk assessment was categorised as low risk although there remained factors present indicating current risks. This would have been a good opportunity to undertake a WARRN.

Notable practice:

- Good evidence of team working and prioritising the referral from the GP by Hamadryad CMHT in assessing and managing his care efficiently and effectively.

- Excellent work by the student nurse, she was aware of the location of Mr A and changed her route when undertaking observations which minimised the time he was found.

- Team response to incident - good response and care provided to Mr A at the time of the incident.

- Good awareness of patient and his mental state presentation noted through interviews despite the high turnover of patients on the ward at that time.

- Good engagement with family throughout Mr A's involvement with mental health services.

Lessons learned

Although there are several points identified as part of this investigation, it is worth noting that the care afforded to Mr A, both before and during admission, was of a high standard. The initial assessment at Hamadryad CMHT was conducted in an efficient and appropriate manner including liaising with medical colleagues within the team and in UHW. There was a good handover of risk to Psychiatric Liaison services and Crisis Resolution and Home Treatment Team ensuring that Mr A received a joined up service. Despite the lack of recorded 1:1s, Mr A received a lot of nursing time which was clear when interviewing ward staff for the purpose of the investigation. The reviewing team felt it important to note that the actions of the student nurse who was observing Mr A at the time of the incident were excellent.

Conclusion

Risk Formulation

There was much discussion regarding risk formulation of patients presenting as depressed with psychotic features. Critical issues should be highlighted. It was noted that some Health Boards only use WARRN risk assessment with bullet points; they do not use any other forms therefore ensuring that information does not get lost.

Recommendations

- Training staff to ask difficult questions. Rolling programme to Adult In-patients, MHSOP Assessment (Daffodil Ward) and Community. Action: Darren Shore will discuss with Will Hallam, Psychology and Counselling Services.

- Consideration of risk formulation training for students in the University.

TO CLOSE.

3.2 Mr B (KT)

Referral received from Mr B's GP. Mr B had been experiencing symptoms of PTSD and alcohol issues. PTSD symptoms stemmed from an event years previously where a relative was assaulted and subsequently died. Mr B witnessed the event and had tried to help but was unable to do so.

The CMHT advised the GP that Mr B's alcohol issues should be addressed before PTSD, as "if his alcohol misuse is significant, it would very much interfere in his ability to engage in the specific treatment required". It was advised that advice from Community Addictions Unit should be taken first before referring him to the PTSD clinic.

Mr B recognised he needed to address his alcohol misuse before services could assess him regarding his PTSD symptoms; he agreed to a referral to alcohol services.

A few weeks later Mr B was taken to the Emergency Unit by ambulance having contacted the police with suicidal thoughts. The police found a rope connected to the attic space with a chair underneath. He was intoxicated and had also taken an overdose of 7 tablets, for which he did not require treatment. He was assessed by a Psychiatric Liaison Nurse and a student nurse. He denied any current suicidal thoughts when he was assessed and did not present as severely depressed though stressed by his situation. Social stressors included loss of driving licence (and the potential of losing employment as a result) and recent divorce from his wife.

A plan was made for him to attend EDAS later that day and Citizens Advice Bureau regarding finances. The liaison nurse also made a referral to Primary Mental Health Support Services (PMHSS).

A telephone call was received a week later from South Wales Police. Very sadly, Mr B had been found deceased at home with a clear plastic bag over his head, attached with a tube to a helium canister. A note was located saying "I'm sorry X".

It appears that Mr B took his own life due to a number of social stressors.

Notable practice:

A thorough case note was written by the student nurse.

A detailed risk assessment and management plan was completed by the liaison nurse.

Issues:

Interface between Drug and Alcohol Services and CMHT/CRHTT. Tara Robinson and Philip Ball to look at the interface between Community Mental Health Services and Addictions Services.

There was much discussion regarding the pathway of referrals and assessment.

Recommendations

A thorough case note was written by the student nurse; however, this was not countersigned by the liaison nurse. MHCB to reiterate to qualified nursing staff the importance of countersigning student's case notes.

MHCB to look at the practice of referral between Drug and Alcohol Services and CMHT/CRHTT.

It was agreed that a letter should be sent from A&E Liaison to patients stating the outcome of the assessment. Gabalfa CMHT have a template letter thanking the client for attending assessment and outlining the next steps. This template letter will be shared with the Liaison service.

Action Plan:

Look at the Liaison pathway to ensure referral to current services (for example, signpost to Debt Controller/Divorce Counsellor). Compile a folder containing telephone numbers of services and leaflets. Jayne Bell will facilitate the meeting regarding the pathway.

Look at the interface between Community Mental Health Services and Addictions Services.

TO CLOSE.

3.3 Mr C (AK)

Mr C had been known to Mental Health Services for many years. He had a diagnosis of Paranoid Schizophrenia and co-morbid impulsive personality traits. Mr C had episodes of psychosis, paranoid schizophrenia, pseudo-auditory hallucinations and a gambling addiction throughout his treatment episode.

During 2017 and 2018 there were several attempts of self harm - scrammed and cut face/burnt hand/deep cuts on wrist/neck area/noticeable marks around neck. Walked out in front of a car fortunately the car managed to stop in time. Mr C had several thoughts of wanting to end his life; he had thoughts of jumping off a cliff.

Mr C was prescribed regular antipsychotic medication. Mr C was last seen in January 2019 for his Care and Treatment Plan review – all involved services were in attendance. No major concerns in terms of his mental health were recorded. Mr C focussed on paranoia but no evidence of psychosis. There was evidence of poor self-esteem. Mr C been issued with a final warning in relation to the state of his flat and had been actively making an effort to keep his flat clean following a housing inspection. Mr C received support from Gofal (Third Sector agency) in relation to housing issues. An outpatient review was arranged for 3 months time.

A week later Mr C attempted to set fire to his flat by lighting a piece of paper and placing it in his bookcase. Mr C bumped into his neighbour and informed them of what he had done and then he hid for a few hours. Mr C believed that his whole block of flats would be set alight and that he would go to prison for it; however, there was superficial damage to a book cover only. The Police spoke with Mr C who at the time of alleged incident had committed the act in frustration as he is concerned that his flat was going to be taken away from him due to it not being kept tidy.

Very sadly, a couple of weeks later an Email was received from South Wales Police to advise that Mr C had been found deceased on Swanbridge Beach.

Issues:

Mr C's Care Co-ordinator had left and there was a delay in the allocation a new one due to re-organisation of the Locality and new ways of working.

Notable Practice:

Mr C was well known to Mental Health Services for 20 years and the correct procedures were followed throughout the majority of the care provided to Mr C.

TO CLOSE.

3.4 Mr D (DC)

Mr D is a 42 year old gentleman. Mr D is well known to mental health services and has been diagnosed with schizophrenia. DC has had numerous admissions (9 admissions since 2008) to secondary services for the treatment of his mental illness and at least 4 admissions for alcohol detoxification.

In February 2018 Mr D was remanded to Prison for possession of a bladed article, ABH and failure to surrender. He was later transferred to Hafan y Coed under the provision of section 48 of the Mental Health Act 1983 for treatment and has remained in hospital since.

In February 2019 Mr D disclosed to staff that he had swallowed a tea spoon. He reported that he had broken it in half and then swallowed it. He also admitted swallowing 4 spoons over the course of the last 4 weeks. Staff monitored his vital signs, including saturation and heart rate. Metal detector bleeped at his stomach area, indicating presence of metals in his stomach. Mr D was taken to UHW for X-Ray. The X' ray showed that he had swallowed a few teaspoons and other objects. "Multiple metallic fragments present". Surgical colleagues discussed the incident and the advice was to allow Mr D to pass these objects naturally. Mr D passed 9 pieces of metal naturally.

Strict measures were put in place to manage Mr D's risks.

In April 2019 Mr D complained of lower abdominal and back pain and scored 5 on NEWS chart. An X-Ray was taken and found "at least two foreign bodies" (wires). Mr D was transferred to UHW, following spiking in body temperature and acute signs of infection. After being scanned a number of ingested foreign bodies were found:

3 biro refills
3 metallic ribbon like object (wires)
2 additional similar metallic foreign bodies
1 plaited foreign body perforated through the duodenum in to the left lobe of the liver, causing liver abscess.
1 metallic foreign body also perforated the duodenum and psoas muscle in close proximity to the right ureter.

DC underwent surgery for removal of foreign bodies and to repair perforated duodenum

Mr D returned to Hafan y Coed following surgery and hospitalisation. Close observations were implemented on return. No more incidents reported since.

The Team have worked hard with Mr D and have achieved a lot; so much that Mr D is soon commencing overnight leave.

Lessons learned

The staff have learned from this incident and measures have been instigated, such as counting cutlery before and after meals.

TO CLOSE.

GOOD PRACTICE:

3.5 Mr E (RM)

Mr E first came into contact with Mental Health services in December 2014 when he was detained under Section 136 of the Mental Health Act and diagnosed with drug induced psychosis following amphetamine use. Mr E was detained for a period of one week where his symptoms settled. He was later reviewed by the Mental Health Team and presented as stable. He was subsequently discharged for non-attendance of a further appointment.

In 2018 Mr E attended the Emergency Unit in UHW following an overdose. Mr E was assessed by Liaison Psychiatry. He denied the overdose to be intentional and described accidental staggered overdose of diazepam in response to sleep difficulties. He denies suicidal ideation or plans but does state that life is not worth living. Mr E was admitted informally to Hafan y Coed. Mr E was advised by the Consultant that his current drug use is detrimental to his mental health and he needs to engage with help. Mr E stated that he did not want to engage with help, he did no intention of going to EDAS believing that he can stop taking drugs independently when he wants to.

Mr E self-discharged from the ward, EDAS information was discussed with him prior to leaving the ward.

Four months later an Email was received from the Police informing that Mr E had been found deceased by a member of the public at the bottom of Porthkerry Viaduct. There was no contact with MH services at the time of death.

Good Practice

- Documented evidence of family members being involved in the assessment process.
- Effective liaison between involved teams.
- Documentation indicates that substance misuse services had been discussed. Thorough examination of mental state, substance misuse and the relationship between the two had been discussed.
- Referral to EDAS is discussed.
- Mr E contacted the CMHT and an appointment was arranged within 5 days of the contact.

Recommendation

It would be supportive if the knowledge base was enhanced within Mental Health Services to obtain a greater understanding of the wider range of interventions available in relation to substance misuse which can be self-facilitated such as Breaking Free online and SMART recovery and the use of drop in facilities available in areas such as TAITH. Awareness of agencies to support families and carers such as CRAFT could also be enhanced within mental health services.

This is likely to be improved upon with the planned implementation of Mental Health Link Nurses which will further improve liaison and knowledge base between substance misuse and mental health services and the planned formation of a Dual Diagnosis team at the Community Addictions Unit.

Action Plan:

- As per case discussed above (Mr B), compile a folder containing details, telephone numbers of services and leaflets.

- CAU Presentation to Mental Health Services for information sharing.

3.6 Mrs F (DH)

Mrs F was open to the Community Addictions Unit (CAU) Alcohol Team at date of death. She had been referred urgently in February 2018 for intervention for alcohol dependence. The reason for the referral being deemed urgent was due to her being a 'Frequent Attender' at the Emergency Unit at University Hospital of Wales due to suicidal ideation when intoxicated. As a result of this Mrs E had been referred and assessed by Psychiatric and Substance Misuse Liaison services in UHW. There was also high frequency of calls to the Welsh Ambulance Service which required a response from them to Mrs E's home address.

Mrs E attended her initial appointment with CAU Alcohol Team supported by staff from the Re – Engagement Team. Mrs E was assessed to be alcohol dependant and a Treatment Plan agreed upon. Mrs E was referred to the Abstinence Preparation Group and a referral for alcohol detox to Pine Ward, Hafan Y Coed.

Mrs E was noted to have considerable alcohol related liver disease, pancreatitis and was diagnosed with Type 1 Diabetes due to pancreatitis in 2017.

Mrs E completed a planned alcohol detox on Pine Ward. Mrs E also completed the Therapeutic Day Program and was referred on to Footsteps to Recovery for post detox intervention. Whilst on the ward the main issue of concern is noted to be poorly managed Type 1 Diabetes. Documentation describes high level of encouragement from staff to avoid eating too many sweets as her BM's were high. Mrs E was seen by a Diabetes Nurse on the ward and onward referral for Dietician was completed.

A month later, Mrs E attended a follow up appointment at CAU Alcohol Team having relapsed into drinking alcohol. Full review carried out, risk and harm reduction discussed. Encouragement offered to continue engaging with Addiction Services. Onward referral to Taith completed by CAU.
A few months later, Mrs E had another in-patient detox on Pine Ward. Concerns were noted regarding alcohol related liver disease and poorly managed diabetes. Onward referral completed for physical investigations to be carried out whilst an inpatient. Mrs E was seen on the ward by a Diabetic Specialist Nurse.

Two months later, Re-engagement staff reported that Mrs E had relapsed into drinking alcohol heavily. An appointment with CAU was booked.

A week later, a telephone call received to inform that DH had passed away.

Good Practice:

- ❖ CAU process followed diligently; good evidence of holistic need being taken into account during admission as well as addiction specific work.

- ❖ Mrs E had been difficult to engage with but the CAU persisted

- ❖ Referral to Abstinence Preparation Group

- ❖ Referrals for in-patient alcohol detox

- ❖ Referrals to the Diabetes Nurse.

- ❖ Referral to Taith for controlled drinking.
- ❖ Supported by the Re-engagement Team.
- ❖ Good liaison between Services.

4.0 DATE OF NEXT MEETING

19th September 2019 at 9.30am in the Seminar Room, Hafan y Coed.

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. <u>National Diabetes Care Processes and Targets summary report and planned actions:</u> 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. <u>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</u>: 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. <u>Cold Chain Audit:</u> 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. <u>Internal Audit Plan:</u> 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** <u>Current position – Business Unit (BU) queues</u>: The BU queues were noted. <u>Datix Update Report:</u> 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)	**<u>UPDATES FROM OTHER GROUPS</u>** **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 OF A MEETING OF THE PCIC CLINICAL BOARD
QUALITY, SAFETY AND EXPERIENCE GROUP
held at 1.30 pm, 12th November, 2019 in Nant Fawr 1&2 Meeting Room, Woodland House

Present

Gareth Hayes (GH) (**Chair**)	Clinical Director, Clinical Governance
Andrea Rich (AR)	Interim Lead Nurse, Palliative Care
Sarah Griffiths (SG)	Head of Primary Care Contractor Services
Helen Earland (HE)	Senior Nurse PC
Helen Donovan (HD)	Senior Nurse, Vale Locality
Julie Loxton (JL)	Lead Nurse, Communications Hub
Karen May (KM)	Head of Medicines Management
Kay Jeynes (KJ) (Vice Chair)	Director of Nursing PCIC
Stuart Egan (SE)	Trades Union representative
Nicky Hughes (NH)	Lead Nurse, S&E Locality
Rachel Armitage (RA)	PCIC Quality and Safety Manager
Tracey Valade (TV)	Senior Nurse, N&W Locality
Tom Narbrough (TN)	Programme Manager
Beth Richards (BR) (minutes)	Quality & Safety Officer

By invitation

Dr Jackie Gantley	IRIS (for agenda item 6)

Apologies

Denise Shanahan	Consultant Nurse
Gneeta Joshi	Community Director, Clinical Governance
Lisa Dunsford	Director of Operations
Anna Mogie	Lead Nurse, N&W Locality
Theresa Blackwell	Business Manager
Matt McCarthy	Patient Safety Facilitator
Nicola Evans	Head of Workforce
Rebecca Williams	Assistant Head of Workforce

Preliminaries		**Action**
11/19/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Chair.	
11/19/002	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
11/19/003	**DECLARATIONS OF INTEREST** GH asked for any declarations of interest – none noted.	
11/19/004	**MINUTES OF THE PREVIOUS MEETING HELD ON 10TH September, 2019**	

	The minutes of the previous meeting were approved as an accurate record.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
11/19/05	**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: **01/19/031 Transition Pathway for Young People with Complex Needs**: Awaiting publication of Welsh Governments revised Childrens Continuing Care Guidance before agreeing finalised document. Action to be removed from Action Log. **05/19/008 Quality Dashboard – Immunisation**: ongoing. **07/19/009 Risk Register – Risk Escalation Reports – Western Boundary Changes:** a meeting has been held; a further meeting is planned. Action completed. Action to be removed from Action Log. **07/19/009 Risk Register – Risk Escalation Reports – Mobile Phones:** KJ has escalated the issue to the PCIC Director of Operations and Locality Managers. Ongoing. **01/19/021 Research and Development – Glucometer Audit Results by Locality:** Results demonstrate that the audit needs to be repeated; Coaguchek audit will also be repeated. Ongoing. Action to be retained on the action log. **09/19/022 Point of Care Testing:** Discussion held with the Medical Director and Executive Nurse Director. They will take forward and establish a protocol. Action to be removed from Action log. **09/19/027 Safeguarding:** Cardiff and the Vale of Glamorgan Council Adult Social Services Joint Escalating Concerns Procedure. Awaiting final copy. Ongoing.	**BR** **BR** **BR**
11/19/006	**PATIENT STORY – IRIS** JG shared an update on the IRIS project and the success that it has had. This is illustrated by the huge increase in the number of referrals within this scheme rising from 7 between 2011 and 2014 to 543 between 2015 and February 2019. C&VUHB has provided funding until 2020 to cover all GP practices. For all referrals to the service 68% are first time disclosures and 60% had children in the home. The scheme has now received over 1000 referrals. The following points were discussed: • KJ questioned the appropriateness of all referrals and whether those who do not fall under the service can be signposted to other resources. JG stated that all	

	referrals are vetted and if they do not meet the criteria are signposted to other services. • GH asked if the increase of awareness of coercive control and the change in legislation has increased the amount of referrals. JG stated that it had. • JG shared a patient story of a patient who attended her GP surgery 1-2 times per week for blood tests. On being questioned by staff on the frequency of her visits the patient shared that she had been in a controlling relationship for around 30 years and her visits to the surgery were a way to leave the home without question. The patient was offered the services of IRIS and as a result ceased her frequent visits to the surgery. • Unfortunately the link to a patient story film did not work so will be shared with the group at a later date. The QSE **noted** this update and JG was thanked for attending and sharing.	
11/19/007	**QUALITY DASHBOARD** KJ reviewed the dashboard. The following points were highlighted. **Business Unit queues**: a continuing deterioration was noted. NH highlighted that the queues for S&W locality had halved over the last few months, however the overall deterioration is a reflection of the District Nurse escalation level. KJ stated that this does need improvement with some targeted interventions. **Concerns:** it was noted that there is a consistent level of concerns for the whole of PCIC. Resolution rates have improved significantly for October. **Primary Care Governance:** RA noted that there are a range of issues being managed by the team. **Vacancies:** It was noted that the vacancy position is decreasing and is looking in a positive position. Turnover rate has been added to the dashboard and shows an average 9.41% turnover rate for Aug/Sept. HR was asked to run an ageing profile of the clinical teams to see if the age profile had changed which has consistently shown at 42%. There is no change. This is partly influenced by the 'retire and return' staff profile. NH stated that all adverts receive a lot of applications but that a significant proportion of candidates do not attend for interview. The statutory training compliance has decreased. Many statutory training modules are not required for certain positions so should be removed from the staff members' profile. ESR can be emailed to remove. It was noted that ESR take approximately 2 months to remove erroneous modules from profiles so the figures should improve over the next few months. **Risk & Compliance Framework:** There will be a requirement to change the process as part of a corporate review and updating of the policy. There will be a nned to review existing	

	processes including scoring of risks. Training will be implemented for business units in January 2020. **Interface Incidents:** the SI that arose from an interface incident report has produced some learning. The project for Datix access into GMS has stalled and is waiting for NWIS input to progress. **Delayed Transfers of Care:** the rates were noted. KJ stated that Primary Care are proactively supportive of patients being discharged home. It is very rare that PC issues are the cause of a delayed discharge. **HCA Infections:** there has been no reduction on rates of infection. It was noted that there were 2 cases of MRSA, 1 case of C diff was entered on to a death certificate. RCA processes to be undertaken. Rates of E coli continue to increase. **Cold Chain Breaches:** KJ stated that these incidences are decreasing. **DN Escalation levels:** KJ stated that there was a peak in the summer months but that this has now come down. It is anticipated that this may increase due to recruitment and retention challenges. **OOH statistics:** it was noted the predicted levels of escalation were at 3-4 but the service is generally working at level 1 which is very positive. Excellent peer review carried out by external stakeholders. The QSE Group **noted** the Quality Dashboard and the agreed indicators.	
11/19/008	**RISK REGISTER** It has been agreed that the full Risk Register will only be discussed at alternate meetings. <u>Patient flow:</u> Without additional resources this risk must be tolerated. Additional investment is needed. HD reported that the pressure on staff due to sickness is increasing. <u>Complex packages of care:</u> this has been escalated to the Executive Board. Services are struggling to support the number of patientswishing to be cared for within the community. There are some bespoke pieces of work being undertaken to try to reduce the risk. HD stated that the Vale locality is able to find packages of care. NH highlighted that South & East are struggling to find packages. RA stated that possible different descriptors need to be found for the risk to accommodate the impact on staff. <u>GMS:</u> scoring is still 20. Evaluation of the short/medium/long term plans are needed. Risk is elevated due to local development plan/estates risks. Some GP surgeries are located in Health Board owned buildings that are not fit for	

	purpose. SG asked how far should the forecast look as the risk, in her opinion, is not 20 at the moment but could be in future. KJ stated that the risk descriptor does not take us to 20 when compared to the national position. GMS has had significant investment for sustainability which is having a positive impact. The risk should describe the current situation. This dialogue will be continued as the risk calculations will be changing. <u>Pressure ulcer prevention:</u> significant numbers have been reported. Revised process of reporting is in place and working well. Risk to remain the same as patient harm is being caused albeit most cases are not avoidable due to many factors. <u>Domicilary Care:</u> merged in to complex care. <u>GP OOH:</u> HE highlighted the IT issues. Platform AdAstra has to be upgraded by January. Citrix will no longer be supported by NWIS. KJ to email IT regarding the plan for this. <u>CDS:</u> Decontamination audit has been undertaken, there have ben immediate assurance issues that have been dealt with immediately. Risk to be reviewed, briefing paper to be provided to the lead Execs. <u>North & West DoLS:</u> Risk to be reduced due to actions taken and transferred back to North & West Locality. NH stated that CHAP has been removed from the register but needs to be reinstated. A number of the risks has been missed off the Risk register during the last update, to be reviewed by the DON PCIC and replaced.	**Action KJ** **Action AM** **Action KJ/BR**
11/19/009	**AUDIT** <u>9.1 Cardiff & Vale Regional Safeguarding Adults Board – Adult Audit Sub Group Report August 2019</u>: submitted to QSE for information. KJ stated that the audit has shown that grade 3 + 4 pressure ulcers are being evaluated and reported via safeguarding and SI reporting, the revised process now only requires avoidable pressure damage to be reported via Safeguarding and SI reporting. This should decrease reporting and provide more meaningful learning . 9.2 Not discussed The QSE Group **noted** the report.	
11/19/010	**DATIX** RA reported that a meeting with Patient Safety was held on 11th November to review Primary Care reported incidents. No themes were identified. The improvement work done with specific departments and on mis-labelling of samples last year has resulted in a reduction of similar incidents being reported. The QSE Group **noted** the update.	

11/19/011	**PHARMACY UPDATE** KM confirmed that an awareness week is being held to highlight the appropriateness of antibiotic use. Stands have been placed in GP surgeries, Libraries and at Cardiff Airport. There has been positive feedback for this initiative. KM stated that the sore throat test and treat service is in the process of being rolled out. There is a POCT issue as NICE does not recommend testing for strep A through this service, this is being further explored. The QSE Group **noted** the report.	
11/19/012	**GMS AND DENTAL SERVICES** <u>12.6 Anti-coagulation national procurement and EQA:</u> A number of anti-coagulation meetings and training have been cancelled due to the contract not having been signed off by the UHB. It is hoped that these will be re-scheduled in January 2020. There has been a GDPR issue with POCT software regarding who owns and uses the data and where it is stored. <u>12.7 Contract Update Clinical Practice Self-assessment Tool (CGPSAT) Requirements:</u> SG highlighted that the CGPSAT featured in the contract changes in 2019/20 and the new QAIF (Quality Assurance and Improvement Framework) which replaces QOF. Practices are required to demonstrate active participation as evidence of operating an effective system of clinical governance in the practice and through engagement in peer review. Contractors will need to evidence completion of the CGPSAT. The primary care team will consider its processes for monitoring compliance and review of the information submitted through tool. The QSE Group **noted** the update.	
11/19/013	**REVIEW OF QSE TERMS OF REFERENCE** All proposed changes to the document agreed by the group.	
11/19/014	**BUSINESS CONTINUITY UPDATE** Update report noted by the group. There are still a number of pieces of work to be completed. The Task & Finish group continues to meet. The Bronze Control room is now situated in PCIC Meeting Room 2 in Woodland House. KJ thanked all for their hard work especially OOH. It was noted that Chris Darling has left for secondment and Kay Jeynes will be retiring shortly so a decision needs to take place on who will lead this work going forward.	
11/19/015	**PATIENT EXPERIENCE**	

	Concerns Update & updated arrangements for monitoring of Concerns: BR updated the group on the mutually agreed arrangements for any concerns received by the Health Board about Contractor Services. It is hoped that these arrangements will improve communication between departments. SG, RA & KJ thanked BR for work on this issue. Compliments: the compliments were welcomed, please forward so we can communicate positive feedback as well as lessons learnt through complaints. NHS Outcomes Framework 2019 -2020 – Performance Measure Reporting: PCIC contribution of methods of feedback collection for each locality noted. KJ stated that previous reports have garnered positive feedback from Welsh Government and it is hoped that this will continue. Ombudsman Report Case 201900735: Anonymised report noted by the group complaint not upheld. Regulation 28 Coroners Report for Welsh Ambulance Service: Trust: Anonymised report noted by group. Report was sent to interested parties as GP surgery involved was C&V. Work is currently being undertaken by Primary Care to establish a protocol and suggested list of resuscitation equipment and drugs within GP surgeries. The QSE Group **noted** the updates**.**	
11/19/016	**CLINICAL WORKING GROUP – OOH AND 111 SERVICE** The QSE Group **noted** the updates.	
11/19/017	**BUSINESS UNIT QSE MINUTES** KJ stated that not all minutes had been received. NH informed the group that the S&E locality have had to cancel several meetings due to staffing issues and office moves. Meeting rooms have also been difficult to access. KJ noted these issues.	
11/19/018	**INFORMATION GOVERNANCE MINUTES** Minutes of the last meeting noted by the group. RA informed the group that 90% of GP surgeries have signed up to the NWIS GDPR scheme. There is a continuing issue with clinical note storage boxes and environments being sub-standard. One issues of a fax being sent to the incorrect surgery containing patient identifying information was noted. It was also noted that there are system anomalies rather than human error that has caused some issues.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
09/19/019	**RESEARCH AND DEVELOPMENT (R&D)** Subcutaneous furosemide: deferred to the next meeting.	**BR to add to agenda**

	Peezy Evaluation & Update: KJ stated that the pilot project has been successful and that this system is the only NICE accredited device to collect mid-stream urine samples. There is now a revised process for GP's to use the accredited device. There is a reduction in samples sent to the lab or showing NAD as samples are cleaner and at less risk of contamination. All practices have felt that the revised process is better and only one practice involved in the pilot has declined to use the device going forward. NICE Updates: Updates noted by the group. Governance Framework for the GP Triage project: The framework was noted by the group.	
09/19/020	**UPDATE TO CLUSTER LEADS ON PROGRESS OF MSK AND MHL PROJECTS** Patient Feedback Results: Positive patient feedback was welcomed by the group. KJ stated that the Executive Team is keen to show the impact of investment on patient outcome and experience. Update to cluster leads on progress: The letter from the PCIC Clinical Board Clinical Director was noted. KJ stated that here is an issue with high DNA rates and Mental Health pathway is that this is due to the client base and cannot easily be improved. Anna Kuczynska's opinion is that all patients should be treated equally and DNA processes implemented.	
SAFE CARE		**Action**
09/19/021	**POINT OF CARE TESTING** The Point of Care Testing Group Minutes were noted by the group. KJ informed the group that Rachel Rayment had resigned her position due to lack of clinical board engagement. The clinical scientist lead for the UHB has left and hasn't been replaced, leaving the POCT Manager only .It has been agreed by the Exec Nurse and Medical Director that we ned to ensure that we have robust processes in place for existing POCT before implementation of new devices. It is essential where there is POCT in place that clinical audit or evaluation is in place. The QSE Group **noted** the update.	
09/19/022	**OUT OF HOSPITAL STANDARDISED ESCALATION AND RESPONSE BUNDLES** KJ informed the group that there has been implementation of the National Early Warning Scheme (NEWS) and escalation process across NHS Wales's community settings. NEWS training is being implemented for all District Nurses and Prison staff with an agreed roll out plan for full implementation by summer of 2020. KJ gave thanks for this impressive piece of work.	
09/19/023	**FLU VACCINE UPDATE**	

	KJ informed the group that there has been a lack of available vaccine. Nevertheless, vaccine programmes have been rolled out. Staff vaccination sessions for Woodland House will begin on 14th November.	
EFFECTIVE CARE		**Action**
09/19/024	**INFECTION CONTROL** The QSE Group **noted** the updates and links to further information.	
DIGNIFIED CARE		**Actions**
09/19/025	**DEMENTIA** <u>Dementia action plan for Primary, Community and Intermediate Care:</u> Dementia Action plan review – b/f to January meeting. **PALLIATIVE CARE** The Marie Curie Hospice and George Thomas Palliative Care feedback reports were noted by the group. KJ highlighted that this is wonderful feedback for fantastic services. It was noted that the George Thomas Hospice is now called City Hospice and has been for several years. Report title is incorrect, however the information is up to date. <u>Anticipatory prescribing in palliative care:</u> the evaluation report was noted by the group. There is clear evidence to support the prescribing of anticipatory meds impacts positively on patients outcomes and reduces unnecessary clinical interventions. It was highlighted that there was an issue with the anticipatory prescribing for care home environments as they have to keep a lot of stock and the logistical implications of this can be challenging. Overall this is a welcome development for palliative care.	**BR to add to agenda**
TIMELY CARE		**Action**
09/19/026	**SAFEGUARDING** The documents were noted by the group. RA highlighted that in recent safeguarding training it was noted that trafficking gangs are recruiting interpreters to assist in human trafficking. The QSE Group **noted** the updates.	
INDIVIDUAL CARE		**Action**
09/19/027	**PATIENT EXPERIENCE** Minutes for the North and West Locality Patient Experience Group from September 2019 were noted by the group.	
09/19/028	**WELSH LANGUAGE STANDARDS UPDATE**: provided for information. SG highlighted that Contractors have been informed that translation costs will be by the Health Board but also that they are exempt from the standards which is causing confusion.	

	KJ informed the group that all recruitment adverts must now be bilingual which has a cost implication for Clinical Boards. NH highlighted an occasion when a patient was issued a form in Welsh and when this form was completed and returned there were no staff available to read it. The QSE Group **noted** the update.	
STAFF AND RESOURCES		**Action**
09/19/029	**WORKFORCE UPDATE** – the relaunch of the Workforce Engagement Group was noted.	
SUB-GROUP REPORTS		**Action**
09/19/030	**PRIMARY CARE BUSINESS UNIT REPORTS** <u>GP OOH Business Unit</u> HE highlighted the IT issues that are ongoing. It has been identified that NWIS will no longer support the Citrix platform from January 2020. Negotiations are ongoing to get 2 servers upgraded before this time. The proposed 111 pilot of the newly procured IT system will still go ahead within the next 18 months. <u>Vale Locality</u> HD highlighted that the GP triage project will go ahead in January 2020. The locality also received an £800 donation for the District Nursing Service from a grateful patient. <u>Cardiff South and East Locality</u> NH highlighted that staffing issues continue to be challenging in the CHAP and Prison teams. There is a lack of recruitment to Prison Nursing. <u>Cardiff North and West Locality</u> TV highlighted that the escalation level for District Nursing is L3. There have been issues with sickness. Staff have also encountered parking issues at St Davids Hospital since being moved there. KJ stated that Park View has closed and that the planned relocation to Grand Avenue has been delayed. This has an impact for unscheduled calls. This needs to be escalated to the HOP's to see what can be done to expedite the move <u>Pharmacy and Medicines Management</u> No additional issues to report. <u>Palliative care</u> No additional issues to report. <u>Primary Care</u> SG highlighted that the majority of work being done is regarding the new GP contracts.	**Action KJ**

PART 2:	**ITEMS RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE GROUP**	
09/19/031	**<u>CMO and CPhO UPDATES</u>**	

	31a	CEM/CMO/2019/4	Flu Vaccination Programme in Schools
	31b	CPhO/MedsLet/2019/12	Disruption of supply of Evorel Hormone Replacement Therapies
	31c	CPhO/MedsLet/2019/13	Disruption to supply of Fluoxetine 10 mg Capsules
	31d	CEM/CPhA/2019/20a	Hormone Replacement Therapy (HRT): Further information on the known increased risk of Breast Cancer with HRT and it's persistence after stopping
	31e	CEM/CPhA/2019/21	Drug Alert Class 2, Action Within 48 hours, Dr. Reddy's Laboratories Ltd, Aripiprazole 1mg/Ml Oral Solution
	31f	CEM/CPhA/2019/29	Class 2 Drug Alert, Action Within 48 Hours, Rosemont Pharmaceuticals Limited, Ranitidine 150mg/10ml Oral Solution
	31g	CEM/CPhA/2019/30	Class 2 Drug Alert, Action Within 48 Hours, Omega Pharma Limited Trading as Perrigo, Zantac 75 Tablets, Zantac 75 Relief Tablets and Galpharm International Limited (Part of the Perrigo Group), Ranitidine 75 mg Tablets (Various Liveries)
	31h	CEM/CPhA/2019/26	Class 4 Drug Alert, For Information / Action, Alliance Pharmaceuticals Limited, Xonvea 10 Mg/10 Mg Gastro-Resistant Tablets
	31i		CNO letter to health and social care staff re annual flu vaccination 24 10 19
	31j		CMO CPhO letter 2019 Continuity of Medicines
	All Pharmacy notices are available at http://www2.nphs.wales.nhs.uk:8080/Contacts.nsf/Main%20Frameset?OpenFrameSet&Frame=Right&Src=%2FContacts.nsf%2FEmailPublicPage%3FOpenPage%35AutoFramed **All CMO updates are available at**		

	https://gov.wales/topics/health/professionals/cmo/updates/?lang=en	
09/19/032	**MHRA MEDICAL DEVICE AND MEDICINES ALERTS** 32a MDA/2019/028 — Microneedling pens: Dermapen 3 and Dermapen Cryo Sterile single use needle cartridge tips for: Dermapen 3 – risk of injury or infection 32b MDA/2019/027 — Automated external defibrillators: All Telefunken HR1 & FA1 – no valid CE certificate	
09/19/033	**WELSH HEALTH CIRCULARS** 33a WHC/2019/031 The Department of Culture, Media and Sport (DCMS) guidance for UK departments on mitigation options for risks to data flows Canllawiau'r Adran Diwylliant, Cyfryngau a Chwaraeon (DCMS) ar gyfer adrannau'r DU ar opsiynau lliniaru ar gyfer risgiau i lif data **All Welsh Health Circulars are available at** http://gov.wales/topics/health/nhswales/circulars/?lang=en All Welsh Government alert documents will appear on the Primary Care Services internet site for your information under the month it was distributed: http://www.wales.nhs.uk/sites3/page.cfm?orgid=435&pid=59386	
09/19/034	**WELSH GOVERNMENT ADVISORY/MINISTRY OF JUSTICE** 34a Guide to new notification of death regulations 34b Guidance for registered medical practitioners on the Notification of Deaths Regulations 2019	
09/19/035	**PATIENT SAFETY NOTICES/INTERNAL SAFETY NOTICE AND GUIDANCE** 35a 2019/October/004 — Security of patient information 35b 2019/October/005 — Supply of ranitidine – Oral formulations of ranitidine are expected to be out of stock	
09/19/036	**SI CLOSURE FORMS** 36a IN101831 Signed No Surprise Form Please access via link **Y:\PCIC\Locality QS&E\Quality and Safety Group papers\2019\06 Nov 12th 2019**	

09/19/037	**NHS ALERTS** 37 Adrenaline for anaphylaxis kits reminder
09/19/038	**PUBLIC HEALTH WALES** 38.1 Public Health (Minimum Price for Alcohol) (Minimum Unit Price) (Wales) Regulations 2019 / Datganiad Ysgrifenedig: Rheoliadau Iechyd y Cyhoedd (Isafbris am Alcohol) (Isafbris Uned) (Cymru) 2019 https://llyw.cymru/datganiad-ysgrifenedig-rheoliadau-iechyd-y-cyhoedd-isafbris-am-alcohol-isafbris-uned-cymru-2019 https://gov.wales/written-statement-public-health-minimum-price-alcohol-minimum-unit-price-wales-regulations-2019 38.2 Public Health Wales Briefing: Start of Respiratory Syncytial Virus (RSV) Wales
09/19/039	**UPDATES FROM OTHER GROUPS** 39.1 Minutes of the UHB Mental Health and Capacity Legislation Committee – not available 39.2 Safeguarding Steering Group Minutes – 19th September 2019 39.3 Minutes from the NHS Nutrition and Catering Co-ordinators Forum – not available 39.4 All Wales Nutrition and Catering group minutes September 2019 39.5 Agenda for the Nursing and Productivity Group Meeting, 17th October, 2019 Public Health Update – now available online: https://public.tableau.com/views/WalesHBAHHCAImonthlyupdatedashboards-Public/WalesHCAIMonthlyUpdate?:embed=y&:display_count=yes Public Health Wales Infections Surveillance Report – now available online: https://phw-tableau.cymru.nhs.uk/views/WalesHCAIMonthlyUpdateDashboards/WalesHCAIMonthlyUpdate?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no Vaccine updates now available online https://www.gov.uk/government/collections/vaccine-update
DATE AND TIME OF NEXT MEETING:	
Wednesday 15th January, 2020, 2 pm – 4 pm ***Nant Fawr 1, Ground Floor, Woodland House*** ***FOCUS: LEARNING DISABILITIES***	

Minutes
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 27th June 2019
Venue: Council Room, UHW

Attendance:
Carys Fox (CF), Director of Nursing (Chair)
Jessica Castle (JC), Director of Operations, Specialist Services
Richard Wheeler, Consultant, Cardiology
Craig Spencer (CS), Consultant, Critical Care
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Kevin Nicholls (KN), Service Manager, Cardiothoracics
Lisa Simm (LS), Service Manager, Neurosciences
Colin Gibson (CG), Clinical Engineer, ALAS
Keith Wilson (KW), Consultant, Haematology
Rachel Barry (RB), Lead Nurse, Neurosciences
Suzie Cheesman (SC), QSE Facilitator
Claire Main (CM), Lead Nurse, N&T
Gareth Jenkins (GJ), Service Manager, Haematology
Sarah Matthews (SM), Senior Nurse, N&T
Sarah Williams (SW), Interim Senior Nurse, Critical Care
Catherine Wood (CW), General Manager, Critical Care and Major Trauma

Present:
Gemma Williams (GW), Personal Assistant, Specialist Services (Note Taker)
Dr Caz Burford (CB), ICU M&M Lead

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome & Introductions The group introduced themselves one by one.	
1.2	Apologies for absence Received from; Nav Masani, Hywel Roberts, Sarah Lloyd, Claire Mahoney, Carol Evans, Judith Burnett, Bev Oughton, Ann Marie Morgan and Ravindran Nanapaneni.	
1.3	To review the Minutes of the previous meeting 6th June 2019 The minutes were agreed as an accurate record. Matters Arising - 1.3 Exception reports – GW confirmed that she had made the amendment to the incident where a patient's diagnosis of stroke had been delayed. - Risk Registers – All Directorates have sent their updated Risk Registers to GW except for N&T and Haematology who will send their registers through to GW today to add to the S-Drive. - Antimicrobial lead – no lead identified as yet. Still outstanding. Directorates to send any nominations through to CF.	**Dirs**

	- The meeting with WAST and A&E is still outstanding. SC did have a date but Hywel Roberts was on leave so looking for a date when Hywel returns. SC will follow this up. - HCS 2.9 and mortality reviews are both on the agenda. - Serious Incidents – death of a patient on renal. SC noted that a meeting had taken place a few weeks ago. Looking at the process of how x-rays are picked up on the pathway. It was agreed that the person who requests the x-ray should report on it but if admitted through the emergency stream then this is more difficult. The Nephrology part has been closed off but need to consider the UHB overall picture. CF noted that this issue could be looked at Health Board wide in order to agree a secure process. GW to carry forward as an agenda item for a future meeting. - POCT meeting still needed GW to arrange (with CF, Hywel Roberts and Navroz Masani). GW to chase TOR from Rachel Rayment. CP will include POCT in the next Practice Educator Forum. It has been discussed within Directorates. GW confirmed that she had carried it forward as an agenda item for Nursing Board. - HCAI Meetings – CM is currently updating the attendance list. CM will then share dates with Claire Mahoney once finalised. - Line infections feedback – CF and CM have met to discuss this outside of the meeting. - Long waiting patients – RB has met with Tom Hughes to discuss this in Neurosciences. JC has spoken to most Directorates now regarding long waiters. JC will table the information and bring back to this meeting. - In82518 Critical Care Serious Incident whereby the notes couldn't be located - SC confirmed that the incident was closed without them. - Open Inquests – Directorates were asked previously to review the list and raise any concerns. - Patient Safety Alert "Insulin: Raising Awareness of Safety Issues" – Directorates were to be aware. - JC/GW to circulate the Critical Care FICM report. - M&M Processes is on the agenda.	**SC** **GW** **GW** **GW** **CP** **CM** **JC** **GW/JC**
PART 2: SAFE CARE		
2.1	<u>Open Serious Incidents</u> Directorates to review. Only 5 open Serious Incidents (SIs). Much better than last year. 2 closed this month and 2 should be closed next month. VRE outbreak not declared over as yet even though ward has moved. Still ongoing. No reported avoidable pressure damage this year which is very good. <u>Open Inquests</u> Initials DW - Cardiac death. Patient admitted for cardiac procedure, became hypertensive and had a cardiac arrest. DNR decided. List of concerns from family. Statement has gone to the coroner. Inquest meeting Thursday with Beth Richards in Concerns (Inquest co-ordinator). May need to update process in relation to the list of who inquests need to go to as currently just goes to the Consultant. CP noted that the family had raised some questions that they felt were unanswered. SC will find out if the family is attending and if they are bringing a legal representative etc. Regulation 28 in relation to Neurosurgery (initials GB) – it was noted that there will be a small pre meet and then Ruth Walker has arranged a wider meeting in order to respond to the Coroner on the 18th July. Ruth has invited representatives from other Health Boards as well.	**Dirs** **SC**
2.2	<u>Closure Forms for Serious Incidents:</u> ***Rolled over from April meeting:***	

	- In65611 JP - In79357 CT - In82409 ET - In79260 MH - 429102January19 IN82222 Not discussed. Directorates to review and raise any concerns if needed.	**Dirs**
2.3	Healthcare Associated Infections - HCAI Report - Max numbers reduction goals per month Reports for information.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Directorate M&M Processes/Mortality Reviews Cardiothoracics RW updated the group. It was noted that the Level 1 mortality review form shouldn't be completed by the SHO doing the death certificate as they may have only met the patient briefly. That needs to be done by a Consultant. Peter O'Callaghan and RW are involved within Cardiac but it was noted that it is hard to get a regular rota. Significant issue of notes not coming back from coding; biggest concern is notes going missing. Discharge summary required which is kept with the notes which is an issue. If there is a need for a stage 2 review then they keep the notes back and present at their QSE meeting – this however is flawed again if the notes are not there/available. No uptake for the Joy Whitlock generic form circulated last year. RW felt that it was not ready for wide use within the hospital. Cardiac have therefore carried on with their own system. The notes issue requires proper management and more investment of time allocated to do it properly. Timing also important. Critical Care CB updated the group. It was noted that she had picked up the M&M Processes work when she was an advanced trainee. The External Review (FICM Report) which was discussed at the last meeting flagged up a lot of concerns. CB noted that she has only been here since March so many of the changes are very new and the systems are not yet embedded. Work is in progress. They are looking at the mortality and morbidity stream. All PACU deaths get reviewed by Anton Saayman, Consultant Intensivist. Any predicted mortality less than 20% has a notes review and a numbr of issues have been identified. Very unilateral as the reviews are all done on paper, which is not a transparent way of recording. Difficult to track outcome and changes that have come about. The next plan is to develop some form of electronic database, along the lines of the level 2 mortality form. Stage 1 reviews have been an issue And compliance in completing the forms has been an issue. A simple solution could be that the ward clerk will not take the notes to bereavement unless the form is on the top. Death paperwork was previously completed by anyone but now by the Registrar or Consultant only. Morbidity is discussed in the weekly teacher session. All trainees go to their teaching. All cases from weekly meetings get discussed at Directorate QSE meetings. CF and JC to meet with Sion O'Keefe, Directorate Manager for Outpatients and Patient Administration as it seems notes availability is a theme. GW to arrange. There needs to be a central point of where the notes go to so that	**GW**

	they are tracked appropriately. RW noted that poor attendance at their QSE meetings is also an issue. Nephrology CM noted that Nephrology was similar to Cardiology in that it was a work in progress but very reliant on Matt Davies, N&T Consultant. Haematology KW raised concern that he wasn't aware of the Level 1 forms. Generally in Haematology all deaths are reported and recorded at their weekly MDT meeting – make a conclusion at the end; either no further action, or whether something additional needs to be done. As QSE lead, if further action is needed, KW will allocate someone to investigate. When that is complete it will be presented at a departmental QSE meeting. They don't have specific morbidity meetings as they will be discussed in the Weekly MDTs anyway. If they need further investigation they will come to KW again. Transplant side – there is a system where they record adverse reactions and events. There is a robust system across the transplant programme. This is reported electronically in real time and reviewed at their fortnightly meetings. Then looked at quarterly by the Quality Manager for trends and for deaths reviewed annually and presented in summary format. It was felt that Junior colleagues may be doing the level 1 forms already even though KW was not aware of them. KW will follow this up to make sure that this is the case. SC will also check to see that these forms have been submitted by Haematology. SC will ask for a report which shows compliance figures for each Directorate. RW noted that the Level 1 form is also not straight forward regarding its wording. Grey areas. Critical Care are meeting in relation to the level 2 forms as none of them have been asked to do any. CF will discuss Level 2 forms with Peter Durning or Tony Turley. Discussions took place around the benefits of a unified approach or Department dependent approach to Level 2 forms. CF noted that it would be useful for each Directorate to have a nominated person to co-ordinate this work. All Directorates to let CF and GW (Pa.SpecialistServices@wales.nhs.uk) know and inform Clinicians of who will be co-ordinator for each area. RW referred back to the generic form circulated by Joy Whitlock last year noting that he felt it had too many questions and that some of the questions were very ambiguous - the answer to some of them could determine whether it becomes a legal case or not.	**KW/SC** **SC** **CF** **Dirs**
3.2	Health Care Standard 2.9 Medical Devices CG sent out a brief summary yesterday ahead of the meeting "Outline MDSO report." The UK Government has confirmed that it will fully implement the Medical Devices Regulation (MDR) and In Vitro Diagnostic Device Regulation (IVDR) by the due dates of 26 May 2020 and 26 May 2022 respectively irrespective of Brexit. Currently none of the Health Boards in Wales are ready for this. The work is an attempt to bring medical device monitoring to the same level as Medicine monitoring. The focus is on the highest risks first. RB noted that Neuro have started these discussions but not at the level described. CG noted that he was currently raising awareness and gathering information.	

	CF noted that this should link into the NatSIPPs and LocSIPPs work. CG noted that if we develop our own software that influences decision making it is also a medical device. The Medical Equipment group that leads on this recognises the massive under-investment and is trying to access capital monies. CG to meet with Directorates if requested and attend their QSE meetings if helpful. Rolling agenda item going forward.	**CG/Dirs GW**
3.3	Feedback from UHB QSE Committee No feedback to be given.	
3.4	Exception reports and escalation of key QSE issues from Directorate QSE groups No exception reports.	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AMND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	Specialist Services Health & Safety Minutes – 19th February 2019	
PART 5: ANU URGENT BUSINESS		
5.1	Any Urgent Business None.	
PART 6: DATE OF NEXT MEETING		
6.1	Thursday 18th July 2019, 8am, in the Critical Care Resource Room, UHW.	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 18th July 2019
Venue: Critical Care Resource room, A3/B3, UHW

Attendance:
Hywel Roberts (HR), Consultant, Critical Care and Medical QSE Lead
Gareth Jenkins (GJ), Service Manager, Haematology
Kevin Nicholls (KN), Service Manager, Cardiothoracics
Rachel Barry (RB), Lead Nurse, Neurosciences
Suzie Cheesman (SC), QSE Facilitator
Claire Main (CM), Lead Nurse, N&T
Sarah Matthews (SM), Senior Nurse, N&T
Sarah Williams (SW), Interim Senior Nurse, Critical Care
John Martin (JM), Consultant, Neurosurgery
Mathew Price (MP), Service Manager, Neurosurgery
Claire Mahoney (CM), Clinical Nurse Specialist, IP&C
Mary Harness (MH), Senior Nurse, Haematology
Gayle Sheppard (GS), Assistant Service Manager, Cardiothoracics
Steve Gage (SG), Pharmacy
Paul Rogers (PR), Directorate Manager, ALAS

Present:
Gemma Williams (GW), Personal Assistant, Specialist Services (Note Taker)

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome & Introduction The group introduced themselves one by one. Paul Rogers introduced himself as the Directorate Manager for ALAS.	
1.2	Apologies for absence Received from; Carys Fox, Jessica Castle, Craig Spencer, Colin Gibson, Jennifer Proctor, Anne-Marie Morgan, Lisa Higginson, Bev Oughton, Sian Williams, Ceri Phillips, Ravindra Nannapaneni and Judith Burnett.	
1.3	To review the Minutes of the previous meeting 27th June 2019 The minutes were agreed as an accurate record. Matters Arising HR noted that he wasn't available to attend the last meeting and asked that the group let Carys Fox know if they have any questions or issues regarding the matters arising. Attendees to follow up on their actions.	**ALL** **ALL**
1.4	Patient Story – ALAS, Paul Rogers PR presented to the group. The presentation related to the ALAS Posture and Mobility Centre and focused on conjoined twins. The father of the twins applied for asylum in the UK (due to the lack of suitable health care where they were born) and were housed in Cardiff. The ALAS Posture and Mobility Centre were asked to look at the twins posture needs. The twins have a fused spine, two hearts, four lungs and two stomachs. PR noted that the team produced a specialised seat for the twins as part of a seating solution. The seat was made using a mould so that the fit was just right. A bespoke harness was also made for them. A second type of pram was then made so that the twins could face the father when moving along instead of outwardly facing as the father had become increasingly concerned that	

	people were taking videos and pictures of the twins when out and about. A privacy canopy was also added. PR noted that due to the fast growth of the twins the centre tries to look 6 months in advance to keep up with their needs. PR was asked if the service provides any psychological support for patients or relatives. PR noted that at this time there was no specific psychological support for the twins and their family from the ALAS service but that the family had support from Social Services. PR will send GW the link on the BBC report which the father wrote in order to try to help to educate the public on the twin's condition. GW to circulate.	**GW**
PART 2: SAFE CARE		
2.1	Open Serious Incidents (SIs) SC updated the group. Currently only 3 open SIs at the moment – 2 of which hoping to close soon. The third one relates to VRE on Haematology and can't be closed until the outbreak has been declared over. Open Inquests SC noted that there were currently a significant number of open inquests but only one that needed to be discussed. Ceri Phillips was asked to look at this case. The statement response from the Consultant was satisfactory. HR noted that Critical Care were in the process of trying to improve correspondence with the Coroner and the Concerns Team.	
2.2	Closure Forms for Serious Incidents: In65611 JP (not presented at previous 27th June meeting) Closed in January but not presented. Gentleman was admitted from EU to the Nephrology ward. His medications were not secured away. Five days after admission, the gentleman received bad news and took an overdose of his own medications. Sadly due to his renal issues, the gentleman died following the overdose. The Health Board was given a Regulation 28 for not following the policy to ensure that medications are kept secure. Staff were unaware that the patient had medications with him and had failed to carry out the required assessments and complete a property checklist; both in EU and on the Nephrology ward. HR asked that Directorates need to make sure that they are securing and locking medications away. CM noted that the patient property policy and medication policy did not refer to each other and they have both since been amended so that they now relate to each other. In80228 closure form and improvement plan KN updated the group. A gentleman was referred to Cardiac Surgery at C&V UHB from Cwm Taf. The patient was identified as requiring aortic valve replacement. Due to various delays surgery was cancelled - put off due to more urgent cases. The patient was contacted to arrange a date for surgery but unfortunately the patient had passed away in his sleep. Coroner reported death as calcific aortic stenosis. KN noted that issues around capacity are challenging, however most of the learning is around how they monitor patients on the cardiac waiting list. There are a few actions from this. Adopted a system of recording planned dates and flagging patients when postponed using the clinical work station. Every patient is given a letter when on the cardiac surgery waiting list noting that if their condition deteriorates they need to contact the department. Every patient is reviewed by a cardiologist approximately every 3 months in order to monitor the patient. Raised issues to cardiac network as well. In81765 closure form and improvement plan. A patient was reviewed in the heart rhythm nurse led clinic following a routine check with their dual chamber pacemaker, which confirmed they had gone into atrial fibrillation. Nurse reported concerns in regard to initiating an oral anticoagulation agent as the patient had a history of falls. The letter advising that anticoagulation should be considered, but this was to be discussed with the Cardiology Consultant first, didn't get to GP surgery. There was a delay in the gentleman being discussed with the Cardiology Consultant. Unfortunately, during delay patient suffered a stroke. It was felt that if it had been initiated the likelihood	**Dirs**

	is that he wouldn't have had the stroke. At the time of the incident there was no clear process in place for referrals. KN noted that a detailed RCA had been carried out. No clear mechanisms in place for physiologists to raise concerns. Letter was posted to the GP but didn't arrive. The opportunity for the GP to review the need for anticoagulation was missed. Clear action plan in place to ensure there is a clear process to escalate patients that require consultant input in a timely manner. No concern raised regarding either closure form so signed off by the group.	
2.3	<u>Specimen labelling error reporting</u> SC updated the group as Carys Fox was not available to provide an update. SC noted that the issue related to the significant number of blood or labelling incidents being raised on Datix. The incidents are being reported but because of the large volume are not always getting looked into. GW to circulate the Zero Tolerance June 2019 Report. HR asked that Directorates refer to page 3 and 4 which lists areas in red. If any of the Directorates are red then HR requested that they review and look to see what can be done to improve this. HR recommended that Directorates batch their incidents so that they can then look for common factors.	**GW** **Dirs**
2.4	<u>Blood Transfusion sampling change – 2 G&S samples now required</u> HR updated the group. Practice has changed with regard to producing blood in that now you have to have two grouped samples saved instead of one. It was noted that this isn't an issue for Haematology patients. The practice has been changed in order to try to prevent transfusion error. The thinking is that if you are taking 2 samples then it is less likely that the wrong blood will be used. The two samples can't be taken less than 30 minutes apart. HR raised concern for new patients presenting with major haemorrhage as there will now be an inevitable delay of at least 30 minutes whilst waiting between samples taken. If patient has been grouped and saved before then this won't be a problem. HR has spoken to Mellissa Rossiter, Consultant in Critical Care and Major Trauma and they are using more cross matched blood as a result. HR asked that Directorates review their processes and ask the question should they be grouping and saving blood regularly in order to ensure there is no delay. Critical Care have gone back to their old practice and save blood when the patient comes to ITU. All Directorates to consider what they will do if patients don't have a blood group on record. HR requested that if Directorates have a patient adversely affected i.e. their transfusion is delayed, then please flag on the Datix system and let him know.	**HR** **Dirs** **Dirs**
2.5	<u>Healthcare Associated Infections</u> <u>HCAI Report July</u> CM noted that the Clinical Boards performance in relation to Welsh Government expectations is satisfactory. For June; slightly over on C.difficile and one over on staphaureus. Under one for E.coli. One over for Pseudomonas and on target for Klebsiella. C.difficile haven't had a case since end of May which is very good. <u>Influenza</u> HR noted that our climate normally follows the southern hemisphere which has had a significant number of more cases reported early on. MH is meeting with Public Health Wales regarding their flu strategy. HR recommended that we start to vaccinate earlier this year. <u>IV Cannulas</u> HR noted that there is a meeting with the Ambulance Service on the 14th August about people who are cannulated at the road side. Trying to remove this as the environment is obviously not as clean at the roadside.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Health Care Standard 2.9 Medical Devices</u> Apologies from Colin Gibson. This will be a rolling agenda item.	

3.2	Feedback from UHB QSE Committee No feedback.	
3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups N&T CM informed the group that they had opened the David Thomas Daley's unit. Hoping building work on T5 will start end of the month to fix the bathrooms. New Drug Chart SG informed the group that there was a new version of the IP administration drug chart. All Directorates to be aware of it. This new version is already in use across the rest of Wales. It is important that the correct information is included on the chart. No stickers needed. Slight differences in layout and design to the old chart. All areas to nominate someone to recycle unused old drug charts. New chart available on oracle. RB noted that Neuro were sticking with the current chart for long stay patients for now as there was no new version for long stay as yet. This is for adult acute areas. It was noted that the booklet feels more robust which is good. Ongoing Issues at Rookwood RB noted that there were ongoing estates issues at Rookwood. Recent worsening of estates in the Old House. Largely offices but clinical psychology area. The roof has been leaking and there is a significant amount of water going through the roof. Working with estates to get this fixed. Ongoing issue. 40 or 50 staff work out of the Old House. OP floor has also recently given way. A pipe was leaking which rotted the wood. Cleared area entirely. Work is underway at UHL on the new site. Estimating this will be finished by end of 2020.	**Dirs** **Dirs**
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFROMATION BY THE COMMITTEE		
4.1	- Specialist Services Health & Safety Minutes – 14th May 2019 - June's Patient Feedback Reports (Inpatients and Outpatients)	
PART 5: ANY URGENT BUSINES		
5.1	Any Urgent Business HR referred to an issue that Carys Fox had asked him to raise in relation to the cleaning of the laryngoscope handles in CITU and the ward resus trolleys. Reusable handles have to be cleaned with Tristel wipes. It was noted that individual wards look after their resus trolleys. HR requested that Directorates look at their infection control regarding laryngoscope handles. Office Move SC noted that the Patient Safety department would be moving to Woodland House on the 5th August.	**Dirs**
PART 6: DATE OF THE NEXT MEETING		
6.1	Friday 9th August 2019, 8am, in the Critical Care Resource Room, UHW.	

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 30th July 2019 08:00-10:30 hours
Council Room, A BI, UGF

CONFIRMED MINUTES

Present		
Clare Wade	Interim Director of Nursing	CW
Richard Hughes	Consultant Anaesthetist (Chair)	RH
Gillian Edwards	Lead Nurse, T&O	GE
Rafal Baraz	Quality & Safety Lead, Anaesthetics	RB
Tracy Johnson	Practice Development Nurse, T&O	TJ
Mark Bennion	Clinical Governance Facilitator, Perioperative Care	MB
Andy Jones	Lead Nurse, General Surgery, ENT, Ophthalmology, Urology	AJ
Adrian Turk	Pharmacy	AT
Vince Saunders	Infection Prevention and Control	VC
In attendance:		
For Item		
Julie Cornish	CB R&D Lead, Consultant Surgeon	JC
Edwina Shackell	PA, Surgery Clinical Board	ES

PART 1: PRELIMINARIES *(Chair)*		**Actions**
19/94	**Patient Story: Trauma & Orthopaedics, Apixaban Root Cause Analysis (RCA)** TJ summarised the patient history. A total knee replacement had been undertaken in early December 2018. The timeline of subsequent events was described. Key events: - The patient had experienced nausea for 2 days post-operatively therefore refused medication. - Apixaban was given from the 3rd day onwards. - 3 days post-surgery the patient felt unwell, was mobilised by physiotherapist, but lost their balance and collapsed. Key findings: - Lack of evidence of full nurse handover when the patient was moved to different areas of the ward. - Two doses of Apixaban had been missed Key Actions: - All nurses had undergone VTE and anti-emetic therapy training. - The process of moving patients to different areas on ward had been reviewed. - The practice of administration of medication on the ward had been reviewed. Previously one nurse had administered medication for the whole ward. Nurses now administer medication to their own patients only. - New medication charts had been introduced. Discussion:	

	- It was considered probable that the omission of Apixaban for 24 hrs did lead to the patient developing a pulmonary embolus and subsequent admission to ITU and prolonged hospital stay thereafter. - Clexane should have been given as an alternative to Apixaban. - Staff had focussed on nausea, and had missed the omission of Apixaban. Learning: - An alternative VTE drug to Apixaban should be considered for patients with post-operative nausea. - Alternative anti-emetics should be requested. In this case Cyclizine was not immediately prescribed.	
19/95	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
19/96	**Apologies for Absence** Received from Catherine Twamley, Cath Bradshaw, Barbara Jones, Catherine Evans, Chris Williams, James Morgan, Yvonne Hyde, Carol Evans.	
19/97	**Declarations of Interest** Nil declared.	
19/98	**Approval of the minutes of meeting held 7th May 2019** Accepted as an accurate record.	
19/99	**Matters Arising:** **To receive Action Log from 7th May 2019 meeting** 18/41 25/9/18: AWMSG 2224: Cefuroxime 50g powder for intracameral injection. Discussed at Ophthalmology Q&S, now in use. AdT advised that he was not aware of any old formula in use. **CLOSED.** 18/105 3/7/18: Orthopaedic Thromboprophylaxis regimes: prescription of Aspirin. There had been no consultant representation at the recent TAAG meeting; any agreement to use Aspirin requires consultant sign off. Current practice therefore to continue. **Update next meeting**. 19/52 12/3/19: Ombudsman's Report: Assurance to be provided by Directorates that their consent for surgery has been reviewed. Directorates to add to risk register any patients consented on the day of surgery. T&O – assurance **RECEIVED** that this had been presented at the last Quality & Safety meeting and minuted. ENT, Ophthalmology, General Surgery, Urology: assurance **RECEIVED** that this had been discussed in consultants meetings and in directorates. **CLOSED.** 19/70 7/5/19: DOSA ward patient care. Datix forms to be completed if staff have concerns. Actioned. **CLOSED.** 19/77 7/5/19: Health Care Standards Audit November 2018: Directorate feedback. Feedback **RECEIVED** post-meeting for ENT, Ophthalmology, General Surgery, Urology. **CLOSED.** 19/79 7/5/19: Waiting List assurance > 36 weeks. Assurance RECEIVED from ENT, Ophthalmology, General Surgery, Urology that this is on the Risk Register and has been discussed at Directorate meetings. **CLOSED.**	
19/100	**Physiotherapy arrangements for colorectal surgery patients** Julie Cornish explained that the complication of prolapse associated with colorectal surgery increases with age. Currently, Urogynaecological patients can access physiotherapy for urine incontinence. There is currently no support for faecal incontinence. The UHB is currently not following the guidelines. Patients should not be operated on without access to physiotherapy.	

	There are now more than 50 bowel surgery patients who should not have been operated on. Ms Cornish cited a surgeon in an English Trust who is facing legal action by 156 women who claim they should not have been operated on without physiotherapy. That Trust is now looking at the tranche of patients, and awarding £75k per patient regardless of whether they have post-operative issues. A Business Case has been written for Cardiff and Vale. . AJ had been unaware of this. **Action: AJ to liaise with Guy Blackshaw and Tina Bayliss to determine progress. CW also to raise this with Tina Bayliss.** Ms Cornish advised that the Chief Executive is supportive of employing a Band 7 Physiotherapist for colorectal patients. The constraint to implementation would appear to be financial; however there is a major issue with regard to both clinical risk to patients, and financial risk. The issue had been brought to this Group as this is a clear clinical risk; it was hoped that this Group could bring pressure to progress the Business Case. RH agreed this would be 100% supported as a Quality and Safety issue. However this Group was outside the financial process. He advised that the route for authorisation of the Business Case would be via the Directorate, then via the Clinical Board via the Integrated Medium Term Plan (IMTP). MB queried if a risk assessment had been completed. This would score high, and would flag this issue via another route.	**AJ & CW**
19/101	**New All Wales Inpatient Drug Charts including new antimicrobial section:** <u>For Doctors – presentation</u> AT identified the key changes to the charts: - New antimicrobial chart included. The Chart is designed as a multidisciplinary document to be used to support antimicrobial prescribing. C&V is the last HB to introduce this. There had been no issues raised by other HBs. A pilot had been completed in C&V with no issues; the charts would now be rolled out. The antimicrobial section was described in particular the section at the back of the document '~~admitted~~ omitted or delayed doses'. - Supersedes the need for antimicrobial sticker. - Clinical indication documented on chart, and prompts to review/change/stop. - 7 day section – indication, duration, rationale, guidelines. - Prolonged section – 14 spaces. Key change is that **individual dates are NOT written across the top** as previously, but are on **INDIVIDUAL LINES requiring individual dates to be written in.** - 48 hr review prompt. - VTE prophylaxis moved to page 5, with a prompt for rationale. New section: Record missing /delayed doses. - Implementation 7th August 2019. The presentation has already been taken to some meetings and AT would present to others. Questions: - The new Chart is already in use in some areas following the directive to order these. - RH noted the areas in Orthopaedics – Foot & Ankle, Shoulder, where consultants are clear that patients do not need VTE. The change is that now they will have to sign to say that they are NOT prescribing. - All old charts to be removed from wards and handed to Pharmacy who will allocate them to appropriate areas.	

	For Nurses – slides noted for information	
PART 2:	**PATIENT SAFETY AND QUALITY**	
19/102	**Director of Nursing Q&S Report July 2019** June data SIs open – 11, a significant reduction on the previous year: - New in month – 3: 2 x pressure damage; 1 x delayed patient transfer Closed SIs – 2, both pressure damage. Datix queues – colleagues are urged to continue to address this; there remain 144 open after 60 days. **Action: Lead Nurses.** Mortality Reviews Level 1 completion 70%, a decrease. **Action: All areas to discuss at directorate Quality & Safety forum**. RH agreed that the need to complete both sides of the form needs to be reiterated with the new tranche of Junior doctors.	**LNs** **Directorates**
19/103	**Directorate Assurance Reports:** 1. <u>General Surgery & Wound Healing, ENT, Urology & Ophthalmology</u> - ENT:UVB decontamination system delayed – anticipated mid-August. - ENT: recent patient death, referred to coroner and an RCA underway - Ophthalmology insourcing RCAs. Expert opinions received. - Business Continuity planning underway all directorates - Surgery vascular mortality review: independent expert report awaited. - Risk registers reviewed/scheduled. - IP&C: C Diff x 1; MSSA x 1: Klebsiella x 1 - Assurance received that actions on the Action log had been completed. 2. <u>Perioperative Services</u> - BD extension sets recall notice. All clinical areas informed, devices removed from Recovery areas. - Neurosurgery microscope: incident forms regarding functioning of this kit. A risk assessment and capital bids request completed. - Scope decontamination room mains, refurbishment underway, due for completion3 to 4 weeks. - SSSU – Patient Group Directive; nurses administering eye drops pre-surgery. - POAC – concerns regarding the isolation of unit and lack of access to emergency services when patients become unwell. - UHL mains – incorrect breast dye injection, RCA complete, actions underway. - UHL mains - wrong site botox injection, RCA complete. A meeting had taken place with the Executive Nurse Director. Closure form now being drafted. - UHL mains – Hire process. T&O Surgeons not following the correct process leading to error and patients cancelled due to lack of availability of kit. - UHL will continue to use re-usable instruments for tonsillectomy and adenotonsillectomy in line with the 2019 report. - DSU building underway and on schedule. - Black & Grey – it was assumed that the funding arrangements for the anaesthetic equipment was in order. 3. <u>Anaesthetics</u> - Zoll Defibrillator: the Phillips are being replaced with Zoll. Dates for drop in training sessions have been circulated. - Lack of anaesthetic equipment: (Nerve stimulators, TIVA pumps and BIS monitors). See report for agreed actions. - Return of traceability labels to blood bank: Increasing incidents. See report for assurance of actions undertaken to address this. - All Wales New Drug Chart: correspondence circulated. A follow up email will be sent by RB alerting the changes highlighted at 19/101 above. 4. <u>Trauma & Orthopaedics</u> - Periop audit VTE assessment audit discussed.	

	- Nurse Practitioners had reviewed pre-operative constraints and noted ECGs, rejected bloods, VTE, AES as issues. Consent forms – ambiguity or wrong side. - PSA 009 Feb 2019 – Wrong selection of orthopaedic fracture fixation plates. Not used in the UHB. Assurance already given - Patient consent discussed. 5. Dental Report saved here: ..\2019 07	
19/104	**Exception reports from Directorates/Working Groups** 1. General Surgery, Vascular , Wound Healing: nil 2. Head & Neck, Maxillo Facial and Ophthalmology: nil 3. Urology: nil 4. Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: o Pain team: McInley Bodyguard infusion devices shortage, currently borrowing from Clinical Engineering. o Shortage of P5000 devices – work underway to identify devices going forward o Pain Unfunded service to paediatrics – on Risk Register, Business Case submitted. o Draft Throat Pack Policy, will go to Directorate Q&S then be brought to this Group before progressing to UHB QSE Committee. o Risk Assessment complete regarding interventional radiology issues, lack of blood gas machines, rapid infuser, scored 25. This is essential for the Major Trauma Centre. A meeting is planned for 2/8/19. 5. Trauma and Orthopaedics 6. Class 3 implantable medical devices. RH noted that bar codes should be scanned and recorded, but the issue is that equipment is unpacked from the barcoded packaging and placed on a generic tray. MB had clarified with Clinical Engineering that Class 3 implants are those where failure give risk to life. Mark Campbell is looking further into spinal screws.	
19/105	**Alerts and other Safety Notices** NICE Guidance 1. Surgery CB summary spreadsheet. There were no outstanding returns. Patient Safety Notice 2. PSN009/February 2019: Wrong selection of orthopaedic fracture fixation plates. **ASSURANCE RECEIVED** not in use in this UHB Medical Device Alerts 3. MDA/2019/023: 25 July 2019: Update of guidance on clearance and management of healthcare workers living with a Bloodborne Virus (BBV) **RECEIVED and NOTED.** 4. MDA/2019/026(Wales): 24 July 2019: Professional use capillary blood specimen collection: BD Microtainer tubes – risk of blood leakage and/or incorrect test results due to defective tubes. CW had contacted Procurement and was awaiting their response as to whether in use within Surgery Clinical Board. **Action: add to action log update next time.** Public Health 5. CEM/CMO/2019/03, 24th May 2019: Influenza season 2018-19 – Cessation of use of antivirals now recommended. **RECEIVED and NOTED.** 6. Public Health Wales Briefing: Influenza southern hemisphere season 2019 – early start and Message for Wales. **RECEIVED AND NOTED for dissemination to teams.** Rates were currently very high in Australia. VC noted that it was likely there would be a high infection rate in the UK. CW confirmed that the “Clinical Board flu campaign”	**CW**

	planning was underway. Welsh Government 7. Medicines Shortage Advisory Group Wales: CPHO/MedsLet2019/03: Disruption to supply of diamorphine 5mg injection/Clinical Memo. AdT advised that this was a sporadic issue which should be resolved in early August. RB will email a reminder to colleagues regarding the dilution rate of 10mg doses. 8. Medicines Shortage Advisory Group Wales: CPhO/MedsLet/2019/04: Disruption to supply of Microgynon 30 tablets and Ovranette tablets/Bayer Healthcare Professional Communication 8th May 2019. **RECEIVED** for information. 9. Healthcare Safety Investigation Branch (HSIB) letter 26th June 2019 re piped medical oxygen. This had been discussed previously. CW confirmed that all Surgery Clinical Board wards had previously provided assurance that all supplies had been disconnected and capped off. Welsh Health Specialised Services Committee (WHSSC) 10. Publication of Commissioning Policy for CP50a, Positron Emission tomography for Welsh residents, letter 3rd June 2019 11. Specialised Services Commissioning Policy: CP50a. Positron Emission Tomography May 2019 **RECEIVED and NOTED.** Communications from UHB: 12. Medication Safety Executive Briefing Issue 30, May 2019: Insulin – Raising Awareness of Safety Issues/Clinical Memo AdT advised that patients continued to be admitted who were on insulin strengths of 200 and 300 units per ml RB confirmed that all insulin prescribed in anaesthetics is Actrapid 100 units per ml. 13. BD Product Concern – all areas had been notified of the recall notice, assurance required from users in SCB. **ASSURANCE RECEIVED** via the Perioperative Report above, that all clinical areas had been informed and all devices removed from Recovery areas.	
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
19/106	**Key Messages from Board/ Committees/ Groups** 1. UHB Medicines Management Group Notes 2nd May 2019 2. UHB Medicines Management Group Notes 6th June 2019 3. UHB Medicines Management Group Notes 4th July 2019 - Hydroxychloroquine retinal monitoring. This was prescribed outside the Clinical Board. Work is in hand regarding the funding of screening, which requires an additional Consultant Ophthalmologist post. Currently 800 patients are prescribed this drug in Rheumatology and Dermatology. A side effect can be retinal deposits of the drug, which needs regular monitoring and is on Medicine Clinical Board's Risk Register. Community Optometry had been consulted; however they did not have the equipment. Mr Banerjee was leading for the Health Board. **Action: AJ to liaise with Mr Banerjee.** - Unlicensed medicines: Oral ~~midazolam~~ metaraminol solution: due to be licensed in approximately 6 weeks. AdT had liaised with Naomi Goodwin, and anticipated that its introduction would save waste. - Methoxyflurane inhalation for manipulations in emergency departments: this had been rejected due to the UHB financial position. Pharmacy had registered its	**AJ**

	concern that this decision came at a cost to the patient, and would have provided savings on resuscitation and beds. 4. Clinical Board IP&C Group – verbal feedback 22nd July 2019 Draft Minutes to follow. 5. Clinical Board Health and Safety Sub Group. Next meeting 14th August 2019 6. 7. Decontamination Committee Minutes 11th April 2019. Next meeting Friday 2nd August. Key issues: - Laryngoscope handles. VC advised that the 3 stage Tristel wipe process had been rejected. Mark Campbell, HSDU Manager, had been tasked with completing a baseline audit of the current process and reporting to the next UHB IPC Committee. - Gastroscope Root Cause Analysis was currently with Clive Morgan 8. Safeguarding Steering Group Minutes 30th May 2019. Meeting 25th July: male staff members had been asked to complete white ribbon training. 9. C&V UHB Safeguarding Children & Adults at Risk, Annual Report 2018/19 An informative report, highlighting the very high and rapidly increasing incidence of FGM in Cardiff. 10. Orthopaedic Infection Quality Improvement Group Minutes 29th March 2019 Good consultant engagement with several workstreams. 11. TAAG Group Minutes. This related principally to Trauma and Orthopaedics, and the use of Anti Embolic Stockings (AES), or Aspirin/Apixaban. SSSU is working through the issues. The cessation of AES use is meanwhile on hold. RH noted that with regard to Urology robot surgery, peer units use TEDS or Flowtron boots. 12. Water Safety Group Minutes 6th March 2019. Minutes of the most recent meeting awaited. Issues raised included Estates policy of removing all self-standing water dispensers. However, concerns had been raised regarding accessibility of fresh water for a significant number of staff. Piped water to all areas is cost prohibitive. **13.** Patient Safety & Quality Newsletter Summer 2019. **RECEIVED and NOTED.**	
19/107	**Medical Equipment Group (standing item)** 18th July 2019 minutes of meeting to follow. RH highlighted the following: - Class 3 implantable devices. - Medical equipment replacement. All colleagues were asked to consider requests. New equipment that would necessitate Estates' involvement regarding water supply should be included in Directorate and Clinical Board Integrated Medium Term Plans (IMTP). - Awareness regarding artificial optical radiation. A survey would be undertaken regarding the risk to staff of ie lasers and UV light (Dental). - It was acknowledged that the Clinical Board is faced with the issue of funding a significant list of replacement kit under the value of £5K, outside of the Medical Equipment Group (MEG) remit. This had been flagged at MEG.	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
19/108	1. Surgery Clinical Board IPC update 20th April 2019. **RECEIVED and NOTED.** 2. Clinical Board HCAI review to end of June 2019: - C.difficile – 6 - MRSA – 2	

	- MSSA – 3 - E.coli – 80 - Klebsiella - 3 Current focus to address MRSA/MSSA is on A2 and B2. VC noted that the CDiff total for 2018/19 had been 9; the current total year to date is 7. 3. IP&C RCA database: - noted 4. Injurious Falls Report – 1, not reported to WG 5. Pressure Damage Report. It was noted that the Interim Director of Nursing was required to meet with the Executive Nurse Director to review a recent case that has been reported to WG to discuss lessons learnt 6. NHFD Update: Lightfoot is engaged reviewing data working with Mr Anthony Johanssen to explore schemes of work to reduce LOS and loss of mobility in frail trauma patients.	
19/109	**National and UHB Audit Reports**: 1. Paediatric Theatres Environment Audit 10/4/19. This has been presented at Nursing Board. Action plan underway. 2. Perioperative Care: an audit to measure VTE risk assessment compliance The Education team had audited in all theatre departments. SSSU and UHL theatres were found to be good. Mains UHW, teams to be reminded to complete risk assessments, sign and date. Assurance was provided that no patient reached theatre if the risk assessment was incomplete. **Action: Share with all theatre using directorates**. 3. Surgery Clinical Board Audit Plan. The Board had been asked to submit to Audit plan to Committee, track, and update in 2020. Support had been sought for central admin support for the national audits; funding for this had been rejected, and falls to the Clinical Boards, e.g. Vascular Centralisation require a data inputted to feed in to national audits. **4.** Feedback on A5 Action Plan: CHC action plan recently submitted. **Action: to be brought to the next meeting. AJ**	**BJ** **AJ**
19/110	**HIW/CHC visits** 1. Feedback on Ophthalmology CHC Action Plan July 2016. Hayley Dixon, General Manager, had been tasked with providing and update on actions and assurance that actions had progressed. 2. T&O Health Inspectorate Wales (HIW) Self-Assessment 12 July 2019 The CB has been notified of a 10 day turnaround regarding the perioperative pathway for T&O patients. The final updated Self-Assessment had been submitted on 25/7/19. The unannounced arrival of HIW was awaited. 3. Update on AU HIW report It was explained that HIW had carried out an unannounced visit to the Admissions Unit lounge at a weekend in March. They had deemed patient care to be unsatisfactory due to some patients being cared for in this area for more than 24 hours, and mandated immediate actions. The Surgery Clinical Board had been asked to support the area. A business case had been written for SAU opening 7 days, and this has been accepted. A Trauma Ambulatory Care Unit (TACU), based in 4 beds on Duthie Ward in August had also been accepted, which it was anticipated would move to SSSU. 4. Ophthalmology HIW IP Feedback. To follow.	

19/111	**Waiting list follow up assurance >36 weeks:** 1. ENT: no significant issues 2. Ophthalmology: ongoing insourcing for cataracts/oculoplastics. The waiting list remains of significant concern 3. Urology: ongoing issues regarding follow ups; efforts to secure funding were underway. 4. General Surgery: no significant issues.	
19/112	**Transfusion Committee** 1. Minutes of meeting 5th April 2019 2. Zero Tolerance Report May 2019 3. Zero Tolerance Report June 2019 4. Traceability Non-Compliance for June 2019 5. Incident Report 1st March 2019 – 31st May 2019. It was noted that CW had received incident forms for any transfusions which Haematology had been unable to trace as given. **Action: CW to share the report.**	**CW**
19/113	**Health Care Standards Self-Assessment** No feedback following submission in April 2019.	
PART 5: GOVERNANCE		
19/114	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. Open Serious Incidents (SIs), No Surprises: 11, one longstanding nearing closure. ▪ Ophthalmology SIs: 14 RCAS nearing completion. Statements had been received from SHS with the exception of one. ▪ Vascular MDT Review – see above. The Clinical Board will fund the cost of the report. ▪ Gastroscope update – see above. RCA complete, awaiting final meeting. 2. Regulation 28 report & Open Inquests: one pending. 3. Serious Incidents: 1. Closure forms sent to WG since 1st January 2019: 30 2. Closed SIs report – please see Director of Nursing Report at 2.2 above. 4. Complaints, Claims and other Concerns 1. All Open Clinical Negligence Claims 25/4/19 to date: 9 open, some longstanding. 2 All Closed Clinical Negligence Claims 25/4/19 to date: 12. Useful and informative reports.	
19/115	**NATSIPPS Task & Finish Group** The last meeting had been cancelled. No current update.	
19/116	**Throat Pack Policy update** Drafted by Margaret Coakley, in process via Perioperative Quality & Safety.	
19/117	**Standing Item:** 1. Point of Care Testing (POCT) Group 2. Glucose Emergency Barcode: updated communication from the POCT Team. None of the Surgery Clinical Board areas are permitted to use the Emergency Barcode. To Note: - Ensure **Patient Number** is scanned **NOT** the NHS Number. - Press Accept to upload - An audit had identified that staff were not dating solution and strip pots. - The Business Intelligence System (BIS) was producing more useable data reports.	

	- Pregnancy testing: Gold standard is to have machines (at a cost of £2k/machine) in all areas enabling Healthcare Support Workers to administer tests. Manual pregnancy tests are to be carried out by a Registered Nurse only.	
19/118	**Electronic Pathology Test Requesting and Results Reporting in the Welsh Clinical Portal** **RECEIVED and NOTED**	
19/119	**Patient Experience:** 1. UHW patient/relative experience "walk through" 30th April 2019 **RECEIVED** for information. To be disseminated via Professional Forums for learning. 2. Your NHS Wales Experience – patient survey form 3. Cardiff National Survey, Surgery Clinical board **RECEIVED and NOTED**	
19/120	**Research & Development** Research Governance Group (RGG) Minutes of meeting 30th April 2019 **RECEIVED and NOTED.**	
19/121	**Delayed Transfers of Care** – Standing Item Report: June 2019. The Clinical Board is required to bring this report to this Group for noting. The Clinical Board continues to report monthly data. The majority of DTOCS related housing needs, and are discussed weekly. The negative impact of an extended hospital stay on patients was recognised. **RECEIVED and NOTED**	
PART 6: DATES OF NEXT MEETING **Tuesday, 10th September 2019, 08.00 – 10.30, Council Room, UHW.**		
PART 7: URGENT BUSINESS		
19/122	1. IP&C: VC referred to winter planning, and that all relevant staff should attend refresher training for fit testing. Codes for masks will be provided. It was noted that the Surgery CB collates an order and stores masks in one designated area. 2. EPIPAC: VC to liaise with Jon Barada, UHL regarding fit testing for this procedure.	
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
19/123	**Recent Reports & Communications** Nil received	
19/123	**Directorate Q&S Agendas/Minutes including M&M activity** 1. Trauma & Orthopaedics Directorate Q&S Notes & M&M information 2. Anaesthetic Q&S Minutes April, May, June 2019	

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 10th September 2019 08:00-10:30 hours
Council Room, A BI, UGF,
CONFIRMED MINUTES

Present:

Richard Hughes	Consultant Anaesthetist (Chair)	RH
Gillian Edwards	Lead Nurse, T&O	GE
Rafal Baraz	Quality & Safety Lead, Anaesthetics	RB
Mark Bennion	Clinical Governance Facilitator, Perioperative Care	MB
Andy Jones	Lead Nurse, General Surgery, ENT, Ophthalmology, Urology	AJ
Adrian Turk	Pharmacy	AT
Michelle Abel	Infection Prevention and Control	MA
Catherine Twamley	Senior Nurse, Perioperative Care	CT
In attendance:		JC
Edwina Shackell	PA, Surgery Clinical Board	ES

PART 1: PRELIMINARIES *(Chair)*		**Action**
19/124	**Patient Story: Ophthalmology** An increasing number of patients were presenting for cataract surgery under local anaesthetic with extremely high blood sugars, resulting in the procedure being postponed. This had highlighted the issue that patients listed in Ophthalmology Outpatients were told that Pre assessment would contact them. However, current practice was that a form was sent out which the patient completes at home. It did not appear that a telephone assessment took place simultaneously. In addition, the front of the form did not refer to blood sugar; it would appear that this change in practice of not telephoning the patient may be the cause of increased numbers of patients presenting. High blood sugar presents a significant risk of macular oedema which requires steroid medication or injections for a prolonged period. It was acknowledged around the table that patients' perception of their health and wellbeing frequently differed from a clinical assessment. Although access to GP records would give some indication of diabetic control, it was noted that this would not be a reliable indication, as patients were checked just twice yearly. Most cataract referrals were via optometrists who may or may not cite diabetes. **Action: AJ to discuss with Sue Mogford and feedback on actions.**	***AJ***
19/125	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
19/126	**Apologies for Absence** Received from Barbara Jones, Rowena Griffiths, Cath Evans, Clare Wade, Susan Mogford.	

19/127	**Declarations of Interest** Nil declared	
19/128	**Approval of the minutes of meeting held 30th July 2019** Agreed as an accurate record.	
19/129	**Matters Arising:** **To receive Action Log from the above meeting** 18/105 Orthopaedic Prophylaxis regimes: To remain on the Agenda. Planned meeting on 11/9/19 at T&O Quality and Safety. **Feedback next meeting**. 19/100: Physiotherapy arrangements for Colorectal Surgery patents. AJ had been unable to action due to Mr Blackshaw's absence on leave. **AJ to feed back next time.** 19/102 Datix queues: long standing queues had been reduced. **CLOSED.** 19/102: Mortality Level 1 completion: RH to write to the UHB medical induction facilitator to include in sessions. Noted that no 'PTO' on the bottom front of the form. **Action: RH** 19/105 MDA/2019/026 (Wales) 24 July 2019: Professional use capillary blood specimen collection: BD Microtainer tubes – risk of blood leakage and/or incorrect test results due to defective tubes. **CW to feed back next time.** 19/106 Hydrochloroquine retinal monitoring. AdT advised this is progressing but will take some months. There was a risk that GPs may refuse to prescribe. **CLOSED**	**CW** **AJ** **RH** **CW**
19/130	**Review Annual Work Plan** All to review and feed back to CW. To be approved at next meeting.	**ALL**
PART 2:	**PATIENT SAFETY AND QUALITY**	
19/131	**Director of Nursing Q&S Report July 2019** Summary: Open Serious Incidents: 11, 3 of which were new in month. Datix: decrease in waiting for review 30 – 60 days, slight increase in those over 60 days Level 1 mortality – decrease in compliance. Pharmacy audits positive IPC: C difficile - 1 MSSA - 1 E coli - 3 Klebsiella - 1	
19/132	**Directorate Assurance Reports:** 1. <u>General Surgery & Wound Healing, ENT, Urology & Ophthalmology</u>: - no audit in August. - ENT decontamination: UV system and room operational end September - RCA underway on complex Resus case A5N. - Ophthalmology: experts' reports received and overarching RCA completed. - Significant concerns regarding the volume of ophthalmology patient concerns received. - Business Continuity planning continuing - General Surgery – Vascular mortality review meeting arranged. - Vascular centralisation and rehabilitation plans continue to be developed. - Risk Registers reviewed recently in all four directorates. - Pressure Damage Reports: 4 overall, RCAs in place.	

	- No injurious falls - IPC – one Klebsiella, A2, July - Hand hygiene good in all areas. 2. <u>Perioperative Services</u> See report - Scope decontamination room refurbishment in main theatres complete. Equipment to be revalidated; supplier's reps to demonstrate use of machines to staff. - No issues SSSU - CHfW theatres – walls need whiterock reapplied, cost £30K, funding source not yet identified. - UHL mains –Grey theatre complete. IPC audited 30/8/19, first list anticipated mid October. - Anticipating Health and Safety inspection in October, focussing on staff Manual Handling and musculoskeletal injuries. RH noted that the Grey theatre had been planned without anaesthetic kit being factored in. This had been borrowed from Orthopaedic theatre 6, which in turn cannot now run general anaesthetic lists. With a view to CHfW theatres, these had been part of Phase 2, and were 5 years old. A source of funding for rectifying the issue remained to be identified. 3. <u>Anaesthetics</u> - Diamorphine shortage now resolved. - All Wales Drug Chart – circulated, and presenting 11/9/19 at Audit. 4. Trauma & Orthopaedics - No audit in August - Thromboprophylaxis issue to be discussed at audit 11/9/19. - Datix queues reviewed and slight improvement; the challenge remained for Ward managers to maintain the improvement. - NICE Guidance: MTG39 iFuse for treating chronic sacroiliac joint pain. **GE to ask Chris Wilson to provide a response.** - Pressure damage - 2 open SIs. Previous month: 6, RCAs completed. - Risk Register Review, date planned. - TACU (Trauma Ambulatory Care Unit) in Duthie ward, opened 9/9/19 – 6 chairs, 2 trolleys, 1 procedure chair for hand procedures/washouts. This had been provided in response to a Health Inspectorate Wales visit to the Assessment lounge where patients were experiencing prolonged stays. Open 0700 – 19.30 seven days a week. TACU patients did need to be able to be discharged home. 5. Dental: Report received and noted.	
19/133	**Exception reports from Directorates/Working Groups** ▪ General Surgery, Vascular , Wound Healing: nil ▪ Head & Neck, Maxillo Facial and Ophthalmology - nil ▪ Urology - nil ▪ Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: Use of TEDS in addition to Flowtron boots, by particularly Urology and some T&O consultants. The TAAG Group recommendation was to use either but not both. Urologists were using both, resulting in theatre staff being put in a difficult position, when surgeons' preference conflicted with UHB policy. MB had emailed Mr Nagappan Kumar, who in turn had emailed all Urology consultants. RH advised that Professor Kynaston had undertaken a comparison with all UK units, which all used double cover. RH was clear that continuing patient care was the surgeon's responsibility. The cost pressure to the directorate was noted; MB asked for a clear decision so that theatre staff could be comfortable. ▪ Trauma and Orthopaedics - nil	

19/134	**Alerts and other Safety Notices** NICE Guidance 1. Surgery CB summary spreadsheet – received and noted. 2. MTG16, September 2018: E-vita open plus for treating complex aneurysms and dissections of the thoracic aorta (Mr Whiston). This had been redirected to Cardiothoracics. 3. MTG17, March 2019: The Debrisoft monofilament debridement pad for use in acute or chronic wounds (Christina Harris, Wound Healing). **AJ to chase**. AdT believed used in community settings. 4. DG34, December 2018: Tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer (Guy Blackshaw). Sent to Helen Sweetland. 5. MTG39, September 2018: iFuse for treating chronic sacroiliac joint pain. (Simon White) **– GE will raise with Chris Wilson.** Public Health 6. Public Health Wales Briefing, 15 August 2019: Middle East Respiratory Syndrome and the Hajj. **RECEIVED and NOTED** 7. Public Health Wales Briefing, 6 August 2019: Ciprofloxacin resistant cases of non-groupable meningococcal infection connected to recent travel to Mecca. **RECEIVED and NOTED** 8. Public Health Wales Briefing, 21 August 2019: Update on listeriosis incidents in the UK. Noted that this relates to incidents associated with sandwiches in N Wales/England 9. Surveillance of Single-use Instruments for Tonsillectomy and Adenotonsillectomy Surgery in Wales, 2002 – 2015, Final Report: 16/7/2019. Assurance **RECEIVED** from Perioperative Care that the UHB is fully compliant with the Report recommendations. 10. Public Health Link 3 September 2019: CEM/CPhA/2019/20a: Hormone Replacement Therapy (HRT): further information on the known increased risk of Breast Cancer with HRT and its persistence after stopping **RECEIVED** for awareness Welsh Government 11. WHC(2019)024: 30 July 2019: Pertussis – occupational vaccination of healthcare workers. It was advised that this is relevant to all directorates. **Action: RB to seek advice from Nicky Bevan, Occupational Health on who should be vaccinated.** Welsh Health Specialised Services Committee (WHSSC) 12. 16 August 2019: Bone Sarcoma Referral Pathway – Letter from Dr Sian Lewis. **GE to raise at T&O audit 11/9/19.** 13. 18 July 2019: 2019/20 Review of the WHSSC Specialised Services Policy CP50a: Positron Emission Tomography (PET) and WHSCC Proforma for new PET indications 2019/20. **RECEIVED and NOTED.** Communications from UHB: The following were **RECEIVED and NOTED:** 14. Anticipated 'flu this winter: email 6 August. 15. Pandemic Influenza: A summary of guidance for infection control in healthcare settings 16. Health Protection Scotland: Assessment of Evidence Optimal Patient Placement during Influenza Pandemics, June 2019. 17. Health Protection Scotland: Assessment of Evidence for Influenza Transmission mode(s), June 2019 18. Health Protection Scotland: Evaluation Tool. It was noted that 'flu was virulent in the southern hemisphere. Patient placement: Michelle Abel was exploring rapid testing in key areas. Flu vaccine was being developed, vaccination planned focussing on key areas. It was noted that many people presented at the front door who should not. Rapid diagnosis and correct placement of patients required improvement to avoid	**AJ** **GE** **RB**

	unnecessary closure of beds. More children outside of the vaccination age ranges were admitted to ITU last year. 19. SBAR 29/8/19: Uptake of Zoll Defibrillator familiarisation training Concern was raised regarding the lack of engagement in completing this training. Feedback had been received from one Anaesthetist only. It was very unlikely that trainees would have watched the training video. **Action: RB to liaise with Resuscitation** RB advised that Anaesthetics was running a course. RB would contact the trainers to check progress. It was noted that one constraint was the requirement to access a PC with speakers. It was confirmed that a computer had been set up on B3. **Action: All to raise this issue at Audit 11/9/19 and to ensure that all those who have not been trained do so.**	**RB** **ALL**
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
19/135	**Key Messages from Board/ Committees/ Groups** 1. UHB Medicines Management Group Notes 1st August 2019 Report received. Medicines for Ratification for inclusion in C&V UHB formulary: one new, NICE ID1039, Ophthalmology, recurrent non-infectious uveitis treatment. RH advised that unpaid NICE Fellowships and Scholarships were available, information on the intranet. These roles were in addition to individual's substantive role. 2. Clinical Board H&S Group. Feedback deferred. 3. Decontamination Committee Minutes 2nd August 2019. **RECEIVED and NOTED.** o Gastroscope RCA now complete. The report would be presented at the next Decontamination Group. o Laryngoscope handles: the Executive Director of Therapies and Health Science had asked to be provided with the risk assessments. The Perioperative Directorate was clear that a UHB wide approach was essential due to the significant cost implication of compliance. The Chair of the Decontamination Committee had relayed this to the Executive Directors who had fed back advising that it was each Clinical Board's responsibility. MB advised that some clinicians felt the risk relative to the cost was 'unproven'. 4. Clinical Board IPC Sub Group – Draft Minutes 22 July 2019 Improvements in IP&C compliance noted.	
19/136	**Medical Equipment Group (standing item)** Minutes of meeting 18th April 2019 Colleagues were advised that 2019/20 funding is minimal, maximum £1m across the UHB. Bids over £5k per device. **Action: Each clinical area to consider their bids, backed by risk assessment and quotes ready for collation and submission**.	**ALL**
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
19/137	1. Surgery Clinical Board IPC update August 2019 Report **RECEIVED.** Key issues: Audits were continuing to identify environment issues. Addressing these remained challenging in the absence of a decant ward. HPV cleaning Urology flexi suite: it was noted that when vents were covered in this new room to facilitate HPV cleaning, they were damaged and needed replacing.	

	Learning from a C.Diff RCA was shared. ANTT compliance. It was noted that this learning module was available to clinicians on line, but that some medical staff remain non-compliant. Some ward areas 100%. 2. Clinical Board IP&C Report 2019 C Diff: increase of 3 compared to 2018/19. . MRSA screening audit: it was noted that some patients were not being screened, and that this needed to improve. VIPS audit identified lack of continuity in documentation, in particular non transfer of line details from the Anaesthetic chart to the nursing document. Environmental factors, linked to housekeeping vacancies, staffing levels, and acuity of patients, continued to be a significant challenge. Michelle Abel advised that MDRO screening in addition to MRSA screening would be rolled out across the Clinical Board. A clinical risk assessment was available. The checklist would identify patients who should be screened as policy, irrespective of area. FIT testing – 2 cascade trainer sessions arranged, 19th & 20th September, 1 hour. Essential for anaesthetists. New staff needed to be tested to see which mask fit them. Sessions were aimed at ward staff. 3. IP&C RCA database: **RECEIVED and NOTED.** 4. Falls Report – one unavoidable fall in T&O. 5. Pressure Damage Report. GE confirmed discussed at all nursing forums.	
19/138	**National and UHB Audit Reports**: Nil received.	
19/139	QUAD Audits Nil undertaken	
19/140	HIW/CHC visits – update A6 – Repeat visit to A6 to check if ward had been refurbished. It had not. Ophthalmology Outpatients – repeat visit as above.	
19/141	**Waiting list follow up assurance >36 weeks:** ▪ ENT ▪ Ophthalmology – long waiting, see report. Meeting set up next week with the Clinical Board and Directorate. ▪ Urology – report received. ▪ General Surgery. ▪ T&O: Preoperative assessment clinic was a significant constraint. GE meeting with staff 11/9/19 to progress.	
19/142	**Transfusion Committee** Traceability Non-Compliance for July 2019: - Shared with directorates, including wards. - Theatre 11 – 3 returned. MB noted that these may relate to one difficult event. All were reported on Datix and reviewed for action. RB confirmed that there had been significant work completed on this issue.	
PART 5: GOVERNANCE		
19/143	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. Open Sis, No Surprises: 14 across several Directorates. ▪ Ophthalmology SIs – feedback received as above. ▪ Vascular MDT Review – update next time.	

	▪ Gastroscope update – RCA complete, action plan completed, to be presented at Decontamination Group to agree actions, then to be brought back to this group. (MB). 2. Regulation 28 report & Open Inquests: 5 3. Serious Incidents: 1. Closure forms sent to WG since 1st January 2019. 1 closed. 2. Closed SIs report – please see Director of Nursing Report at 2.2 above. 3. Closure Summary In87825 – Never Event. MB summarised the incident dating to March 2019 in CAVOC, the Action Plan and learning: - correct WHO procedures had been followed. - correct leg marked. - marked leg had been covered, examination by the surgeon when all other staff had left theatre led to a botox injection in the wrong ankle. The correct ankle was subsequently successfully treated. - 11/9/19 audit would give opportunity to individual staff for debrief. - Perioperative Care exploring setting up a minors injection procedure. - Requirement for staff to be present in theatre had been discussed. - daily worksheets completed. - reminder of 'stop before you block' protocol. - RCA, Action plan had been shared with the Clinical Director with a request for - Closure form drafted and sent to Carol Evans. 4. <u>Complaints, Claims and other Concerns</u> 1. All Open Clinical Negligence Claims 25/4/19 – 27/8/19 .It was noted that it was informative to take to directorate quality and safety meetings, for medical staff to see. 2 All Closed Clinical Negligence Claims 25/4/19 – 27/8/19 – for noting and sharing via Q&S 5. Ombudsman's Report Datix 19179 Surgical patient. Relating to analgesia and pain management information. **Defer to next meeting in absence of CW**.	**ES/CW**
19/144	**NHFD Report** GE advised there were some issues re data entry, the data entry clerk post was held up at Scrutiny. GE to progress.	
19/145	**Review of Clinical Board Risk Register** Directorates confirmed that directorates reviewed monthly.	
19/146	**Standing Item:** Point of Care Testing Group No update available.	
19/147	**Patient Experience:** Cardiff National Survey 1st July 2019 RH – Medical Director and Chris Jones promoting PROMs, patient feedback. GE confirmed that this had been shared extensively with nursing areas, and actions undertaken.	
19/148	**Research & Development** Research Delivery Management Board Minutes 10th July 2019 – **RECEIVED and NOTED**	
19/149	**Delayed Transfers of Care 2019**– Standing Item Numbers remained constant, constraints due to CRT, packages of care, rehousing or nursing home placement. Meetings were held twice weekly in bed holding directorates.	
19/150	**Policies & Protocols** 1. <u>IV Lidocaine for Management of Acute Pain in Adult Patients Protocol and Care Plan</u>	

	Catherine Twamley presented the Protocol, which had been amended incorporating comments from Angela Jones, Resuscitation. This will be taken via Medicines Management Group and ratified as part of the complete updated Adult Pain Services Guidelines. The Protocol is would be implemented in PACU, 24 hours post-operatively with a very low threshold for stopping this. No adverse events to date. .. 2. <u>Paediatric Prescription Chart for Intravenous Patient/Nurse Controlled Analgesia</u> For noting. CT explained the measurements for different age groups, regimens as previously agreed. The previous format had been changed, with the 4 different regimes now together. This had been taken to Perioperative Care Quality and Safety, and to Paediatrics who had agreed to feed back to Medicines Management Group. **Update next meeting.**	**CT**
PART 6: DATES OF NEXT MEETING **Tuesday, 19th November 2019, 08.00 – 10.30, Council Room, A BI, UGF, UHW**		
PART 7: URGENT BUSINESS		
19/151	There was no urgent business.	
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
19/152	**Recent Reports & Communications** None received.	
19/153	**Directorate Q&S Agendas/Minutes including M&M activity** 1. Anaesthetic Q&S meeting 16th July 2019 – Agenda and Minutes **RECEIVED.** 2. Ophthalmology OP Q&S meeting 16th July 2019 – Agenda and Minutes **RECEIVED.**	