Quality, Safety and Experience Committee - 15 December 2020

Tue 15 December 2020, 09:00 - 13:00

Agenda

1. Standing Items

Susan Elsmore

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 8th September 2020

Susan Elsmore

1.4 Draft Public QSE Mins - 08.09.2020.pdf (9 pages)

1.5. Action Log – 8th September 2020

Susan Elsmore

1.5 Action Log Sept 2020.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Susan Elsmore

1.7. Advancing Applied Analytics Health Foundation Project Presentation

Carol Evans / Andrew Carson-Stevens

1.7 Advancing Applied Analytics Health Foundation Project.pdf (11 pages)

2. Items for Review & Assurance

2.1. Quality Indicators Report

Ruth Walker

2.1 Quality Indicators - DEC QSE v2.pdf (7 pages)

2.2. Exception Reports

Ruth Walker

Verbal

2.3. Impact of COVID-19 on Patient Safety

Ruth Walker / Stuart Walker

- 2.3 Impact of COVID-19 on Patient Safety-V2.pdf (3 pages)
- 2.3 Appendix 1 - Follow up letter from DCMO re SI and NS reporting - 2020-11-25 PDF.pdf (3 pages)
- 2.3 Appendix 2a - ToolKit.pdf (7 pages)
- 2.3 Appendix 2b - HCA Covid-19 Rapid Patient Assessment form V7.pdf (2 pages)
- 2.3 Appendix 3 - COVID 19 MCCD (1).pdf (1 pages)
- 2.3 Appendix 4a - CoRSEL report 1.pdf (1 pages)
- 2.3 Appendix 4b - CoRSEL report 2.pdf (1 pages)

2.4. Public Services Ombudsman for Wales Annual Letter

Ruth Walker

- 2.4 Ombudsman Annual Letter QSE report final.pdf (5 pages)

2.5. Clinical Board Assurance Reports:

Alun Tomkinson / Clare Wade / Mike Bond

1) Surgery Clinical Board

- 2.5.1 Surgery Clinical Board QSE assurance report.pdf (21 pages)

2.6. Health Care Standards Self-Assessment Plan and Progress Update

Ruth Walker

- 2.6 Health and Care Standards - December 2020 - V3.pdf (29 pages)

2.7. Board Assurance Framework – Patient Safety

Nicola Foreman

- 2.7 BAF Covering Report.pdf (2 pages)
- 2.7 Patient Safety BAF Risk Dec 20.pdf (3 pages)

3. Items for Approval / Ratification

No Items

4. Items for Noting & Information

4.1. Quality, Safety & Experience Workshop – Feedback & Action Plan

Ruth Walker / Stuart Walker

- 4.1 QSE Workshop Feedback - Dec 2020.pdf (14 pages)

4.2. Minutes from Clinical Board QSE Sub Committees – Exceptional Items to be raised by Assistant Director, Patient Safety & Quality

Carol Evans

4.2.1. Clinical Diagnostics and Therapeutics – 8 July, 12 August, 9 September, 14 October

- 4.2.1 CD&T Minutes 8.7.20.pdf (10 pages)
- 4.2.1 CD&T Minutes 12.8.20.pdf (11 pages)
- 4.2.1 CD&T Minutes 9.9.20.pdf (10 pages)
- 4.2.1 CD&T Minutes 14.10.20.pdf (14 pages)

4.2.2. Mental Health –

4.2.3. Primary, Community and Intermediate Care –

4.2.4. Specialist Services – 5 June, 26 June, 17 July, 25 September

- 4.2.4 Specialist Minutes 05.6.20.pdf (8 pages)
- 4.2.4 Specialist Minutes 26.06.20.pdf (5 pages)
- 4.2.4 Specialist Minutes 17.7.20.pdf (7 pages)
- 4.2.4 Specialist Minutes 25.9.20.pdf (8 pages)

4.2.5. Medicine – 20 August, 24 September

- 4.2.5 Medicine Minutes 20.08.20.pdf (6 pages)
- 4.2.5 Medicine Minutes 24.9.20.pdf (8 pages)

4.2.6. Surgery – 22 September

- 4.2.6 Surgery Minutes 22.9.20.pdf (17 pages)

4.2.7. Children and Women – 23 June, 27 August, 27 October

- 4.2.7 C&W Minutes 23.6.20.pdf (6 pages)
- 4.2.7 C&W Minutes 27.8.20.pdf (4 pages)
- 4.2.7 C&W Minutes 27.10.20.pdf (6 pages)

4.3. Self-assessment of Committee Effectiveness & Forward Action Plan

Nicola Foreman

- 4.3 Self-assessment of Committee Effectiveness.pdf (2 pages)
- 4.3 Appendix 1 - Committee Effectiveness Results 2019-20.pdf (9 pages)
- 4.3 Appendix 2 - Committee Effectiveness Action Plan.pdf (3 pages)

4.4. HIW Activity Overview

Carol Evans

- 4.4 HIW update on activity_QSE December 2020_V3.pdf (7 pages)

4.5. HIW Primary Care Contractor Report

Carol Evans

- 4.5 HIW Primary Care Contractors - December 2020 - V2.pdf (4 pages)
- 4.5 Appendix 1 GMS.pdf (3 pages)
- 4.5 Appendix 2 GDS.pdf (9 pages)

4.6. Blood Inquiry Update

Nicola Foreman

- 4.6 Blood Inquiry Update.pdf (3 pages)

5. Items to bring to the attention of the Board / Committee

Susan Elsmore

6. Any Other Business

Susan Elsmore

7. Review of the Meeting

Susan Elsmore

8. Date & Time of Next Meeting:

Tuesday 16th February 2021

9:00am – 12:30pm

MS Teams

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on Tuesday, 8th September 2020, 01:00pm – 04:30pm
Via Skype

Chair		
Dawn Ward	DW	Committee Vice Chair & Independent Member – Trade Union
Present:		
Michael Imperato	MI	Independent Member – Legal
Susan Elsmore	SE	Committee Chair and Independent Member – Local Government
In Attendance:		
Carol Evans	CE	Assistant Director of Patient Safety and Quality *(via Skype)*
Nicola Foreman	NF	Director of Corporate Governance
Akmal Hanuk	AH	Independent Member – Community
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
Caroline Bird	CB	Deputy Chief Operating Officer
Dr Raj Krishnan	RK	Assistant Medical Director
Observers		
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Abigail Harris	AH	Executive Director of Strategic Planning
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Fiona Kinghorn	FK	Executive Director of Public Health
Steve Curry	SC	Chief Operating Officer
Hywel Pullen	HP	Assistant Director of Finance
Angela Hughes	AH	Assistant Director of Patient Experience

Minute Ref		ACTION
QSE 20/09/001	**Welcome & Introductions** The Committee Chair welcomed everyone to the meeting and handed over to the Vice Chair due to IT difficulties. The VC was advised that the Quality Indicators paper was a previous version and therefore an up-to-date version would be presented at the next meeting. Dr Raj Krishnan, Assistant Medical Director was welcomed to his first meeting.	
QSE 20/09/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 20/09/003	**Declarations of Interest** There were no Declarations of Interest.	
QSE 20/09/004	**Minutes of the Committee Meeting held on 16th June 2020** The minutes of the meeting held on 16th June 2020 were reviewed. **Resolved that:** (a) the minutes of the meeting held on 16th June 2020 be approved as a true and accurate record.	
QSE 20/09/005	**Action Log – 16th June 2020** The action log of the meeting held on 16th June 2020 was reviewed and the following updates noted: **QSE 20/02/008** **QSE 20/04/005** — Medicine Clinical Board Assurance Report. Date to be agreed on work to follow up on the Frailty and FIT process – the Executive Nurse Director (END) confirmed this would be brought to the next meeting. **QSE 20/02/015** **QSE 20/04/005** — On the agenda **QSE 20/02/017** — Director of Corporate Governance (DCG) confirmed that work is still in progress with the END working towards a December timeframe although this was dependent on work done in the workshop. **QSE 19/12/009** — To come to the December meeting **QSE 19/12/014** — END confirmed that they were in the process of reviewing the internal inspection process and	**RW**

		looking to introduce a new accreditation process which would be brought to a future QSE.	
	QSE 19/12/016/ QSE 20/04/005	The Executive Director of Public Health was the lead but had sent apologies, the VC was happy to keep on the agenda.	
	QSE 19/12/019	To come to the December meeting	**CE**
	QSE 19/09/011	Work was outstanding but was willing to bring to a future meeting	**CE**
	QSE 20/06/008	Would be picked up on review of quality governance	
	QSE 20/06/009	Complete and a progress update would come to the February meeting	
	QSE 20/06/012	On the Agenda	
	QSE 20/02/009	DCG advised this was likely to come to the October Board Development Session.	
	Resolved that: (a) the Committee noted the action log and the verbal updates provided.		
QSE 20/09/006	**Chair's Action taken since last meeting** It was confirmed that no Chair's Action had been taken since the last meeting.		
QSE 20/09/007	**Exception Reports – IP&C Position** The END advised the Committee of the incidents and outbreaks of COVID-19 infection within the hospital settings in Cardiff & Vale UHB and items classified as hospital acquired infection. She highlighted that this was the same report as presented at the previous Private Board meeting. There had been 845 Covid positive patients and a breakdown of each clinical area was provided. The END advised the following key factors influenced the outbreaks: • Recognition of broad symptomatology • Transmission from healthcare workers • Changing PPE guidance • Overwhelmed IPC resources The END provided the Committee with assurance on actions taken to control these incidents and outbreaks. The outbreaks at East 2, University Hospital of Llandough caused the most concern in terms of the numbers. The END advised that measures were put in place such as PPE, placing patients in different wards and clear diagnostic processes but despite this, on 10th June 4 patients and 1 staff member were symptomatic on a nightingale ward. The observations made from this incident was that although staff were in PPE and social distancing, the patients were not and had been interacting with one another. 3 days		

	later the entire ward was closed as there were further spreads into the single rooms. The following key points were raised: • 31 patients tested positive to COVID-19 • 13 staff members tested positive to COVID-19 and • Further 6 who were symptomatic • 328 bed days were lost over the outbreak period The END emphasized that work was still required but was in progress to mitigate further risks. **Resolved that:** • The Committee noted and discussed the incidents and outbreaks of COVID-19 infection within the hospital settings in Cardiff & Vale UHB during the pandemic. • The Committee noted the actions taken to control these incidents and outbreaks, with particular emphasis to East 2, University Hospital of Llandough.	
QSE 20/09/008	**Healthcare Inspectorate Wales Update Review / Healthcare Inspectorate Wales Re-inspection Report EU / AU** The Assistant Director of Patient Safety and Quality (ADPSQ) stated that the report provided a standard update on HIW activity however most activity had been stood down since the start of the Covid pandemic and would now take a tiered approach offsite. The updates related to: 1. National maternity review 2. Community clinics 3. National user survey of women who had children - were asked to review this report due to the unsatisfactory delivery - they had asked HIW to review approach 4. Announced visits 5. Unannounced inspections 6. Sam Davies Ward, Barry Hospital 7. Hafan Y Coed- Elm and Maple wards 8. Emergency Unit/Assessment Unit follow up inspection 9. Self- assessment of surgical services – trauma and orthopedic care 10. Primary Care Contractors The ADPS provided an overview of the follow up HIW inspection carried out in 2019, there were a few immediate assurance issues at the time which were acted upon with a focus on the assessment unit and lounge. An improvement plan was in place and had been taken forward by the Clinical Boards, this had been monitored throughout the year and when HIW returned in March, positive feedback was received on the progress being made. The footprint of the EU during the pandemic was referenced as the issue around the lounge did not exist at the moment. The END assured the Committee that the environmental issues referred to within the report were being addressed although the issue regarding the tunnels was not easily resolved. The Executive Medical Director further added that managing the front door would be challenging and would involve	

	consideration of how much room would be allocated to covid and non covid work streams. He commented that the right plan for acute medicine at the front door had not been established, how the ambulatory unit was utilized, the balance between UHL and UHW, and stated that until this was right it would be hard to determine the future of the AU area and what the permanent solution would be. **Resolved that:** • The Committee noted the level of HIW activity across a broad range of services. • The Committee noted the outcomes of the re-inspection and the progress with implementation of the improvement plan • The Committee considered sufficient progress was being made to improve quality, safety and experience in this area.	
QSE 20/09/009	**Maintaining Quality and Safety in Non-COVID Essential Services** The Deputy Chief Operating Officer highlighted within the report the summary position and that the report indicated success in protecting access to non COVID essential services and in balancing risk. She provided assurance that actions would continue to be guided by clinicians and be within the frameworks outlined in the report with the overriding principle of minimising harm for Covid and non Covid patients. The ADPSQ further commented that from a patient safety point of view there would be much wider impacts due to the pandemic which would be monitored through the incident reporting and complaints systems. The VC queried whether these systems would pick up on patients who had not been referred or had not accessed services. The ADPSQ responded that they would only pick up intelligence on patients who present and if clinicians recognise there has been an adverse incident or additionally audits may pick up on these wider impacts. The EMD further added there had been a dip in referrals but the level of cancer type activity had now returned to 90% pre-COVID levels and even though there may be a small cohort within our catchment that would present late, it was largely dealt with in real time. He added that the real issue was that from a national position we could have to support a more regional delivery. The END raised that individuals may now present due to mental health issues. The Committee were happy with the progress made in service continuity and services returning to pre-COVID levels as well as scheduled care with assurances being given by this further discussion. **Resolved that:**	

	• The Committee noted the range of actions that had been taken to ensure both the delivery and quality and safety of essential services had been maintained. • The Committee noted that actions taken had been based on clinical risk, local Executive led support groups and national guidance. • The Committee noted the continued uncertainty as a result of a potential second wave meaning that the current balance of risk approach would continue to be applied.	
QSE 20/09/010	**Mortality Review** The Assistant Medical Director (AMD) advised that the Medical Examiner Service was delayed due to Covid and would be reviewed in April 2021 although the ME recruitment process would be starting in the coming months. There would be a significant change in regards to the data as they would be looking into the stage 1 reviews and what triggers stage 2 whereas at the moment, junior doctors were currently doing the stage 1 reviews. The AMD updated regarding the Once for Wales approach to acquiring E-datix for implementation in March 2021 which would provide great benefits. He referred to the National Mortality Steering Group, set up in July 2020 and advised that this will be expanded to primary care deaths as the ME role expands. The purpose of the Group was contained within the report. Two meetings had been held thus far due to COVID, in July and September. The EMD added that this was a component part of the work being done by the team in regards to the quality, safety processes and praised the AMD and the team for progress made. The VC commented that the paper provided assurance especially in regards to the setting up of the Mortality Group. **Resolved that:** • **The Committee noted** the progress and future plans associated with learning from deaths.	
QSE 20/09/011	**Safeguarding Annual Report** The END advised that this was an annual report to the Committee that laid out activity undertaken for the year. The END admitted that an increase had been seen following the 2015 legislation on domestic homicide and FGM. The report highlighted referrals of children around neglect, mental health and domestic abuse and of adults around physical abuse, neglect and pressure damage although pressure damage was linked to how they were reporting at the time.	

	The END was keen that the Committee understand the depth and breadth of the work, the significance to those who are at the end of a difficult time in their lives and how traumatic it could be to those staff delivering this agenda. The openness and transparency of the internal reporting regarding allegations made against staff was also mentioned. The key areas were highlighted as being: • Volume • Depth • Breadth • Complexity • Partnership Working The CC queried the forecast areas (items 1 and 5) and asked for an update and reassurance. The END referred to the fact that some audits had not taken place due to delays and redeployment of staff so next year's report would look to prioritize areas of safeguarding that needed reporting on. The END provided assurance for the Committee in regards to safeguarding patients, information governance, and collaborative working with other local bodies and the Committee were happy with the report. The VC queried about collaborative practice and data protection and how the sensitivity of the information shared across sectors was managed. The END responded that sharing of safeguarding information was permissible in the interest of safety of the individuals involved. The END highlighted two upcoming court cases involving staff having allegedly assaulted patients. **Resolved that:** • The Committee noted the report.	
QSE 20/09/012	**Systemic Anti-Cancer Therapy Peer Review** The EMD flagged up respiratory cancer chemotherapy administration, which was administered at UHL and was an out of date model. This had been flagged previously in 2016 and 2019 as a significant concern, it had now been resolved but he queried why these issues were reoccurring and what it told us about governance around Cancer peer reviews. The EMD suggested that a Cancer governance framework was needed and this was currently underway and included an Executive led cancer group at which clinical pathways issues, peer reviews, performance metrics, and quality reviews would be considered. This was due to start in March but was now delayed to October. The EMD added that this would likely feed back to the Strategy and Delivery Committee as well as the QSE Committee. The CC appreciated the openness of the EMD and queried how the Committee could be assured that we were not missing issues in other	

	areas, and gave the example of the mortuary review. The EMD responded that although Clinical Boards are responsible for delivering on actions, plans, monitoring and providing assurance, it was clear at times this does not happen so a central monitoring function was a good approach. The Committee were happy with the approach of an Executive led group. **Resolved that:** • The Committee noted the paper • Reviewed and agreed the action plan • Noted Cancer Services would monitor progress against the agreed action plan and report to the QSE by exception on a quarterly basis.	
QSE 20/09/013	**Neonatal Peer Review** The EMD advised that this paper followed a template of peer review in general but was pleased that it showed a lot of strong reassuring outputs of the right standards of care. It also highlighted areas of improvement but flagged one important issue, the absence of a 24 hour neonatal service. The EMD expressed that a 24/7 neonatal solution was needed as the absence of the same left a gap in the service which had been filled by staff in their own time, with nursing and medical staff staying all evening or night to manage urgent transfers which was unsustainable. He informed Committee that there was a 6 week consultation that came out of WHSSC to increase to a 24/7 neo-natal transport arrangement, he was hopeful that this would result in a new commissioning arrangement. **Resolved that:** • The Committee noted the paper.	
QSE 20/09/014	**Annual Quality Statement 2019-20** The END thanked the ADPSQ and Ann Jones for the work done on the AQS. An early draft had been presented to the previous Committee meeting. The ADPSQ provided an overview of the AQS, the Committee were happy with the work undertaken and the final output. The Committee Chair asked that the final comment be removed from the CEO paragraph and be added to the end of the document. The ADPSQ advised that this would be the last version of the AQS although there would be a duty to report against compliance with the Quality Act but it was uncertain at this stage what this would look like. **Resolved that:** • The Committee noted the paper and ratified the AQS for 2019-20.	

QSE 20/09/015	**Use of Antimicrobial Agents Policy** The Committee were requested to approve the policy for dissemination and implementation. The END gave an overview of the policy and stated that it was to ensure the right use of antibiotics in different clinical situations and clarified that it was a C&V policy not a national one. **Resolved that:** • The Committee noted the paper and ratified the Policy.	
QSE 20/09/016	**Health & Social Care (Quality & Engagement) (Wales) Act** The ADPSQ advised that the Act came into force in April 2020 and Welsh Government were aiming for full implementation over the next two years. There was a duty now to be open with patients in respect of any incidents where there was more than minimal harm, the meaning of this was being looked at across Wales and whether it also included near misses. There would be an abolition of the CHC and the establishment of a Citizens Voice body. The provisions of the Act in relation to a duty of quality, was to reframe and broaden the current duty of quality, to ensure that it became a system-wide way of working and that focus was placed on outcomes. **Resolved that:** • The Committee noted the contents of the paper.	
QSE 20/09/017	**Controlled Drugs Local Intelligence Network** The Committee were happy to note the content of the report, approved the actions contained therein and noted that the same met the statutory obligations. **Resolved that:** • The Committee noted the contents of the paper.	
QSE 20/09/018	**Items to bring to the attention of the Board / Committee** There were no items.	
QSE 20/09/019	**Any Other Business** The END mentioned that the UHB Chair had asked for the IP&C exception report to be presented at the open Board meetings.	**RW**
QSE 20/09/020	**Review of the Meeting** The Committee and colleagues were thanked for their attendance and contribution.	
QSE 20/09/020	**Date & Time of Next Meeting:** Tuesday, 13 October 2020 9:00am – 12:30pm Via Skype	

Action Log

Quality, Safety & Experience Committee

Following the meeting held on Tuesday 8th September 2020

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 20/02/015 **QSE 20/04/005**	HIW Activity Overview	Feedback to be brought to Committee once the report on the recent Hafan y Coed visits had been published	15.09.20	Ruth Walker	**Complete**
QSE 20/06/009	COVID-19 Related Incident Reporting – Themes and Actions	A future report detailing the work carried out by Welsh Risk Pool in relation to potential harm caused to patients due to COVID-19 be brought to a future meeting.	15.09.20	Carol Evans	**Complete - progress update to come to the February meeting**
QSE 20/06/012	Annual Quality Statement	The final Annual Quality Statement be brought to the Committee in August for sign off	15.09.20	Carol Evans	**Complete**
Actions In Progress					
QSE 20/02/008 **QSE 20/04/005**	Medicine Clinical Board Assurance Report	Meeting to be arranged with Medicine Clinical Board and Community Health Council to help understand the Frailty and FIT process	To be agreed.	MCB / SA	Agreed at the meeting held on 14.04.2020 this would be brought after the COVID-19 pandemic.
QSE 20/02/017	Annual Committee Work Plan	Director of Corporate Governance to bring updated Terms of Reference and Work Plan to the September meeting.	16.02.20	N Foreman	To provide at year-end.
QSE 19/12/009	Health Care Standards Self-Assessment Plan and Progress Update	To bring a report on areas of work not doing well but to also include areas of good practice	**15.12.20**	R Walker	On December agenda, item 2.6.

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 19/12/014	Internal Inspections	To share the App designed to improve the quality and consistency of audit outcomes with the Community Health Council.	To be agreed	Ruth Walker	New accreditation process will be brought to a future QSE.
QSE 19/12/016 **QSE 20/04/005**	Update on Health Eating Standards for Hospital Restaurant and Retail Outlets	Revisions to be made to the Policy and brought back to a future meeting.	**15.12.20**	Fiona Kinghorn	To come to the December meeting
QSE 19/12/019	Healthcare Inspectorate Wales Primary Care Contractors	The Community Health Council to provide a paper to a future meeting of the Committee relating to their visits to Primary Care Contractors	**15.12.20**	S Allen / Carol Evans	**On December agenda, item 4.5**
QSE 19/09/011	Gosport Review	To provide timeframes from the recommendations of the Gosport Review	To be agreed	Carol Evans	To come to a future meeting.
QSE 20/06/008	Clinical Board Assurance Reports	Reports to be further developed to include recovery plans and improvements to IMTP going forward.	To be agreed	Stuart Walker / Ruth Walker	To be picked up in review of quality governance.
Actions referred to Board / Committees					
QSE 20/02/009	Health Inspectorate Wales Assessment Unit Update	Multi Agency approach to patient flow to be discussed at Board Development.	To be agreed	Ruth Walker	Aiming for October Board Development session
QSE 20/09/019	Exception Reports – IP&C Position	END mentioned that the Chair had asked for the exception report for the IP&C Position back into the Open Board sessions	To be agreed	Ruth Walker	

Applied Analytics Awards. Guidance for submission of End of Project Reports

Please ensure that your end of award report begins with the following information:

Reference No / AIMS ID	1554239
Organisation	Cardiff and Vale University Health Board
Primary Contact	*Andrew Carson-Stevens*
Project/ Programme	*Advancing Applied Analytics*
Length of award and reporting period	*15 months*

Section 1 – Project Overview

1. **How have you performed against your original milestones? Please use this format to report on the milestones within your report.**

Milestone	Achieved ? Yes/No/ Partially	Comments
Delivery of a workshop in Child Health directorate to set QI priorities informed by data analysis and review of QI projects and plans for future projects.	Yes	An initial workshop was held to inform child health staff about the range of data available within the Health Board and how it can be used to identify areas for quality improvement. Following on from the workshop, the project team worked with clinical staff to identify priorities for improvement from patient safety data. As part of the project, improved systems and processes have been established that allow directorates to more easily analyse patient safety data in order to target quality improvement projects.
Summary of evaluation findings.	Partially	Professor Sir Liam Donaldson is carrying out a key stakeholder interviews will members of the project team and organisation's leadership at the close of the project in November 2020. Sir Liam is using the WHO Guidelines for Incident Reporting System as a reference frameworks to evaluate our project, as well as to consider the wider enabler and barriers to the spread and scale up of our innovation across Cardiff and Vale University Health Board.
Evidence of integration of findings into future plans for analysis of incident reports	Yes	The process for using incident data to target quality improvement work which has been successfully piloted in the Acute Child Health Directorate, will be rolled out to the wider Health Board. The supporting systems and materials, such as the Business Intelligence System

and safety improvements.		(BIS) dashboard and the e-learning modules have been designed to be suitable for use outside of Acute Child Health.
Dissemination: • Event within organisation • A 'how to guide' of best practice guidance informed by learning from SOP development and testing • Completed evaluation report paper	Yes	The programme has developed: - a series of short e-learning modules covering the basics of patient safety theories, the strengths and limitations of each type of patient safety data available in the organisation, and how to analyse the data and use the learning to inform quality improvement projects; - workshops to facilitate key discussions between clinicians, managers and leaders in the Child Health directorate; - directorate-level fora for project progress, reviewing data as a multidisciplinary team, agreeing priorities and planning future projects; - a secure data-sharing platform for staff to request, review and analyse a range of patient safety data; and, - quality improvement project support to staff leading data-driven quality improvement projects. We have organised and presented at a number of events across the organisation. As well as workshops with the Acute Child Health Directorate, the project has been shared a the Health Board's Medication Safety Executive meeting to explore how data-driven QI could be used specifically with medication related incidents. As part of the wider roll out of data-driven QI within the Health Board, we will be presenting at the Clinical Senate meeting and the Quality, Safety and Experience Committee in December. A 'how to' guide has been developed which shares our learning from the project and how data-driven QI can be implemented in other organisations. Ethical approval has been obtained and we plan to write up our experiences of developing the patient safety data analytics programme for academic publication.

Please can you address the following questions (Max 500 words each):

2. Outline the main activities undertaken during the full course of your project.

Initially the project team process mapped several aspects of quality improvement, including the selection of projects for junior doctors, the process for requesting patient safety incident data and the arrangements for sharing and discussion of learning from incidents.

The process mapping identified a disconnect between the knowledge of key themes and trends in incident reporting and the selection of topics for quality improvement within clinical services. The overarching aim of the project was to address this disconnect by supporting staff to use analysis of patient safety incident data, in conjunction with other data sources, to inform quality improvement projects.

▲Figure 1 – Overview of the aim for data-led quality improvement

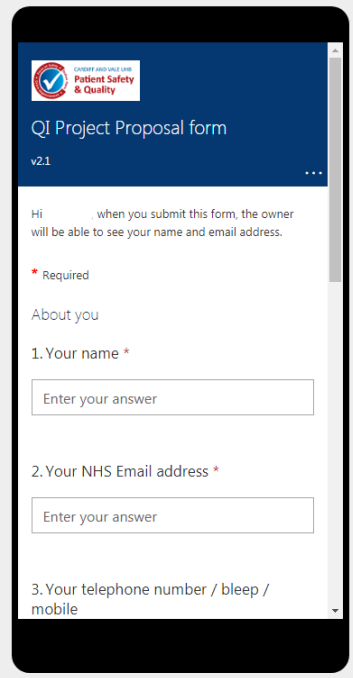
Working with clinical staff, themes from incident reporting within the Acute Child Health Directorate were identified for further analysis. The two key themes taken forward were medication errors and communication errors.

Clinical staff were supported to undertake analysis of the incident themes, which included the combination of other data sources to assist in understanding the causes of reported patient safety incidents. For example, when comparing reported medication errors between different wards, pharmacy prescription data was used to explore the relationship between the numbers of errors and the number of doses given.

Building on the experience gained from teaching clinical staff about incident data analysis in a face to face setting, four e-learning modules were developed that allow a much greater number of staff to learn about incident data analysis and therefore is key to ongoing sustainability of the project. Having e-learning modules accessible to staff also safeguards against the impact of restrictions on face to face training due to the COVID-19 pandemic.

▲Figure 2 – Screenshot from e-learning module 2

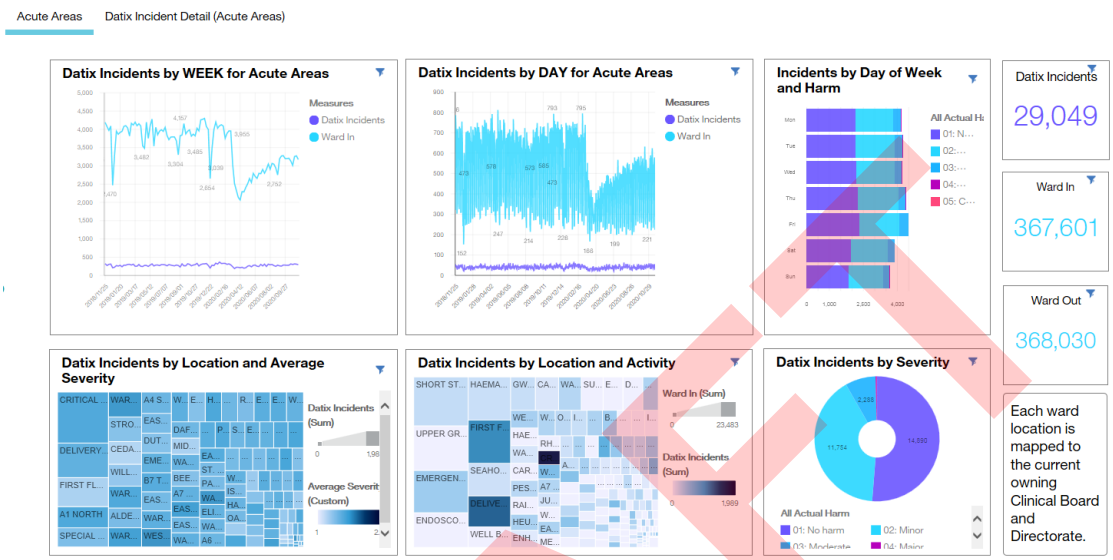
Through process mapping and discussions with the Acute Child Health Directorate, it was identified that it was difficult for staff to know what QI work was underway as there wasn't a specific repository for information on projects. In order to address this issue, an electronic project proposal form was developed. This is easily accessible to staff via a PC or smartphone and allows for projects to be registered. The form includes an approval process and the option to request patient safety incident data if required. The system also helps staff to ensure that they are following data protection regulations when accessing data for quality improvement. Ongoing work is underway to give electronic access to a database of recent and ongoing quality improvement project. This will not only allow QI leads to see at a glance the project that are taking place within their Directorate, but also to identify similar projects in other areas and encourage collaboration.



►Figure 3 – Preview of QI project proposal form on a mobile device

3. Do you feel that this work has led to changes in analytical capability that will be sustained? Are there any plans to continue this work as part of business as usual?

The development of a dashboard within the Health Board's Business Intelligence System (BIS) is a key part of the ongoing sustainability of the project. The dashboard allows for easy exploration of incident report data in real time.



▲Figure 4 – Data dashboard

Terms of reference have been prepared to guide clinical directorates on establishing regular data-driven QI meetings and successful workshops were held by the Acute Child Health Directorate at the start and close of this project.

The dashboard has been made available to staff from the Acute Child Health Directorate and a wider roll out is planned, with a presentation to the Health Board's Clinical Senate in December 2020.

The Health Board has committed to the ongoing sustainability of the project and has appointed a Patient Safety and Organisational Learning Manager who will lead on the roll out of data-driven QI across Cardiff and Vale University Health Board.

4. What are the key lessons that can be shared with others? What have been the main successes and failures of this project?

The project has shown the value of making data accessible to clinicians and healthcare teams.

We have identified and iteratively developed standard operating procedures to aid successful working between clinicians and analysts working in the patient safety team to request data, know its strengths and limitations and in turn understand how to analyse it.

Overall, the project has demonstrated to the Child Health Directorate, and more widely as an exemplar for the organisation, the benefits of analysing routine patient safety data to identify themes and trends that serve as the signals to drive further inquiry by teams seeking to improve patient safety.

Each of the data-driven QI projects in Child Health has demonstrated important knowledge that would otherwise have gone undetected without this structure and coordinated approach to data analysis.

Throughout the course of the project, the power of combining multiple sources of data with incident report data has been strongly reinforced.

It is vital that data is made accessible to clinical staff in a way that make analysis easy and the work to develop the BIS dashboard has been crucial to this. Further enhancements to the dashboard are planned, which will allow specific incident types, such as medication-related patient safety incidents, to be more easily analysed.

Ongoing and planned next steps for the programme over the next 18 months, include:

- Researchers-in-residence (clinicians, graduates) in the patient safety and quality improvement team to support the analysis, identification and investigation of priorities;

- Work procedure(s) for learning and acting from sources of insight such as ‘near misses’ and patient safety themes (the most frequent incidents and the most common reported / apparent contributory factors).

- Capturing the latent conditions and active failures arising from system constraints (e.g. COVID-19 pandemic) and observing efforts to mitigate apparent challenges.

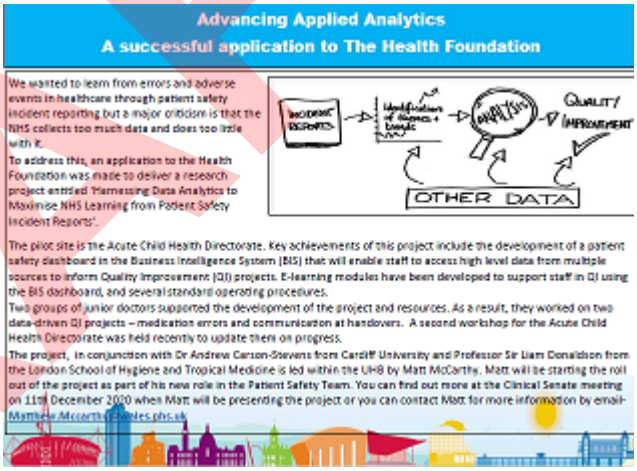
From the recent World Health Organization report (2020), ‘WHO: Patient safety incident reporting and learning systems: technical report and guidance’, it is apparent that detailed exemplars of data-driven patient safety improvement programmes are in short supply and this proposed evaluation could contribute that much needed learning.

5. What progress have you made in disseminating learning from this work? Outline any significant meetings/reports etc.
You may attach or provide links to any products that have been created throughout this project.

Throughout the project, we have been sharing and presenting our progress at a range of internal and external events.

◄ Early progress with the project was presented at Health Education and Improvement Wales' national 'QISTmas' conference in December 2019.

► We have kept staff up to date with the project via the Patient Safety Team's newsletter, which is distributed widely within the Health Board.



◄ Workshops were held with the Acute Child Health Directorate at the beginning and end of the project.

▼ An intranet site has been developed as a central repository of information about the project. It holds the four e-learning modules, a link to the QI project proposal e-form and a link to apply for access to the BIS dashboard.

The e-learning modules are accessible using the links below:

Module 1 - Using patient safety data to inform the planning of a QI project

Module 2 - Incident data analysis

Module 3 - Further analysis and other data sources

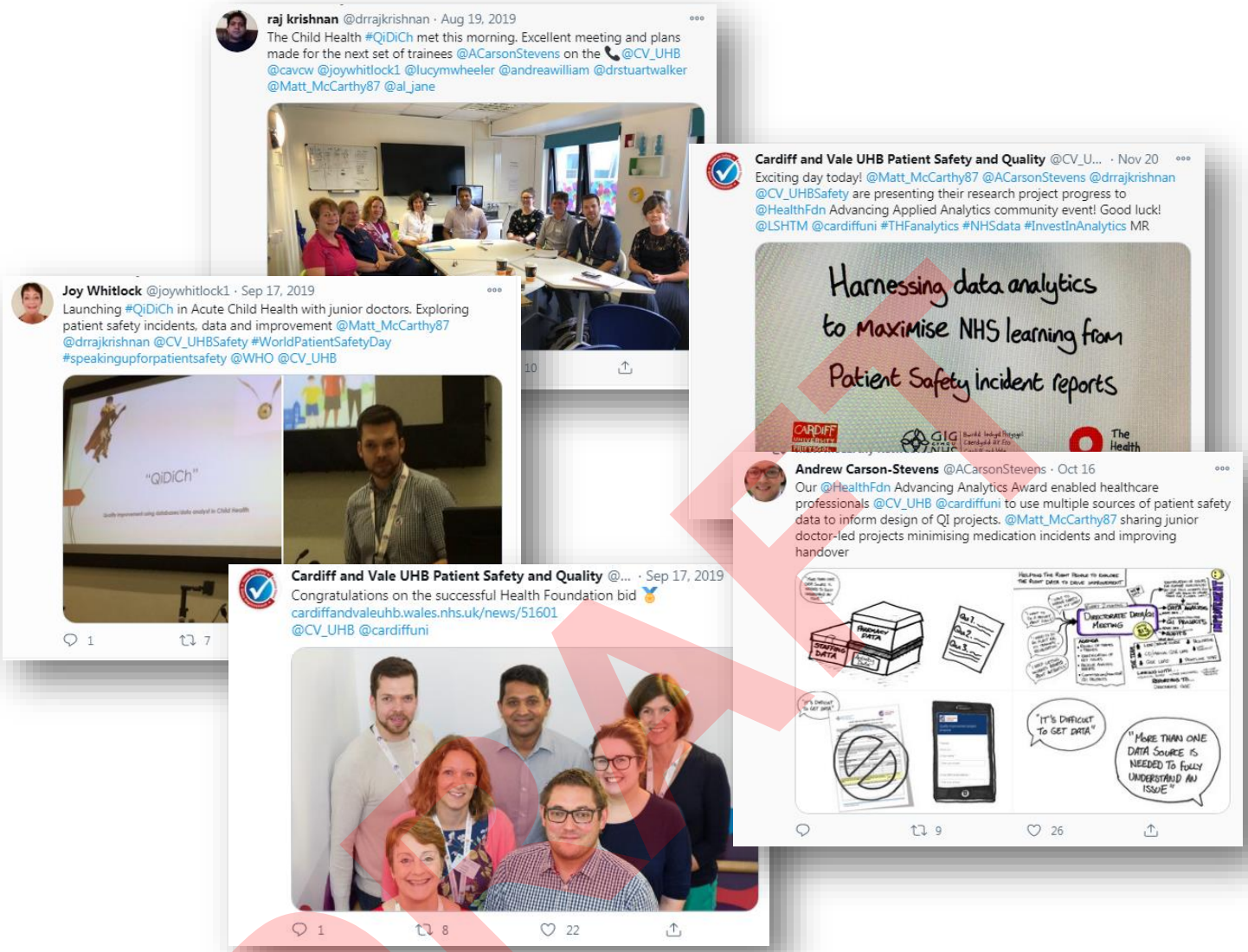
Module 4 - Permission to improve

The project was presented to the Health Foundation's Advancing Applied Analytics community event on 20th November 2020.

In December, the project is being presented to the Health Board's Clinical Senate meeting, which is attended by clinicians from across the range of specialties and is open to all staff. The Clinical Senate meeting is chaired by the Health Board's Chief Executive Officer.

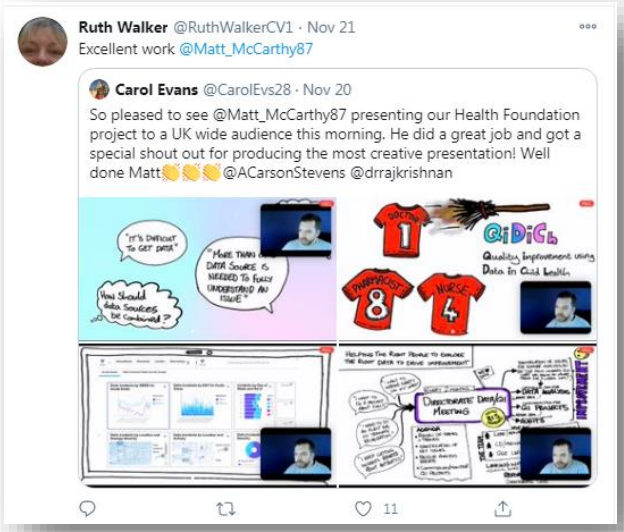
The project will also be presented at the Health Board's statutory, public-facing Quality, Safety and Experience meeting on 15th December to update Executives and Independent Board Members.

▼ We have been using Twitter to share updates on a wider basis throughout the project:



► We also had engagement from Cardiff and Vale UHB's Executive Nurse Director

In November 2020 the project was presented to the Executive Medical Director and senior medical leadership team. The Chief Executive Officer has also been briefed on the importance of the project.



We will be preparing publications to share this project more widely, with a paper highlighting the benefits of combining patient safety data sources to maximise understanding and a wider paper on the transferable lessons from our experience using the WHO Guidelines for Incident Reporting Systems as a reference standard.

6. **Any other comments on the Advancing Applied Analytics programme that you would like to share with us?**

We would like to express our thanks to the Health Foundation for their funding and support of this project.

Section 2 – Financial Information

This section should be completed and / or informed by your finance department. Please ensure that you submit your financial information using the embedded summary expenditure template (see below) in a way that includes all the lines of expenditure as agreed in your award agreement. Please note that we may ask you to provide receipts for larger items of expenditure.

2.1 – Summary of expenditure

Please see separate document titled '1554239 Finance summary'

2.2 – Variance

Band 7 Analyst
- Initial delays with recruitment to backfill the Band 7 Analyst shifted costs into year 2 (2020/2021). Unfortunately after 4 months, the person recruited to the backfill position was unable to continue in the role due to unforeseen family reasons. In order to ensure that the project could continue, the Band 7 Analyst maintained their time commitment without backfill. This has led to a backlog of work which if unresolved would negatively impact on patient safety. Therefore, it is proposed that with Health Foundation approval, the remaining funds from this aspect of the budget be used to recruit to a short term backfill post to address the backlog of work caused by the lack of Band 7 Analyst backfill following the unforeseen departure.

Grade 6 Qualitative Research (LSHTM)
- Invoicing for the work of the team at the London School of Hygiene and Tropical Medicine has not yet been received, but is expected following completion of the evaluation report. No variance in the amount of this budget item is expected.

Cardiff University – Reader and Data Manager

A delay in invoicing shifted costs into year 2 (2020/2021). A final invoice is expected at next billing cycle for work in October and November.

Report Title:	**Quality Indicators – progress report**						
Meeting:	Quality, Safety and Experience (QSE)				**Meeting Date:**	15/12/2020	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Executive Nurse Director Executive Medical Director						
Report Author (Title):	Assistant Director of Patient Safety and Quality						

Background and current situation:

In June 2020, the QSE Committee agreed a range of quality indicators that would be routinely monitored at each meeting. To enable this, work has been undertaken with the Information Department to develop a QSE dashboard. This is the first report and at the time of writing the dashboard is still under development.

This paper provides an overview of current performance against those quality indicators that are available within the dashboard. It is anticipated that the QSE dashboard will be fully implemented by the next report to the Committee in February 2021 and the process will be iterative.

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

The number of Serious Incidents (SI) reported has reduced significantly over the last two years. This is due mainly to the change in the requirement for reporting pressure damage. SI reporting reduced during the Q1 of 2020/2021 but is now retuning to pre-covid rates. Again, this is due mainly to revised incident reporting processes implemented by Welsh Government (WG).

The number of SI closure forms submitted to WG has dropped during Q1 and Q2 of 2020/2021. The Patient Safety team are working closely with Clinical Boards to ensure timely investigation and closure of SIs, so that the UHB can achieve pre-covid rates of SI closure. At the time of writing the UHB has 103 open SIs.

The number of reported pressure ulcers has increased in the last two months. This trend will be kept under review by the UHB Pressure Ulcer Group.

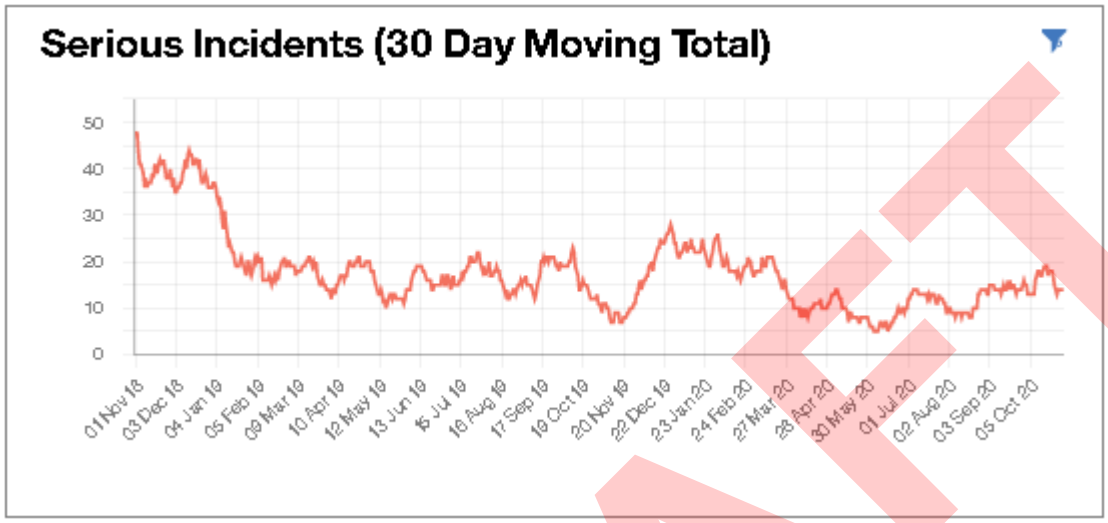
There has been a reduction in the % compliance of patients who are admitted to the stroke ward within 4 hours of presentation to the Emergency Unit. The last published national SSNAP audit indicated that the national average is that 58.9% are admitted to a stroke unit within 4 hours of arrival at hospital. UHB performance in the last report was 52.1% of patients go directly to a stroke unit within 4 hours. There has also been a reduction in the % compliance of patients seen by a stroke consultant within 24 hours. This issue will be discussed in detail in the January 2021 Clinical Effectiveness Committee.

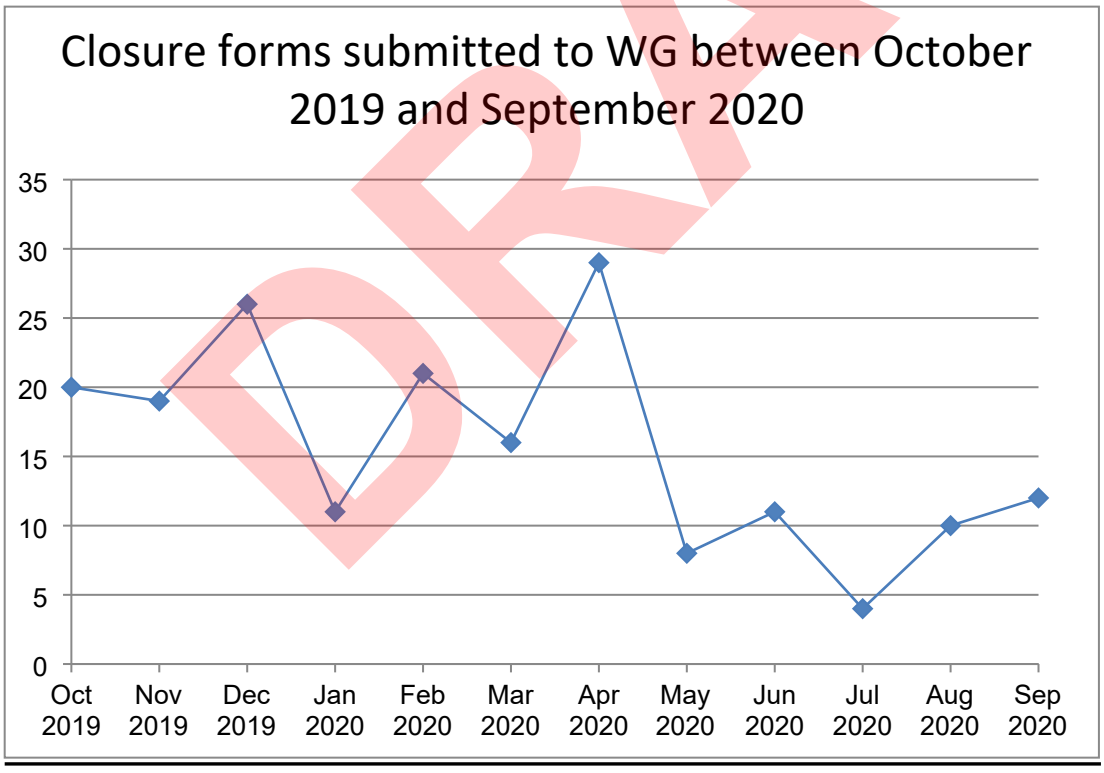
In April 2020, there were spikes observed across a range of mortality indicators (under 75s elective admissions, fractured neck of femur deaths within 30days of admission and mortality within 30 days of admission). A more thorough scrutiny of this will be undertaken and presented to the next Mortality Group meeting in January 2021.

Currently, compliance with Level 1 mortality reviews across the organisation is 100%. There has been a marked increase in the number of Level 1 reviews which trigger a Level 2 review, at University Hospital of Llandough during October 2020. Again, a thorough review of this trend will be undertaken and reported to the Mortality Group in January 2021.

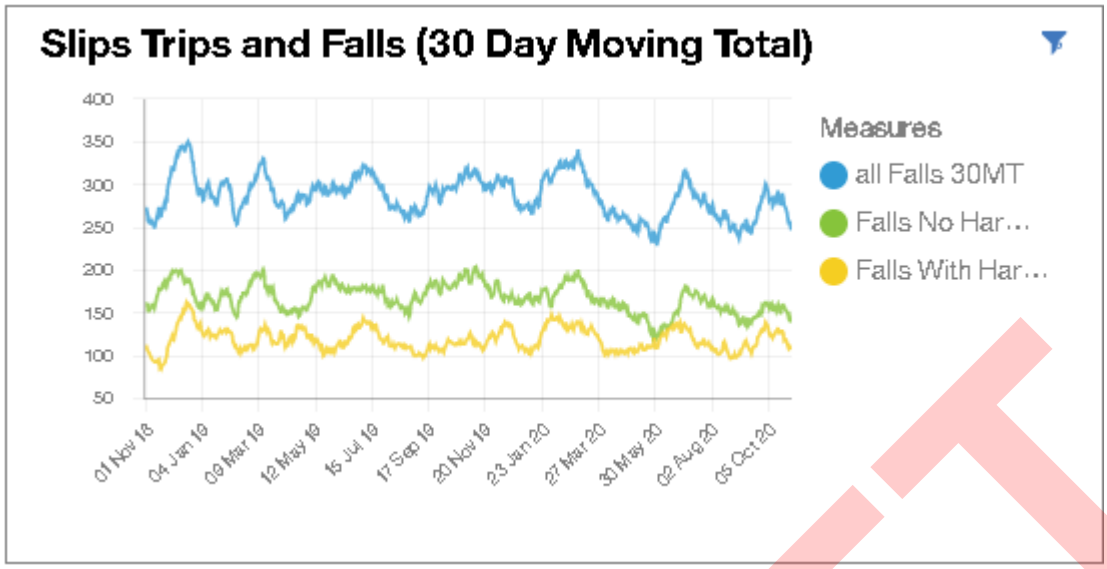
Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

Serious Incidents

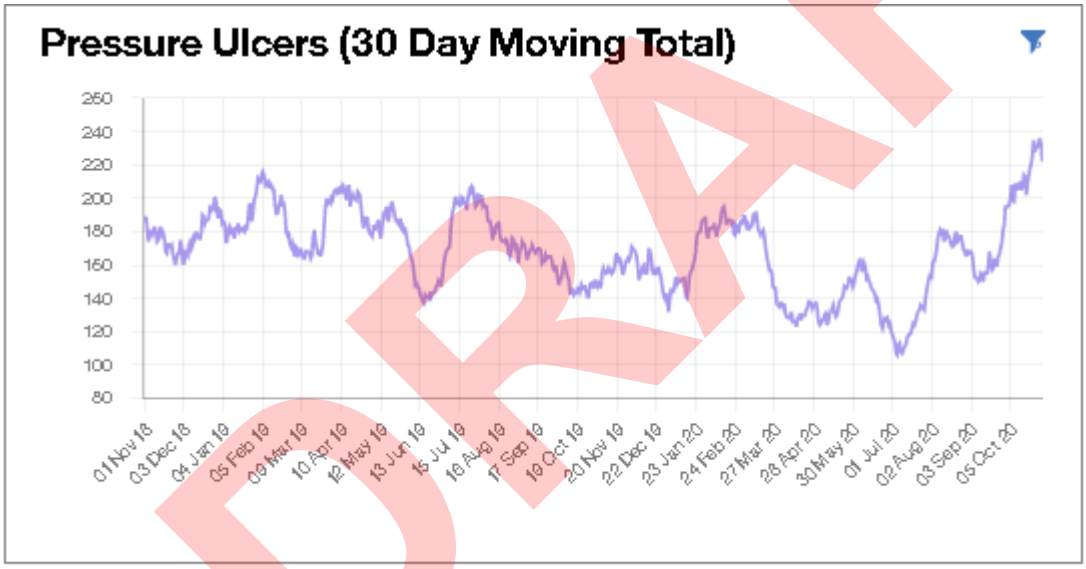




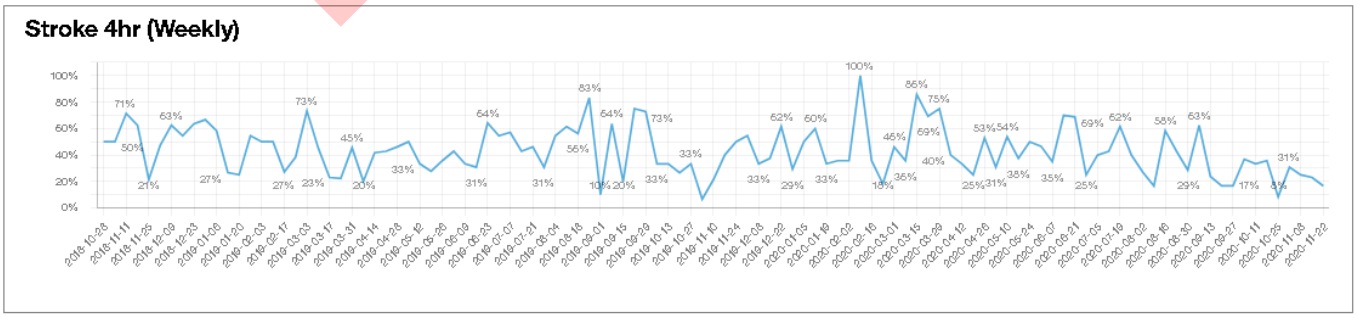
In-patient falls

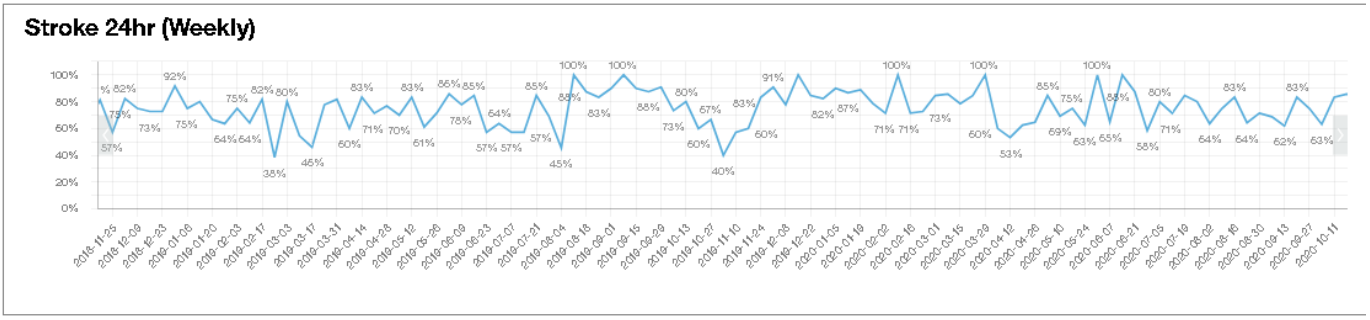


Pressure ulcers

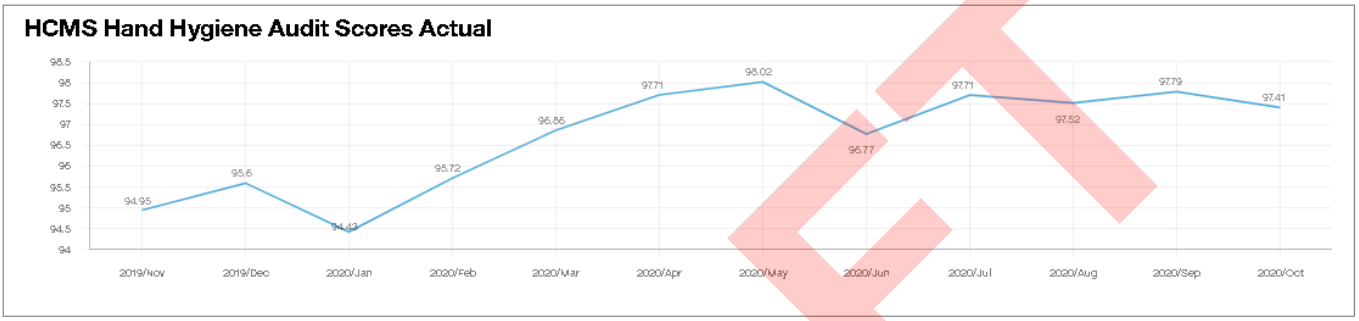


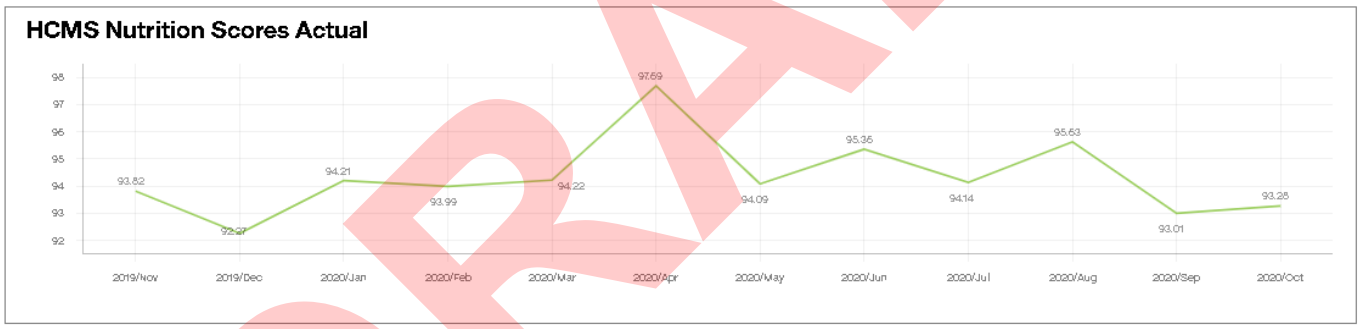
Stroke indicators



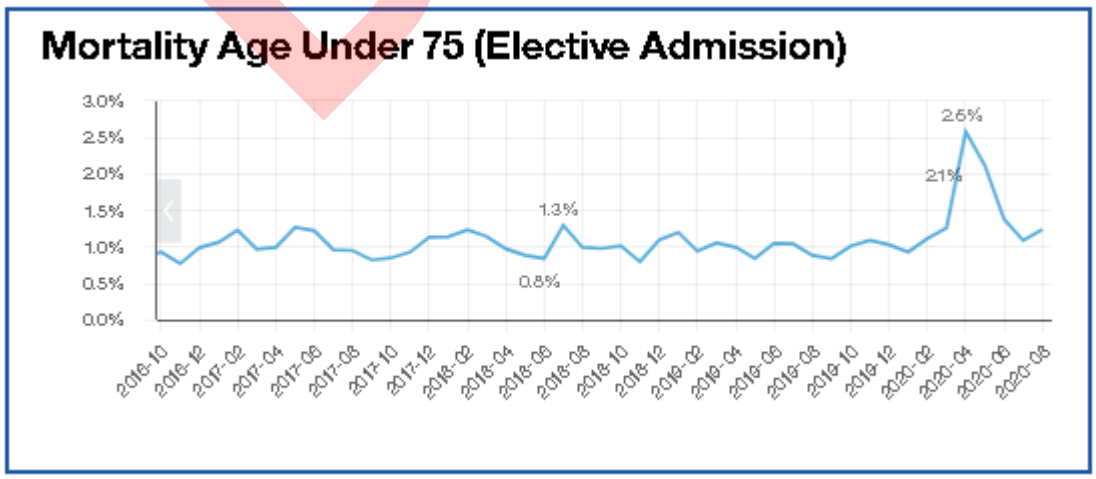


Hand hygiene and nutritional assessment scores

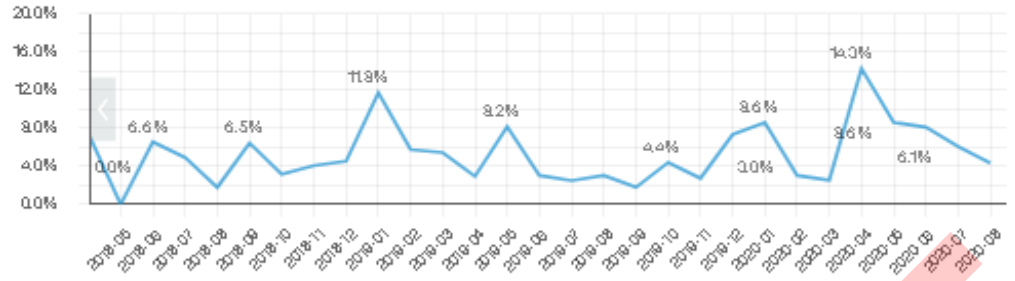




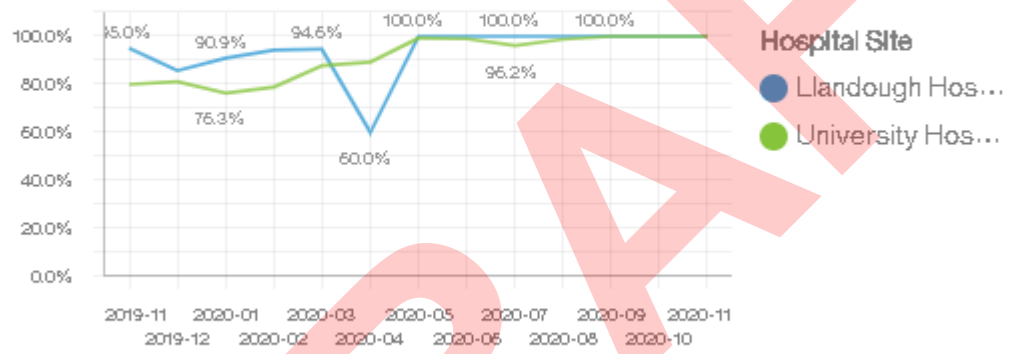
Mortality



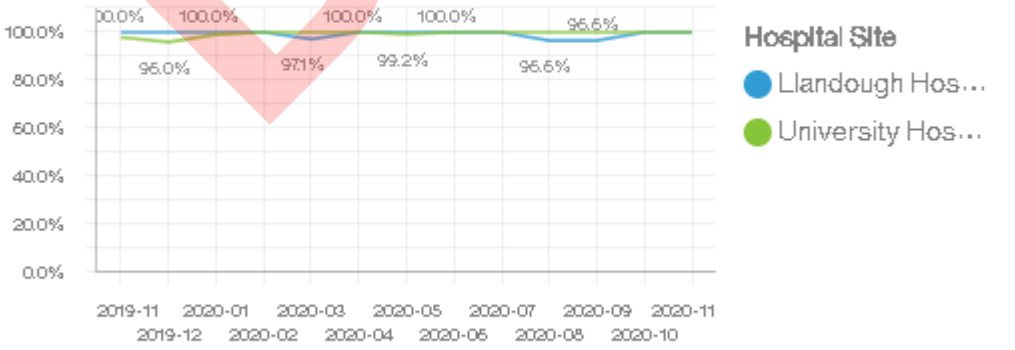
FNOF - Mortality within 30 days of Emergency Admission

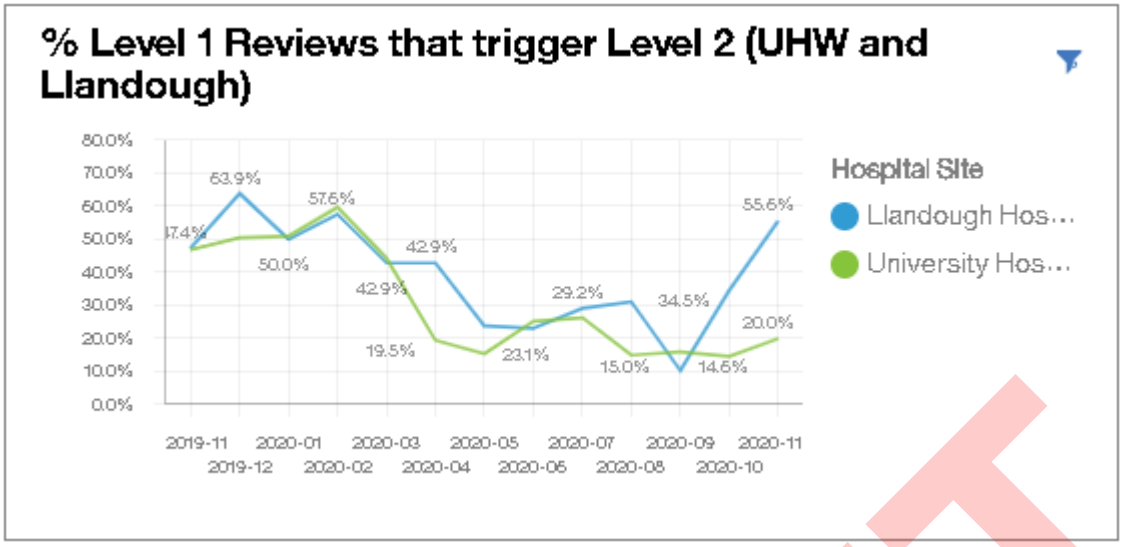


Level 1 Mortality Reviews Completion Rates (UHW and Llandough)

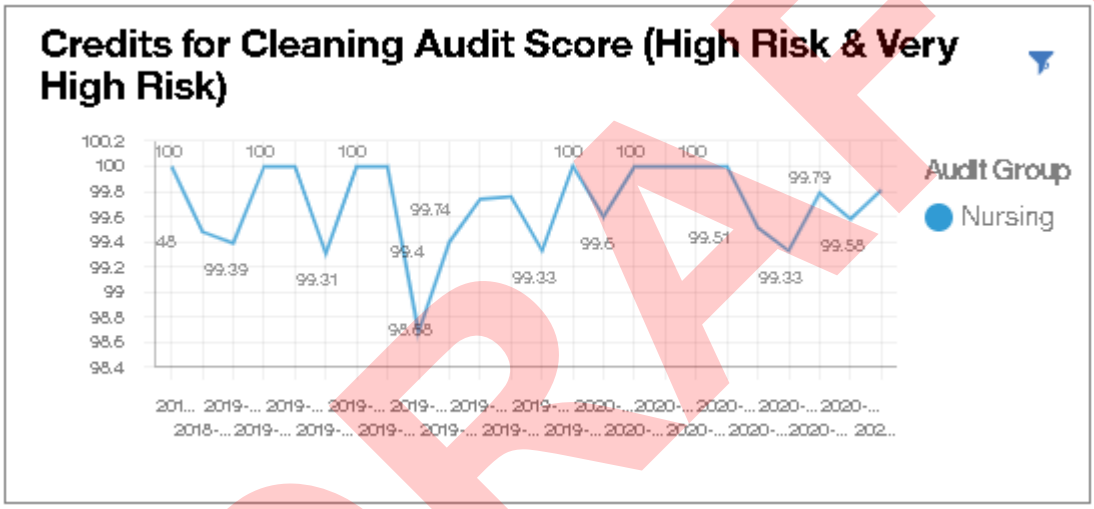


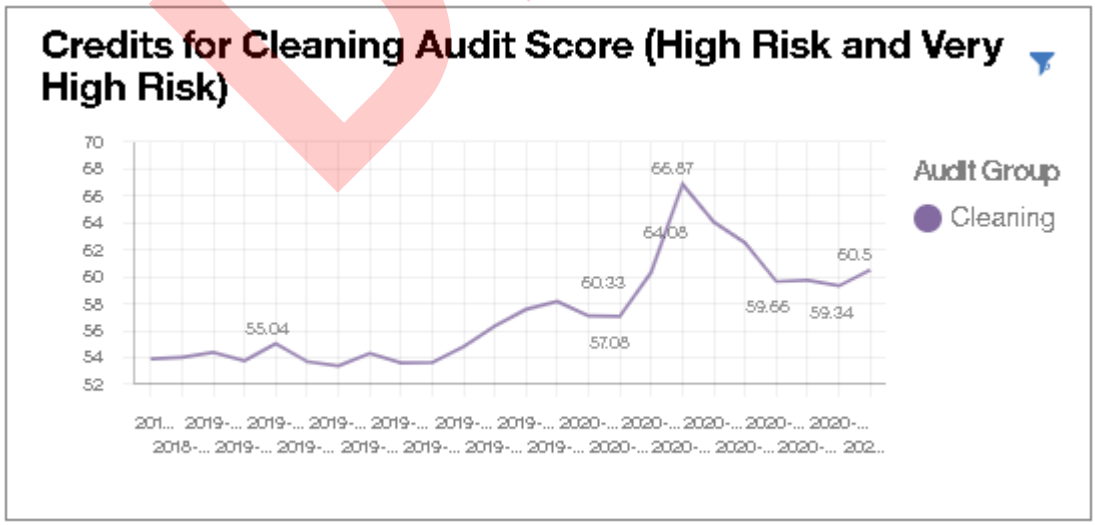
Level 1 Mortality Reviews Completed in 28 days (UHW and Llandough)



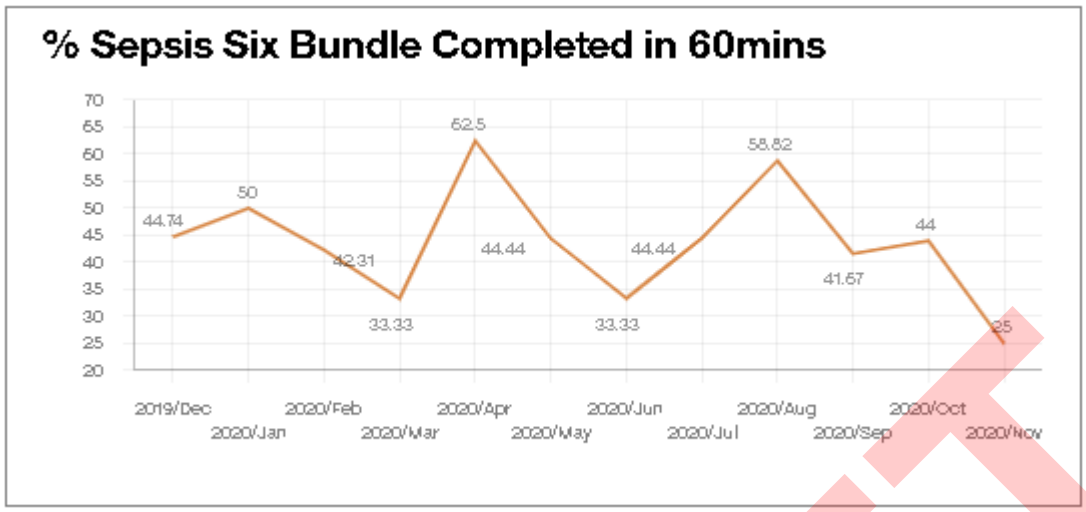


Cleaning scores





Sepsis



Recommendation:

The Quality, Safety and Experience Committee is asked to **NOTE** the contents of the Quality Indicators report and the actions being taken forward to address areas for improvement.

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								

Report Title:	**Impact of COVID-19 on Patient Safety**								
Meeting:	Quality, Safety and Experience (QSE) Committee					**Meeting Date:**	15 Dec 20		
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**	**x**	
Lead Executive:	**Executive Nurse Director** **Executive Medical Director**								
Report Author (Title):	**Assistant Director Patient Safety and Quality**								

Background and current situation:

As detailed in the Proposed Changes to Governance Arrangements report presented at the November 2020 Board, a new COVID-19 Update Report has been developed for approval following recent review of Governance arrangements. As with the other measures being implemented, the intention is to ensure robust and improved governance arrangements are in place during the second wave of the pandemic.

To support this strengthened reporting arrangement, regular reports on the impact of covid on patient safety will be provided at each QSE Committee meeting.

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

Covid 19 outbreak position - There are currently a number of wards across the UHB where there are outbreaks of covid-19. There is robust monitoring of the situation with daily operational meetings chaired by the Executive Nurse Director and outbreak procedures in place for all affected areas. There is daily update reporting (Monday – Friday) in to Welsh Government in line with current reporting arrangements (see Appendix 1 – Letter from Deputy Chief Medical Officer – November 25th 2020). A full update will be provided at the Committee meeting by the Executive Nurse Director.

Serious Incident and No Surprise reporting channels – revised arrangements have been put in place. All new SIs are reported to the Delivery Unit while No Surprises continue to be reported to Welsh Government.

The investigation of the care of patients with hospital acquired coronavirus – the Board recently received an update from the Executive Nurse Director in relation to the numbers of patients with hospital acquired coronavirus (HAC). Work is underway to review the care of all patients with HAC as well as the deaths of all patients with HAC who have died with a diagnosis of covid 19 on the death certificate. Reviews are being undertaken in line with the All Wales investigation toolkit (Appendix 2a) and are being undertaken by a small team of staff under the guidance of and reporting to the Patient Safety team. A local rapid review tool (based on the All Wales toolkit) has been developed by the Patient Safety team. This will enable the swift and timely review of the care of patients with hospital acquired covid and will help determine whether a more in-depth review is required. The tool can be viewed at Appendix 2b.

Covid related incidents - The UHB has been working with Cardiff University to undertake a thematic review of covid related incidents. The results were presented to the Medical Leadership Group on 12th November 2020 and will be used to identify learning opportunities. The work will continue with prospective analysis of all reported incidents during the 3 next months (Academic GP trainee will be working with the patient safety team) to ensure rapid learning as necessary. All covid related patient safety incidents are also reported as part of the regular Integrated Quality, Safety and Experience (QSE) report to Board. Emerging themes from the reviews will be discussed by the UHB Infection, Prevention and Control (IP&C) Cell and in the weekly SI/Concerns meeting.

Covid e-notification – The Committee has received a report in June 2020 providing assurance in relation to the reporting of covid deaths in line with All wales policy. The UHB was instrumental in working with PHW to establish an electronic reporting system and the Assistant Medical Director for Patient Safety and quality continues to sit on the All Wales COVID-19 mortality surveillance assurance group overseeing this. Recently, a document to support Doctors with accurate recording of the cause of deaths for patients with Coronavirus has been developed by one of the UHB Consultant Histo-pathologists. This has been shared with colleagues across Wales and is attached at Appendix 3.

Personal Protective Equipment - The PPE cell continues to meet to ensure appropriate procurement, distribution and management of PPE related issue across the UHB. PPE incidents are also reported as part of the regular QSE report to Board. There are currently plentiful supplies of PPE available to the UHB.

IPC and QSE arrangements at the Lakeside Wing Field Hospital - a full update will be provided to the Committee at the December 2020 meeting.

WAST notification of handover delays and joint investigations – the UHB continues to work with colleagues in WAST to jointly investigate incidents in which handover delays have contributed to a poor outcome for patients. The UHB currently has 3 incidents under joint investigation and has arrangements in place to meet regularly to progress investigation and closure of these incidents.

Sharing early learning related to in-hospital transmission of Covid-19 (CoRSEL) – an early learning reporting system has been established by the Delivery Unit and the UHB is reporting as required to share any early learning opportunities. Feedback reports issued by the Delivery Unit are being shared with Clinical Boards when issued and are attached for information (Appendix 4a and 4b).

Recommendation:

The Quality, Safety and Experience Committee is advised to **NOTE** the content of this report. A full brief on these issues will be provided at the forthcoming Committee 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	
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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								

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer
Dirprwy Gyfarwyddwr Gofal Iechyd Poblogaeth
Deputy Director Population Healthcare Division

Llywodraeth Cymru
Welsh Government

To: Chief Executives – LHBs and NHS Trusts
Medical Directors – LHBs and NHS Trusts
Nurse Directors – LHBs and NHS Trusts
Assistant Directors of Quality and Safety – LHBs and NHS Trusts

25 November 2020

Dear Colleagues

Serious incident (SI) and No Surprise (NS) notifications

As you are aware through previous correspondence, the reporting of serious incidents at a national level transferred to the NHS Wales Delivery Unit (DU), from 1 October 2020. I am pleased to confirm this change to the reporting process is working well and I want to thank you and your teams for helping to ensure a smooth transition.

There are however a couple of issues which need further clarification to improve the process going forward. In the interests of clarity this letter sets out in one place the processes to be followed when reporting / advising of incidents where the provision of care has resulted in harm or potential harm to patients.

1. **SI and NS reporting channels**

All new SI notifications should now be being submitted to the DU via NationalSIreports@wales.nhs.uk, in line with *Putting Things Right* (PTR) guidance.

Again in line with PTR guidance no surprise notifications are the mechanism through which NHS organisations provide an 'early warning' alert which might not result in direct harm to patients, but may have an impact on service provision. They may also impact on areas relating to organisational reputation, adverse media coverage or political challenge. NS notifications will continue to be submitted to Welsh Government via the ImprovingPatientSafety@gov.wales mailbox. In addition some NHS organisations contact colleagues direct within the Healthcare Quality Team to alert Welsh Government to potential issues and this is welcomed.

On occasions there may be a need for both SI and NS notifications to be submitted and in these circumstances information will need to be shared via the separate and distinct channels referenced above in the most timely manner.

NHS organisations are not required to inform Welsh Government of upcoming coroner inquests unless they have the potential to be particularly sensitive or result in a Regulation 28 or are of particular media interest.

Ffon/Tel03000257028
Parc Cathays, Caerdydd CF10 3NQ Cathays Park, Cardiff CF10 3NQ
Ebost/Email:PSChiefMedicalOfficer@gov.wales

2. **'Upgrading' of no surprise notifications**

Sometimes NHS organisations have submitted no surprise notifications when they actually meet the criteria for a serious incident and Welsh Government has automatically upgraded these and notified the reporting organisation. With immediate effect this process will change; the NS notification will be returned to the reporting NHS organisation who will be asked to submit a SI notification relating to the incident direct to the Delivery Unit.

3. **WAST notification of hand over delays and joint investigations**

Currently where harm or potential harm has been caused due to patient hand over delays at hospital emergency departments, WAST submits a NS and the LHB/ Velindre Trust submits a SI to Welsh Government. A joint investigation is undertaken between the two organisations and the learning shared.

Going forward the requirement to undertake a joint investigation still stands as does the requirement to submit a SI to the Delivery Unit by the LHB / Velindre Trust.

There is a change with immediate effect relating to the notification which was submitted by WAST. In instances of hospital patient hand over delays WAST will no longer be required to submit a NS to Welsh Government. Instead WAST will be required to email the DU via the NationalSIreports@wales.nhs.uk mailbox providing confirmation that a joint investigation will be undertaken for delays in patient handovers. The DU will finalise a minimum data set with WAST which is likely to include the following information:-

- date of delayed handover
- confirmation of LHB / Velindre Trust – NHS hospital
- outcome of patient
- any immediate make safes actioned
- confirmation of agreed joint investigation

The onus will still remain with the LHB/ Velindre Trust to report the SI via the notification process clarified above.

4. **SI closure process**

In addition to the clarification above I would like to take the opportunity to provide clarification around the assurance and closure of SIs, too.

The Delivery Unit has now taken responsibility for the closure of SIs originally reported to Welsh Government from 1 April 2020. Any SIs therefore reported on or after 1 April 2020 and now due for closure should have their closure notifications submitted to the Delivery Unit via NationalSIreports@wales.nhs.uk. Any closures which have already been submitted to Welsh Government for incidents this financial year will continue to be assured by colleagues in Welsh Government.

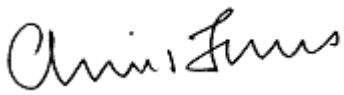
We still have a number of outstanding, historical SIs prior to April 2020, which I know you are making a concerted effort to close in liaison with the Healthcare Quality Team in Welsh Government. These should continue to be submitted to Welsh Government for closure consideration.

Finally we are considering the relationship with the new Covid-19 outbreak reporting requirements and SI reporting and specific advice in this regard will follow shortly.

I want to thank you and your teams once again for your patience while the transition of SI reporting moves to the Delivery Unit and the process is embedded. Work is also being undertaken to establish a reporting process that supports both Welsh Government policy leads and NHS organisations in terms of what the data is telling us and how we can share learning to help improve the quality and safety of care provided as well as improved outcomes for patients. Something I know NHS colleagues are keen to have shared with them.

Although early days, should you have any observations / comments / queries regarding the changes being implemented or the content of this letter please do not hesitate to contact Jan Firby jan.firby@gov.wales or 03000253485, who will be happy to help.

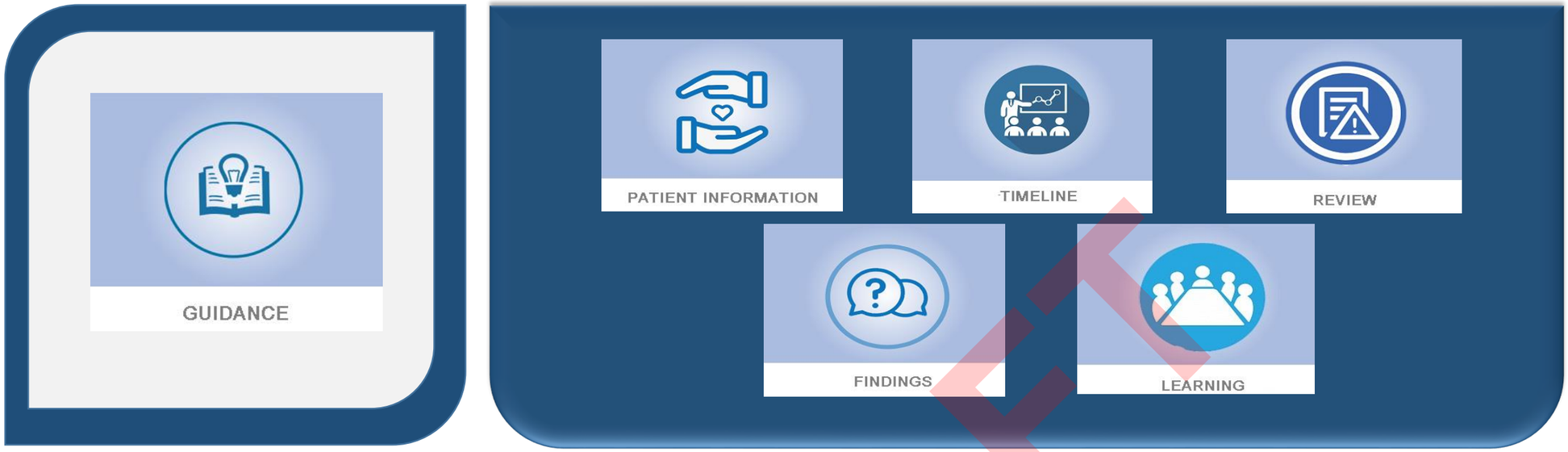
Yours sincerely



PROFESSOR CHRIS JONES

Cc: Jules McCabe and Melanie Harries, NHS Delivery Unit

COVID-19 RAPID REVIEW TOOLKIT (PATIENTS)



COVID-19 Rapid Review Toolkit (Patient)

HOME

The toolkit has been developed to ensure consistency when undertaking rapid reviews where patients have a positive COVID-19 result, and it has been established by the organisation that a review is required to establish nosocomial infections.

The Rapid Review comprises of 5 Parts:

Part 1 Patient Information
Part 2 Timeline of events (14 day period)
Part 3 Review based around 4 key Themes
Part 4 Findings
Part 5 Learning

Part 1
The purpose of this section is capture patient demographics and to identify symptom and testing arrangements in place at the time. For current inpatients, this part of the review should be completed within **48 hours** of the positive test being reported. When undertaking retrospective reviews for previous inpatients the organisation will identify a prioritised approach to undertaking this review.
This section of the investigation toolkit can also be used in isolation when identifying nosocomial infections and to identify the level of further review required and priority of the further review.

Part 2
where a probable or actual hospital acquired COVID-19 is suspected, it is essential that a timeline is completed to identify, wherever possible, exposures and transmissions to the COVID-19 virus. The timeline should include **14 days** from the date symptoms were reported (or where this is not known, the date of diagnosis or date of death).

Any exposures and risks identified from the timeline will be included in the review analysis.

Part 3
The review has been themed around 4 key areas;
•Testing
• Environment
• Contact
• IPC

A series of questions have been provided to help provide a consistant approach for identifying care or service issues.

Part 4
To facilitate learning, the findings from the rapid review should be presented against each of the 4 key themes.

Part 5
Where relevant, an action plan should be produced to capture any recommendations and actions from the review.

Demographics	
Patient identifier (NHS Number / CRN Number)	
Datix Incident Number	
Date of Birth	
Gender	
Ethnicity	
Date of current or most recent admission	
Was patient screened on admission	
Ward or Department	
Consultant	
Diagnosis	
Was patient diagnosed with COVID-19 on admission	

Reason for current or most recent admission

Brief description of underlying condition (including COVID-19 risk factors), treatment, and progress

Symptoms & Testing	
What symptoms were present on date of admission	
Were COVID-19 risk factors identified on admission or at the time of symptoms	
What symptoms were present at time of specimen collection or radiology	
Date of clinical decision to swab or image	
Rationale for decision to swab or image	
Date specimen/radiology taken	
Any additional risk factors identified	
Was the diagnosis communicated to the patient	
Did the patient demonstrate an understanding of the condition	
Did the patient have any contact with known COVID-19 cases during their period of admission (identify via timeline in part 2)	

Patient Death	
Did the patient die within 30 days of COVID-19 diagnosis	
If so, was the death linked to COVID-19	
Did COVID-19 appear on the Death Certificate	
Provide details of all conditions listed on death certificate	
Has a mortality review been undertaken (stage 1 or stage 1 & 2)	
Were any failures of care identified within the mortality review, and if so, what failings	
Has the mortality review identified further areas for review	

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	Pre Timeline notable events	DAY 14	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7	DAY 8	DAY 9	DAY 10	DAY 11	DAY 12	DAY 13	Post Timeline notable events
		01/04/2020	19/03/2020	20/03/2020	21/03/2020	22/03/2020	23/03/2020	24/03/2020	25/03/2020	26/03/2020	27/03/2020	28/03/2020	29/03/2020	30/03/2020	31/03/2020	
Key Events																
Timeline of Ward Stays and Transfers (transfers for investigations e.g Xray)																
Date of symptoms; test request; test result																
State previous admissions to any healthcare institution in the previous 14 days prior to symptoms or confirmed diagnosis of COVID-19																
Were any of the environments where the patient was being cared for identified as a COVID-19 area																
What interactions or contact occurred with other patients with a suspected or confirmed COVID-19 diagnosis																
What interactions or contact occurred with other patients who were later diagnosed with COVID-19																
What isolation arrangements were in place																
Were any suspect/ positive COVID-19 patients non-compliant with isolation precautions?																
Were any staff members directly involved in the care of this patient displaying symptoms of COVID-19 or later diagnosed with COVID-19																
Is there any evidence of insufficient supplies of PPE resulting in exposure of staff to COVID-19?																
Did staff members caring for this patient work with patients who were later diagnosed as COVID-19 Positive																
Was there a need to escalate treatment for COVID-19?																
Was the patient in need of transfer to another site for treatment?																
other key events																
other key events																

Key findings for analysis :

HOME

RAPID REVIEW THEMES			
Theme	**Summary of Review**	**Response**	**Evidence obtained**
Symptoms & Testing	Was symptom identification robust and in line with national guidance at the time?		
	Were COVID-19 risk factors identified in accordance with the known risk factors at the time?		
	Were testing arrangements robust and performed in accordance with local guidance at the time?		
Environmental	What was the environmental cleaning scores for the area(s) where patient was being cared for during the period? Provide date.		
	Provide details of cleanliness/environmental issues reported in the area(s) in which the patient was cared for prior to the diagnosis of COVID-19		
	What was the hand hygiene audit compliance results for the areas where patient was being cared for at the time? Provide date.		
	Any additional environmental or cleanliness factors identified as being of concern?		
Contact Management	Was visiting restricted during the 14 day period prior to the confirmed results?		
	Was there sufficient separation in space and or time between suspected and confirmed COVID-19 patients?		
IPC Precautions	Is there evidence that mandatory training and IPC training has been undertaken by staff relevant to this case?		
	Staff utilised transmission based precautions when a suspect case was identified? Namely FRSM, Plastic apron, gloves and risk assessed visor		
	what steps were undertaken to make sure staff had appropriate changing facilities for donning and doffing PPE?		
	Were any issues identified with PPE at the time?		
Additional Considerations	Were there any other factors (avoidable or unavoidable) relating to this patient's overall management that could have contributed to the incident?		

ANALYSIS		LEARNING	
Theme	Findings - Good Practice	Care & Service Delivery Issues	Recommendations
Symptoms & Testing			1. 2. 3. 4. 5.
Environmental			
Contact Management			
IPC Precautions			
Additional Considerations			

LEARNING FROM EVENTS

HOME

Datix Reference _____
Date of Incident _____
Lead for action plan _____
Date action plan commenced _____

Recommendations	Action and Progress	Monitoring and Evaluation	Responsible Person	Deadline for Completion	Status

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

Probable or Confirmed Hospital Acquired Covid-19 Infection (NOT deaths)

Patient – Rapid Assessment of Exposure Tool

Please complete this tool for each Patient who has acquired a Covid-19 Infection whilst an inpatient >8days

Patient Contact Details	
Name:	Date of symptoms onset:
DOB:	Date of swab:
Hospital Number:	Date of Positive test Result:
Paris No:	Reason for completing swab:
Ward/Location:	Date completing this rapid assessment tool:

Patient Exposure Pre Admission					
	14 Days prior to symptoms or testing positive for COVID -19	**Yes**	**No**	**Details:**	**Date (if known/applicable)**
1.1	Has the patient been in contact with a confirmed or suspected case of Covid-19 in their household or Community?				
1.2	Has the patient been self-isolating due to known Risk factors, please specify reason?				
1.3	Inpatient stays – Please indicate any other inpatient (hospital or care home) stays the patient has had in the last 28 days?				

Patient Admission					
				Details: (including Ward)	**Dates (if known/applicable)**
2.1	Where was the patient admitted from? For instance A&E, Home/Community, Another Ward or Health Board. Please specify where and reason for admission/transfer?				
2.2	Any known inpatient areas attended? For instance Theatre, Radiology, Dialysis - if so please specify details and dates.				

Patient Journey

3. Please record the patient's journey 14 days <u>prior</u> to Covid-19 Test, as below.

Please see example below:

Day 14	Day 13	Day 12	Day 11	Day 10	Day 9	Day 8
<u>Patient tests positive for Covid-19</u>	*(eg admitted to Ward A or off ward for CXR/ Dialysis)*					
Day 7	**Day 6**	**Day 5**	**Day 4**	**Day 3**	**Day 2**	**Day 1**

	14 Days prior to symptoms or testing positive for COVID -19	Yes	No	Details: (including Ward)	Dates (if known/applicable)
3.1	Was the patient exposed to Covid-19 in a Health Care Setting?				
3.2	Were there any patients on the Ward with confirmed Covid-19 results?				
3.3	Was the patient exposed to any staff / visitors with suspected or confirmed positive Covid-19 results? a) Suspected b) Positive results?				
3.4	Did the patient have any visitors during this period? Date and reason for visit?				

Positive Covid-19 Result – Action taken

		Yes	No	Details:	Date (if known/applicable)
4.1	Was the patient moved following a positive result? a) Patient Isolated b) Moved Ward c) Other				
	➢ Was the patient moved following advice from Infection, Prevention & Control?				
	➢ Was the patient moved for clinical reasons?				
	➢ Other please specify				
4.2	Has there been a recent Outbreak of Covid-19 in the Clinical area within the last 28 days?				
4.3	What is the Ward's Mandatory training (%) level for Infection, Prevention and Control training?			%	
4.4	What was the Ward's last Environment (Cleaning) score (%)?			%	
4.5	What was the Ward's last Hand Hygiene and Bare Below Elbow Audit score (%)?			%	
4.6	What PPE was in use on the Ward during the patient stay? *(e.g. fluid repellent surgical mask, visor, gloves and apron)*				
	Are you confident that these measures were adhered to? If no, please provide details				
	Were there any issues with the supply of PPE?				
4.7	Are appropriate social distancing measures in place? If no, please provide details				
4.8	Was the patient made aware of their swab results? Was the patient's NOK aware of the results?				
4.9	Any other possible contributing factors?				

Incident Reporting for Probable or Confirmed HCA Covid-19 Infection

		Datix reference	Date uploaded
5.1	Datix Ref: (Upload a copy of this completed assessment to the Datix record and answer yes to "Does this Incident need to be Reported to: Delivery Unit (DU) as a Serious Incident or Never Event" question in Section 2.3 which alerts Patient Safety).		

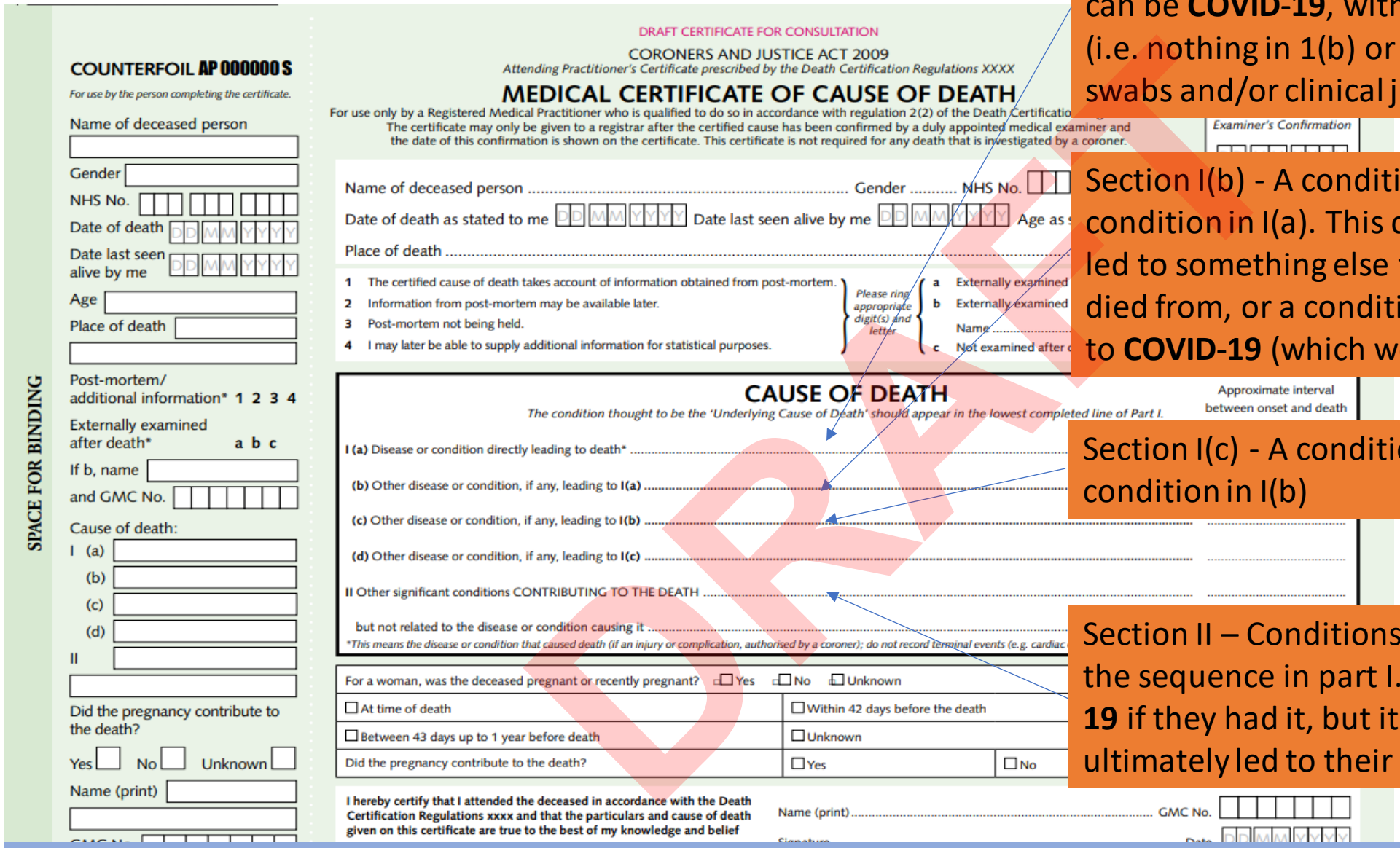
Person completing the Assessment

Name: Designation: Ward :	Directorate: Clinical Board: Contact Telephone Number:

Please attach completed tool to Datix Incident Form

(If you need support with attaching the tool to Datix, please contact PST on 36314 or Patient.SafetyTeam@wales.nhs.uk)

MCCD Completion – with particular reference to **COVID-19 deaths**



DRAFT CERTIFICATE FOR CONSULTATION

CORONERS AND JUSTICE ACT 2009

Attending Practitioner's Certificate prescribed by the Death Certification Regulations XXXX

MEDICAL CERTIFICATE OF CAUSE OF DEATH

For use only by a Registered Medical Practitioner who is qualified to do so in accordance with regulation 2(2) of the Death Certificatio
The certificate may only be given to a registrar after the certified cause has been confirmed by a duly appointed medical examiner and the date of this confirmation is shown on the certificate. This certificate is not required for any death that is investigated by a coroner.

Examiner's Confirmation

COUNTERFOIL AP 000000 S

For use by the person completing the certificate.

Name of deceased person

Gender

NHS No.

Date of death DD MM YYYY

Date last seen alive by me DD MM YYYY

Age

Place of death

Post-mortem/ additional information* 1 2 3 4

Externally examined after death* a b c

If b, name

and GMC No.

Cause of death:

I (a)

(b)

(c)

(d)

II

Did the pregnancy contribute to the death?

Yes No Unknown

Name (print)

SPACE FOR BINDING

Name of deceased person ..... Gender ..... NHS No.

Date of death as stated to me DD MM YYYY Date last seen alive by me DD MM YYYY Age as

Place of death .....

1 The certified cause of death takes account of information obtained from post-mortem.
2 Information from post-mortem may be available later.
3 Post-mortem not being held.
4 I may later be able to supply additional information for statistical purposes.

Please ring appropriate digit(s) and letter

a Externally examined
b Externally examined
Name .....
c Not examined after

CAUSE OF DEATH

The condition thought to be the 'Underlying Cause of Death' should appear in the lowest completed line of Part I.

Approximate interval between onset and death

I (a) Disease or condition directly leading to death* .....

(b) Other disease or condition, if any, leading to I(a) .....

(c) Other disease or condition, if any, leading to I(b) .....

(d) Other disease or condition, if any, leading to I(c) .....

II Other significant conditions CONTRIBUTING TO THE DEATH .....

but not related to the disease or condition causing it .....

*This means the disease or condition that caused death (if an injury or complication, authorised by a coroner); do not record terminal events (e.g. cardiac

For a woman, was the deceased pregnant or recently pregnant? ☐ Yes ☐ No ☐ Unknown

☐ At time of death	☐ Within 42 days before the death
☐ Between 43 days up to 1 year before death	☐ Unknown
Did the pregnancy contribute to the death?	☐ Yes ☐ No

I hereby certify that I attended the deceased in accordance with the Death Certification Regulations xxxx and that the particulars and cause of death given on this certificate are true to the best of my knowledge and belief

Name (print) ..... GMC No.

Signature ..... Date DD MM YYYY

DRAFT

Section I(a) - The immediate cause of death, this can be **COVID-19**, with no other underlying factors (i.e. nothing in 1(b) or 1(c)) Based on positive swabs and/or clinical judgement

Section I(b) - A condition or disease that led to the condition in I(a). This could be **COVID-19** if that led to something else that the patient ultimately died from, or a condition that predisposed them to **COVID-19** (which would be in I(a))

Section I(c) - A condition or disease that led to the condition in I(b)

Section II – Conditions that did not directly cause the sequence in part I. This could include **COVID-19** if they had it, but it was not the condition that ultimately led to their death

If the patient has a positive test for COVID-19 in the past 28 days then the E-form on WCP needs completing
COVID-19 is a notifiable disease (but not notifiable to the *coroner* by itself)

CoRSEL learning update #1

To all HBs/Trusts: this update provides a summary of **early learning** provided by organisations within NHS Wales and are related to in-hospital transmission of Covid-19. Please consider these messages in line with your organisation's governance framework and determine if any local action needs to be taken as a result.

Thank you to all HBs/Trusts who contributed to this learning update

- **Guidelines** can't be reinforced enough – staff can become complacent particularly if transmission was low in the first wave. Daily staff compliance audits are very important
- **Limit footfall** on wards however possible, including limiting e.g. big ward rounds, porters, cleaning staff, designate staff by pathway
- No car sharing
- **Reinforce messages** to staff for the need to isolate if **anyone** in their house is sick. There are lots of staff doubting that child / partner have virus and feel duty to be in work, then later finding that their relative has a positive result. Daily reminders / daily questioning staff along with providing clarity on expectations if they need to isolate (for example, does this need to be taken as leave)
- **Promote the culture** where everyone is confident in challenging / gently reminding each other etc.
- **Manage staff outbreaks** in the same way that IPC manage patient outbreak. One HB reports losing valuable time by not understanding who the index case was
- **Stay on top of the process** – if decision taken to screen staff, there is lots of opportunity for delay – send swab, wait for staff to be on duty, return swab, wait for lab, get result, wait for TTP etc. Days can be lost and contacts can still be in work
- There can be very high rates of asymptomatic staff
- Single rooms are not Covid free. Isolation precautions still need to be robust to prevent transmission occurring to the wider clinical area through compliance with PPE use, decontamination of the environment and any shared equipment
- **Communication is key** - ensure Agency staff have routine access to Health Board/Trust communications particularly as they often work on more than one site
- Staff changing rooms often don't have windows or air changes. Where ventilation is poor in changing areas, it is important to stagger use and limit the number within the room at any one time, 2m distancing, always facing away from others when masks are taken off, and staff should still be wearing a mask when walking in corridors etc. (anywhere indoors until they leave the building)
- Staff breaks – need to ensure breakout rooms are large enough to **socially distance** when taking off mask and eating. Also ensure mechanisms are in place to monitor staff are adhering to maximum numbers in breakout rooms
- **Cleaning of shared facilities** Sharing of kitchens, toilets and other facilities can be an issue – need for frequent wiping down of kettles, phones etc. after use
- There have been reports of staff in offices who are sufficiently socially distanced at desks becoming infected. Key learning is for those staff to **wear masks** when getting up from desks, and wipe all shared equipment
- No patient notes in clinical area
- Reduce clutter +++++

Covid-19 Rapid Sharing of Early Learning (CoRSEL)	
Issue number	1
Date of issue	5 November 2020
Approved by	CoRSEL oversight group
Contact	NHS Wales Delivery Unit via PatientSafety.Wales@wales.nhs.uk

CoRSEL learning update #2

To all HBs/Trusts: this update provides a summary of **early learning** provided by organisations within NHS Wales and are related to in-hospital transmission of Covid-19. Please consider these messages in line with your organisation's governance framework and determine if any local action needs to be taken.

Thank you to all HBs/Trusts who contributed to this learning update

- **Suitable PPE for log rolling**. National guidance is available at: https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/nipcm/chapter-1-standard-infection-control-precautions-sicps/#wales. Long sleeve fluid gowns are advised for high risk areas (including where there is risk of splash/spray wet contamination), otherwise disposable (no sleeve) aprons are advised which will allow staff to wash their hands and forearms easily.
- **Reducing number of staff attending a MET call**. One organisation has shared that one member of ward staff is allocated to stand at the ward door to ensure that only those required attend to the patient requiring resuscitation, thus limiting the number of staff involved. HBs/Trusts should consider how they will determine who is needed at the call e.g. is it based on first staff to arrive at the door
- **Decontamination of desks, equipment and items passed between staff**. Good hand hygiene and decontamination is of key importance whenever passing items between staff or whenever multiple staff will be in contact with the same equipment. This includes e.g.:
    - keys, bleeps and phones being passed between Nurse-in-charge of shifts;
    - pens/scissors etc. which have been handled by staff;
    - ensuring keyboards are cleaned when being used by multiple staff including e.g. entering passwords for contractors
    - not sharing food or mugs/cups during breaks, making rounds of drinks etc.

  One organisation has shared that they have developed cleaning checklists which are checked weekly, along with constant reinforcement messages of the need to clean relevant equipment - including specifying e.g. telephone, keyboard, mouse etc. - between uses.
- **Car sharing**. National guidance is available via: https://www.gov.uk/guidance/coronavirus-covid-19-safer-travel-guidance-for-passengers#private-cars-and-other-vehicles. Staff should avoid travelling to work together as social distancing cannot be maintained, but if car sharing is essential all travellers will need to wear a face covering for the duration of the shared journey. The passenger should sit in the back of the vehicles and windows should be opened to improve ventilation.
- **Use of PPE where social distancing is not possible -** social distancing requirements must be adhered to at all times when possible, but where this is physically not possible, it is acceptable for staff to use appropriate PPE to minimise risk. One HB has shared that they undertook a risk assessment of an area where social distancing was physically challenging and required use of appropriate PPE in those areas, but still on occasion observed a lack of adherence. Constant vigilance is required to ensure adherence to requirements in these settings https://phw.nhs.wales/services-and-teams/healthy-working-wales/covid-19-information-and-advice-to-support-employers-and-employees/workplace-workforce-risk-assessments/
- **Contractor management**. One organisation has shared issues with contractors attending work whilst symptomatic, and contractors travelling to Wales from English high incidence lockdown areas. The organisation has updated their Standard Operating Procedure (SOP) to include more comprehensive education and information around COVID-19 and infection control requirements, and compiled an associated educational video. This kind of information could form part of the mandatory contractor induction to the organisation.

Covid-19 Rapid Sharing of Early Learning (CoRSEL)	
Issue number	2
Date of issue	25 November 2020
Approved by	CoRSEL oversight group
Contact	NHS Wales Delivery Unit via PatientSafety.Wales@wales.nhs.uk

REPORT TITLE:	**OMBUDSMAN ANNUAL LETTER 2019/20**						
MEETING:	Quality, Safety and Experience Committee				**MEETING DATE:**	**15/12/20**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information** ✓
LEAD EXECUTIVE:	Executive Nurse Director						
REPORT AUTHOR:	Assistant Director of Patient Experience						

PURPOSE OF REPORT:

SITUATION:

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

Appendix 1 is a copy of the letter which will be published on the PSOW Website.

Annual Letters section on website the current letters are not yet published.

A report was provided to the September Board meeting.

REPORT:

BACKGROUND:

It is pleasing to note that the Health Board was below the average for complaints received and investigated with Health Board average adjusted for population distribution.

Factsheet

A. Complaints Received

Health Board	Complaints Received	Complaints received per 1000 people (population)
Aneurin Bevan University Health Board	140	0.24
Betsi Cadwaladr University Health Board	227	0.33
Cardiff and Vale University Health Board	100	0.20
Cwm Taf Morgannwg University Health Board	80	0.18
Hywel Dda University Health Board	92	0.24
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	91	0.23
	753	0.24

B. Complaints Received by Subject with percentage share

Cardiff and Vale University Health Board	Complaints Received	
Children s Social Services - Adoption procedures	1	1.00%
Complaint Handling- Health	11	11.00%
Health - Appointments/admissions/discharge and transfer procedures	6	6.00%
Health - Clinical treatment in hospital	59	59.00%
Health - Clinical treatment outside hospital	11	11.00%
Health - Continuing care	3	3.00%
Health - De-Registration	2	2.00%
Health - Medical records/standards of record-keeping	3	3.00%
Health - Other	1	1.00%
Health - Patient list issues	2	2.00%
Various Other - Whistle-blowing	1	1.00%
	100	

For context, across the UHB In 2019/20 we received 3166 concerns, 590 were managed under early resolution, providing a satisfactory outcome to the person raising concerns within 2 working days (including the day of receipt).

Therefore these figures demonstrate that less than 0.3 % of people who raised concerns with the UHB in 2019/20 approached the Ombudsman because they were dissatisfied with the Health Board response.

The 11 concerns in relation to Complaints Handling were further reviewed and 6 related to a delay in responding, the current response time is 86% and we will continue to liaise directly with complainants at the outset to agree the questions for investigation. Of these concerns 3 were not investigated following initial review and a further 2 were not upheld in any part.

C. **Complaint Outcomes** (* denotes intervention)

Complaints Closed	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/ voluntary settlement*	Discontinued	Other Reports- Not Upheld	Other Reports Upheld - in whole or in part*	Public Interest Report *	Grand Total
Cardiff and Vale UHB	4	10	50	17	1	10	12	0	104
Percentage Share	3.85%	9.62%	48.08%	16.35%	0.96%	9.62%	11.54%	0.00%	

From the 100 concerns received by the Ombudsman following initial review of our responses a full investigation was undertaken into only some 22 cases and 12 were upheld whole or in part.

Public Interest reports

There were no public interest reports issued against Cardiff and Vale UHB.

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

- Present my Annual Letter to the Board to assist Board Members in their scrutiny of the Board's Performance

This action has been completed at September Board meeting

- Work with my Improvement Officer and my Complaints Standards Colleagues to improve

complaint handling and standardise complaints data recording

We have met with the Ombudsman lead for the Complaints Standard Authority which is intended to help support complaint handling staff in delivering excellent outcomes for service users. As part of their work the Ombudsman's office are providing Training Sessions tailored to fit organisation's needs and provided without charge. Core modules focus on the complaints process, investigations, and communicating with complainants.

Soft skills modules explore additional sets of skills used in effective complaint handling and can provide an ideal refresher session for experienced staff.

We will ensure that the central concerns team will attend the modules when there is availability and we have been discussing a communications virtual module being developed for our UHB staff. This will be considered in the context of development of the Patient Experience framework.

Assurance

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

We have also considered **The Parliamentary and Health Service Ombudsman (PHSO) – Making Complaints Count** report and **The Health watch England** '**Shifting the mindset – A closer look at hospital complaints'** report.

Both reports offer direct feedback about what it is like to use the NHS in England and other public services. Complaints matter because feedback can help staff learn from when things go wrong and improve services as a result. However, the complaints system needs reform if people who rely on public services are to have confidence that their voices are being heard and being used to make improvements.

Both reports cover a large number of matters and the issues highlighted from across the NHS in England is stark, but remarkably consistent between the reports.

The reports indicate a lack of consistency and learning from complaints handling and call for a Complaints Standards Authority and the development of a complaints standards framework. They also show that the NHS needs to invest in its staff through access to better, more consistent, training and professional development in complaints handling. The promotion of a learning and improvement culture from the top is vital.

The Parliamentary and Health Service Ombudsman (PHSO) – Making Complaints Count: Supporting Complaints in the NHS and UK Government Departments report was published on 15 July 2020.

The PHSO conducted a thematic review of final investigation reports in NHS England where complaint handling was an issue. Two online surveys of healthcare staff were conducted between October and December 2019 and interviews held with senior staff and complaint handlers. The report focuses specifically on the NHS England complaints system and found:

A lack of consistency on how to deliver excellent complaints handling

- Staff responsible for resolving complaints should be properly trained and ensure that all parties – including staff who are cited in the complaint – are kept involved and engaged throughout.

- A lack of consistency in guidance and approach can have a negative impact on the experience of those who raise complaints.

The Healthwatch England 'Shifting the mindset – A closer look at hospital complaints' **report** was published on 15 January 2020. It looked at how well NHS hospital trusts across England communicate their work on complaints and found:

Local reporting on complaints is inconsistent and inaccessible

Staff are not empowered to communicate with the public on complaints

Reporting focuses on counting complaints, not demonstrating learning

We have in our annual report considered these reports and recognized that the process of early contact with complainants, a 7 day service, offering to meet following responses and the open culture committee to sharing learning is conducive to addressing some of the issues identified in the reports.

Development of the Once for Wales Concerns system and the service user experience system will enable more effective thematic and sentiment analysis to identify areas for improvement. There should also be an increased ability to benchmark comparable data across Wales to promote national learning and sharing of good practice and areas for improvement.

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

RECOMMENDATION:

The Committee is asked to **NOTE** the findings of the Ombudsman's Annual Letter 2019/2020 and the actions being taken.

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

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

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

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

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

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

Report Title:	**Surgery Clinical Board Assurance Paper – 2019/2020**								
Meeting:	**Quality, Safety and Experience Committee**						**Meeting Date:**	15 Dec 2020	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Executive Nurse Director**								
Report Author (Title):	**Director of Nursing for Surgery Clinical Board**								

SITUATION

This report provides details of the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety and Patient Experience agenda during 2019/2020. It will also highlight the actions and progress of the Surgery Clinical Board during the COVID pandemic.

BACKGROUND

Between April 2019 – March 2020 the Surgery Clinical Board had 4 Service Groups which provide a significant number of emergency and elective services to Cardiff and Vale residents which include Trauma and Orthopaedics, General Surgery and Urology, Head and Neck and Perioperative Care. The Clinical Board employs over 2067 wte staff and has a budget of £140 million.

In addition to direct service provision for the local community of Cardiff the Surgery Clinical Board provides a significant number of services beyond the local population at both the University Hospital of Wales and University Hospital Llandough such as regional Spinal Surgery and Hepatobiliary Surgery.

The Surgery Clinical Board also supports the activities of all other Clinical Boards within the Health Board through the provision of services provided by the Perioperative care Directorate, which includes Anaesthesia, Pain Management, Operating Theatres, Pre-Assessment and Sterile Services.

Whilst the majority of services provided by the Surgery Clinical Board are core activities, due to the high volume of activity and the diversity of its services, risk in the Clinical Board is high. Therefore robust risk management arrangements are in place to reduce and manage these in order that our service users and staff are kept safe.

The Surgery Clinical Board has a well-established formal Quality, Safety and Patient Experience (QSPE) that meets bi-monthly which is co-chaired by the Clinical Quality and Safety Lead (Consultant Anaesthetist) and the Director of Nursing for Surgery Clinical Board. This structure is formally replicated in each of the Clinical Directorates. The QSPE group has

three key sub-groups that report to it; a Health and Safety group, Infection Prevention and Control group and the Thromboprophylaxis Thrombosis and Anticoagulation group.

Due to the COVID pandemic these groups have not met at such regular intervals due to the challenges of the environment and challenges of workload in 2020. To support the ongoing operational and governance requirements of the clinical board during the pandemic the Clinical board looked to set up a differing arrangement for tight operational and governance control over the first wave of the COVID pandemic. These were in the form of regular daily clinical board meetings which were attended by the Clinical board and directorates triumvirates and lead for each of the clinical services. These meetings still currently take place virtually 3 times per week and are noted and actioned.

ASSESSMENT

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

Quality, Safety and Patient Experience is the highest priority for the Surgery Clinical Board which has a robust and well attended quality and safety groups with strong representation from Management, Medical, Nursing and Allied Health Professional staff from both within and external to the clinical board.

The Clinical Board Covid Risk Register is monitored at Directorate and Clinical Board level on a regular basis locally. The top 4 current risks on the Covid Risk register as of Nov 2020 are:

Risks	Mitigation
Patient or staff harm due to insufficient deployable workforce (medical and nursing) and challenges to separate staffing amber and green zones and new additional capacity areas in both inpatients areas and theatres on the back of COVID. There is also the impact staffing issues have or remaining staff in regards to, morale, sickness levels, training & development.	UHB wide multi professional approach is being utilised. Ongoing efforts of the work force hub and public recruitment campaign for nursing. Allocation of workforce lead for Surgery Clinical Board for junior doctors. Micromanagement and contingency plans put in place on a daily basis by lead/senior nurses.
Increased morbidity and mortality to emergency surgical patients not presenting to hospital with significant medical illness due to COVID related fears. Lack of Surgical Assessment unit space due to social distancing requirement	Work undertaken by communications team to reassure the general public that hospitals remain safe places to present with acute medical illness. Ongoing monitoring of non-covid mortalities/morbidity by Public Health. Audit data on emergency and elective surgical patients has been collected since March 2020. Screening for Covid for every DTA patient. Clear zoning of Areas in UHW

	and UHL. Consultant triage of GS patients via dedicated hot line in SAU. TACU review for ambulatory trauma patient
Failure timely access to cancer and urgent elective surgery which significantly affects the patient's quality of life and can in some cases exacerbate their condition. Increased risk to those patients who's condition may deteriorate whilst waiting for surgery due to Covid	Development of Green Zones in both UHW and UHL to protect cancer and urgent patients who require surgery. Proactive Discharge Planning required to ensure bed availability in a timely manner and ensure. Quality assurance of patients waiting on list is undertaken and treatment expedited if GP requests urgent referral or if information received indicated urgent need of referral - this is overseen by a consultant. Weekly discussions to review longest waiters and the appropriate booking of them. Audit data on surgical patients outcomes has been collected since March 2020
There is a risk of suboptimal staff experience due to the unprecedented number of changes and departmental moves, at pace, over recent months and likely for over the next few months. This may lead to increased absence and decreased retention.	Increased face: face Comms by Clinical Board Senior Leadership Teams with ward/departmental staff; Prospectively plan ward/dept moves in advance in order that good Comms can take place; Engage with Staff Wellbeing team should staff require enhanced support. Early engagement with Union Colleagues. 3 times a week CB meetings with Senior Teams - regular updates disseminated from meeting. Staff drop in sessions

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

Pre-op assessment

Centralisation of Preoperative Assessment services as a result of the COVID-19 pandemic has brought forward planned improvements, and we have seen significant reduction in delays in the clinic pathways and on last minute cancellation rates. Across elective surgery the average day of surgery cancellation rates were previously 15% of all cases. It has already dropped to approximately 6%. Cancellation with reasons attributable to POAC processes were around 8% previously and are now less than 2%. This is a significant improvement in patient safety, costs, and service utilisation. As **Prehab to rehab** develops we will be able to realise further benefits and improve quality of care for all surgical specialties.

Prehab to rehab

A business case has been submitted and approved by BCAG to further progress the prehab to rehab programme sets out to prepare, support and improve people's health and wellbeing from the point of suspicion of cancer through to treatment. This will be achieved with a multi-professional team approach across the health system in both primary and secondary care. There are three areas that the programme focuses on:

- Primary care optimisation
- Prehabilitation
- Pre-operative Assessment Clinic services and Enhanced Recovery after Surgery (ERAS)

The aim of the teams across the pathway are to empower, support and enable people to optimise their preparation for treatment before surgery, and for those receiving preoperative chemo/radiotherapy as well as longer term after the active treatment has concluded.

Prehabilitation and optimisation have been proven to:

- Improve patient outcomes
- Improve recovery following treatment and reduce length of stay
- Improve patient experience and emotional resilience
- Improve cardiorespiratory fitness and nutritional status
- Reduce post treatment complications (including those related to existing medications)
- Provide a teachable moment in both health and lifestyle, and enhance quality of life.

Covid Safe

Our IPC and H&S meetings over the last 6 months have focused on making all our clinical/ admin and communal areas as COVID safe for our staff and patients as we can. This has been a challenge but we have been able to work closely with our IPC, Microbiology , Union and Health and Safety colleagues in managing and monitoring this and in supporting staff in making the right decisions.

The Eyefficiency App

The Ophthamology and Anesthetics teams have introduced a novel quality improvement tool (the Eyefficiency App) to five different hospitals in Wales. This allows real-time analysis of both productivity and carbon footprint of a cataract operating list. The app has been developed to facilitate audit, measure carbon emissions, encourage best practice but also help raise awareness of resource management. One of the major contributors to the health service's environmental impact is the use of various anesthetic gases. Some of these gases, used every day across many surgical operations, are potent greenhouse gases, which account for around 5% of the carbon dioxide equivalent (CO_2e) emissions of NHS organisations across the UK (SDU 2017).

One of the gases alone, desflurane, accounts for around 80% of CO_2e emissions from the use

of inhaled anaesthetics and has a climate change impact over 2,500 times worse than carbon dioxide itself.

This problem was recognised by a team of anaesthetists in Cardiff and Vale UHB, who, in September 2018, established *Project Drawdown*. The aim of this project was to educate healthcare staff about the impact on the climate of the anaesthetic gases they use in their daily practice and see if this alone induced a behaviour change. Within six months, they had reached their initial goal of reducing emissions by 50% from baseline.

Key stakeholders included patients, surgeons, anaesthetists, ward nurses, theatre staff, estates managers, theatre managers and in the community both GP's and optometrists. Using the app, they showed a 33% reduction in carbon emissions from cataract surgery using simple measures such as reducing visits to hospital, using energy efficient lighting, reducing waste and working with industry to improve the supply chain and minimise packaging.

Working with the Accelerate programme, which is part of the Life Sciences Hub Wales, the team hosted a Sustainable Anaesthesia Innovation Conference in June 2019. Out of this conference, they formed the Welsh Environmental Anaesthetic Network (WEAN) with the goal of reducing the CO_2e emissions of inhalational anaesthetics by 80% across Wales by 2021. By taking this coordinated approach, Cardiff and Vale UHB has seen its desflurane use drop by 95%, a CO_2e saving of over 87,000kg per month (an 86% drop in emissions) and a cost saving of around £80,000 each year

SAFE CARE

Electronic Nursing Documentation

- Ward A1 link (emergency surgery) was selected as the pilot ward for the UHB to test the first phase of the newly approved, All Wales electronic nursing documents. The pilot occurred in Feb/ March 2020 and the ward have given an evaluation to Swansea University based on their experiences and use to the documents and IT systems

Serious Incidents and No Surprise Incidents reported to Welsh Government

Between 1/4/19 and 31/3/20 the Surgery Clinical Board reported 30 Serious Incidents and 2 No Surprise events to Welsh Government.

Never events

There were 2 reported never events in this period all of which have robust RCA's carried out

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

Table 1- Themes of the SI's

	Total
Administrative Processes (Excluding Documentation)	3
Diagnostic Processes/Procedures	2
Patient Accidents/Falls	5
Pressure Ulcers/Moisture Lesions	12
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	8
Total	30

2062 patient incidents were reported by Surgery CB between 01.04.2019 – 31.03.2020

Table 2 - Top 10 themes

	Total
Patient Accidents/Falls	666
Pressure Ulcers/Moisture Lesions	444
Medical Devices, Equipment, Supplies	173
Medication/Biologics/Fluids	148
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	116
Documentation	84
Communication	81
Administrative Processes (Excluding Documentation)	79
Diagnostic Processes/Procedures	71
Anaesthesia Care	56
Total	1918

Falls

There were 5 injurious falls reported as Serious Incident between 01.04.2019 – 31.03.2020. 2 were from T&O, 3 from General Surgery Directorate. No common themes were identified.

HM Coroner's inquests and regulation 28 reports

The Clinical Board has been involved in 8 inquests between 1/4/19 and 31/3/20 (where Surgery was the managing Clinical Board). Of these, none received a regulation 28 report. Relevant Coroner and Ombudsman reports and recommendations are considered by the Directorate and Clinical Board Quality and Safety Groups.

Infection prevention and control

Overview of position from 1/4/19 and 31/3/20

Clostridium difficile
15 cases - from 1/4/19 and 31/3/20
Only 2 cases from 1/4/20 - 31/10/2020

Meticillin Resistant Staphylococcus Aureus (MRSA) bacteremia
2 cases - from 1/4/19 and 31/3/20
0 cases from 1/4/20 -31/10/2020

Meticillin Susceptible Staphylococcus aureus (MSSA) bacteraemia
11 cases from 1/4/19 and 31/3/20
Only 3 cases from 1/4/20 -31/10/2020

Escherichia coli (E. Coli) bacteraemia
26 cases from 1/4/19 and 31/3/20
Only 8 cases from 1/4/20 -31/10/2020

P.aeruginosa
4 cases from 1/4/19 and 31/3/20
Only 3 cases from 1/4/20 -31/10/2020

Klebsiella spp
10 cases from 1/4/19 and 31/3/20
Only 3 cases from 1/4/20 -31/10/2020

Surgery Clinical Board have made reductions in all their HCAI over the last few years and have not had a MRSA since May 2019.

EFFECTIVE CARE

TransOral Robotic Surgery (TORS)

TransOral Robotic Surgery (TORS) is a modern surgical technique used to identify and treat head and neck cancers. It has a number of benefits: improved visualisation with 3D imaging, improved range of motion, ability to access narrower areas and reduced operator tremor. It has now been used for 11 months, since December 2019, in the University Hospital of Wales (UHW), to great effect.

Extensive training is required to use the robot. Surgeons undergo more than 40 hours of simulation training, as well as several days of cadaveric training and a number of test modules.

The DaVinci Xi model used in UHW was initially being used to deliver surgery urological cancers and since December 2019 has been utilised in 20 life-changing operations for patients with head neck cancers. This was the target number of operations for the first year, and has been achieved a month earlier than predicted despite disruption to routine services due to the ongoing covid-19 pandemic.

13 operations have occurred in patients with cancers of unknown primary, i.e. those with evidence of carcinoma in lymph nodes in their neck, with no obvious source, despite extensive imaging and surgical investigation. Of those, 46% were diagnostic; locating the primary tumour in the tongue base; allowing modification of additional treatments such as chemotherapy and radiotherapy, or (as in 4 cases), avoidance of adjuvant treatment altogether.

The remaining 7 operations occurred in patients with known cancer, in sites difficult to reach via traditional methods, such as the base of tongue and the glossotonsillar sulcus (the area between the bottom of the tonsil and the base of the tongue).

Almost all patients received concurrent neck dissection (removal of lymphoid tissue on the ipsilateral neck to the carcinoma or positive lymph node), except for those who had previously undergone dissection at their referring centre.

There were no in hospital complications, and the average patient stay was 3-4 days. Patients received carefully curated post-operative care, as per BAHNO (British Association of Head and Neck Oncologists) guidelines and experiences from other regional centres.

COVID-19 incidence has brought a massive impact on the way services have been run Below are some examples of how services have adapted to keep a patient centred focus

Tissue Viability Service

- More virtual consultations with the help of medical illustration and the e-referral system – flexibility in receiving the referrals, sometimes via email/telephone to support areas in the red zone
- Moving all training to virtual, with sessions carried out via Teams
- Development of three new learning workbooks forward staff to replace the previous monthly face-to-face training sessions– which have been very well received and are going to be transferred to ESR
- Outpatient Clinic numbers at UHW greatly reduced, with virtual consults and photos sent in by patients initially to ensure they only physically attend when absolutely necessary – liaising with community teams to implement care plans
- Commencement of a pilot to proactively provide treatment and endeavour to reduce recurrent hospital admissions for infected leg ulcers and cellulitis (previously highlighted as 23% of the referrals received by the inpatient Wound Healing Team)

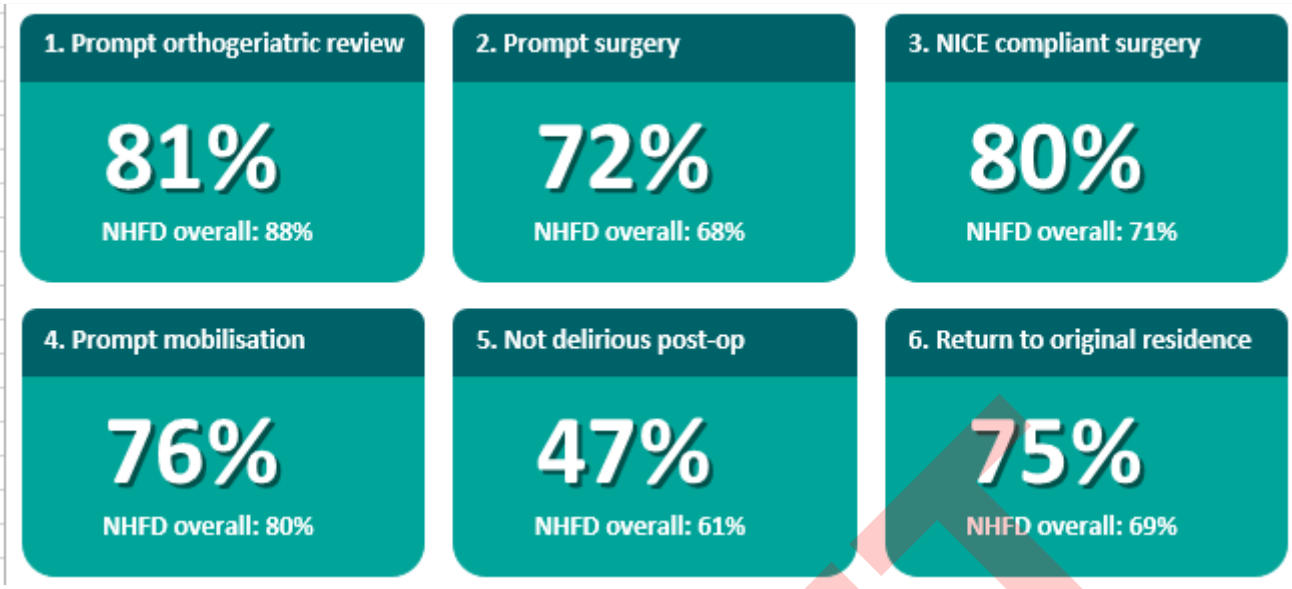
Ophthalmology Outpatients Department

- Language Line Translation Machine (has been put in place) to reduce people coming in to the department
- Telephone Consultation for both Eye Casualty and Routine Clinics
- Virtual Clinics where patients had their scans and results are reviewed by consultants virtually. No need for patients to stay in the unit for long and can go home right straight after.
- Dedicated Room for COVID suspected patients
- AMD Service diverted to Spire Hospital until 18th December
- Patient Pagers funded by heath charity

DIGNIFIED CARE

Dignified care inspections and CHC inspections carried out in 2019-2020 have not identified any areas of significant concern specifically in relation to dignity.

Overview Analysis of the KPIs detailed in the National Hip Fracture Database (NHFD)



Summary of Key Performance Indicators (KPIs)

- Prompt orthogeriatric review: Above expectation
- Prompt surgery: Within 5% of expectation but above NHFD and All Wales averages
- NICE Compliant surgery: Above expectation
- Prompt mobilisation: Above expectation
- Not delirious post-op: Below the 75% expectation and NHFD and All Wales averages
- return to original residence: above expectation

TIMELY CARE

In January 2020 Surgery Clinical Board Launched the start of Right Bed, First Time" following 2 well attended workshops with SCB staff in November and December 2019

The aim of this scheme was to empower all member of the team to "pull" their speciality patients from the " front door/ Critical care/EU/ SAU" in a timely manner giving more ownership to Clinical Teams by following to basic principles

- Forecasting discharges more accurately
- Being aware of where there specialty patients are in the system

PESU

Extensive work has been carried out by Surgery Clinical Board at University Hospital of Wales (UHW) and University Hospital Llandough (UHL) to create dedicated green zones to enable more patients to undergo urgent surgery. The green zone in UHW was enabled patients to undergo surgical procedures including neurosurgery, urology and general surgery, gynaecological, ear, nose and throat (ENT), and cataract surgery. At UHL, a green zone has been established to enable increased access to cardiac and thoracic surgery, orthopaedics and breast surgery.

Protecting patients, their families, and staff from COVID-19 is of vital importance, with the meticulous planning by the Surgery Clinical Board in conjunction with Children and Women, Specialist, CD&T and the support of estates and IPC allowing for an increased number of time sensitive surgeries to take place.

Patients due to have surgery are asked to self-isolate for two weeks prior to their procedure and take a COVID-19 test 72 hours before being admitted to hospital. When travelling to hospital, patients are asked to travel in a private vehicle avoiding public transport and the use of taxis. To further increase patient safety, the green zones have dedicated entrances and exits, and staff working in the green zones are required to remain in the dedicated zones for the entirety of their shift.

In order to support staff in this endeavour, new staff areas, changing rooms and showers have being constructed within these green zones. Any deliveries to the units are contactless using a “drop off” door system. All of these measures are absolutely necessary so that staff are supported in their efforts to make patients as safe as possible as we continue to bring more of our services back online.

So far as of the 26th November 2020 we have operated on the following numbers :

Patients treated in PESU Green Zones		
UHW	UHL	SPIRE
2,582	487	1,119

Positive Pre Op COVID Swabs
26

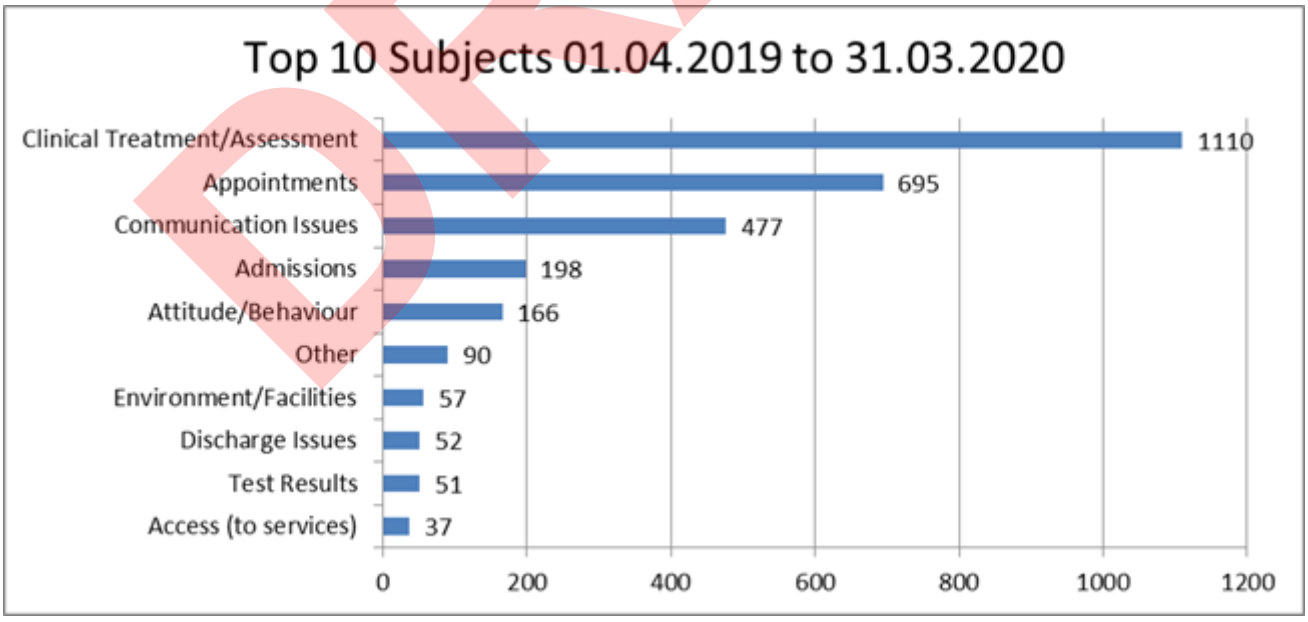
INDIVIDUAL CARE

Formal concerns

This remains a challenging aspect of quality for the Clinical Board to manage efficiently and effectively. Between 1/4/19 and 31/3/20 the Clinical Board received a total of:
1,145 new concerns during 01.04.2019 to 31.03.2020.

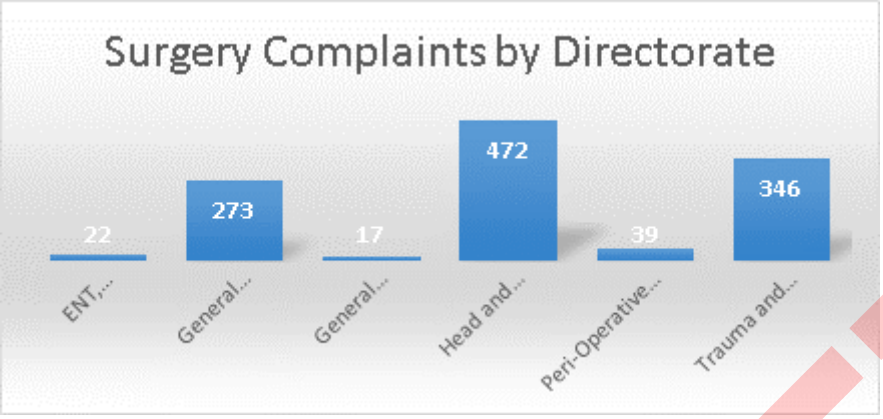
During this period Surgery Clinical Board closed 1152 concerns with 81% of these closed within the 30 working day target. This is a significant improvement on the previous year's performance and the Clinical Board continue to attend weekly tracker meetings with the concerns to maintain focus on quality timely responses.

Top 10 Themes identified from Concerns in this time period 1st April 2019 to 31st March 2020



The Highest number of concerns, 1110 related to Clinical Treatment and assessment, followed by Appointments (695) and communication issues (477)

Surgery Clinical Board consistently receive a significant higher percentage of concerns. The graph below shows that a high number of Surgery Clinical Board Concerns were logged with Head and Neck and Dental during 2019/ 2020



On review, the majority of these concerns related to Ophthalmology Services and the cancellation of Ophthalmology appointments were a theme throughout this period. One key approach to address the delays in treatment was to commission services from an in sourcing team.

There were also a high number of concerns raised relating to the treatment provided by the Insourcing Team raised by staff and patients commissioned by Cardiff and Vale UHB and investigations concluded that there were failures in care. Contact was maintained with complainants and those who wished to pursue litigation were advised of the most appropriate route and the availability of independent clinical advice etc.

Throughout this period a number of comprehensive reports have been shared with the QSE Committee by both the Chief Operating Officer and the Surgery Clinical Board.

The Executive Nurse Director shared the review of the serious incident with the QSE Committee in February 2020.

<u>Report</u>

A number of actions have been agreed to address the issues raised relating to cancellations of appointments and loss to follow up including:

- Ophthalmology Department arranged additional sessions to clear all new patient referrals waiting over 5 weeks or more.
- Consultant Ophthalmologist drafted acceptance criteria to manage new patient referrals including out of area boundaries.

- Ophthalmology Directorate reviewed the commissioning arrangements for out of area boundaries.

- Ophthalmology Service Manager and Deputy Health Records Manager meet weekly to agree where referrals should be sent to ensure there are no delays and list urgent patients as necessary.

- Ophthalmology Service Manager and Deputy Health Records Manager meet to agree the information accessible to the Appointment Booking Centre is accurate.

- Changes will be made to the PMS to allow staff in Health Records to input a target date for new patients.

- The Ophthalmology Directorate Management structure was reviewed to ensure that there is sufficient capacity to undertake the additional responsibilities associated with the monitoring and management of follow-up patients that have breached their target date.

Clinical Negligence Claims

There were 50 new Surgery claim files opened from 01/4/19-31/3/20. This increase may be reflected as a general increase across all clinical boards for claims served to Cardiff & the Vale and possibly due to the unusual low case files opened the same period 2018-2019.

	General Surgery	Dental	Head & neck	Spinal Surgery	Peri Operative	T&O	Total
Surgical Services	12	3	15	1	5	14	50
Totals:	12	3	15	1	5	14	50

The Clinical Board has received 19 compliments which have been logged formally. These are shared with staff appropriately.

In implementing the National User Experience Framework service users are telling us we are in the main doing a good job but there is still work to do.

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

Retrospective – Patient stories are shared at relevant groups within the Clinical Board

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

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

STAFF AND RESOURCES

Finance

The financial position at the end of Month 12 (March 2020) was an overspend of £1.216m for the year.

2019/2020	In year overspend
Pay	76
Non pay	996
Income	114
Totals	**1216**

Staffing

Surgery Clinical Board Workforce Summary Report October 2020 Data

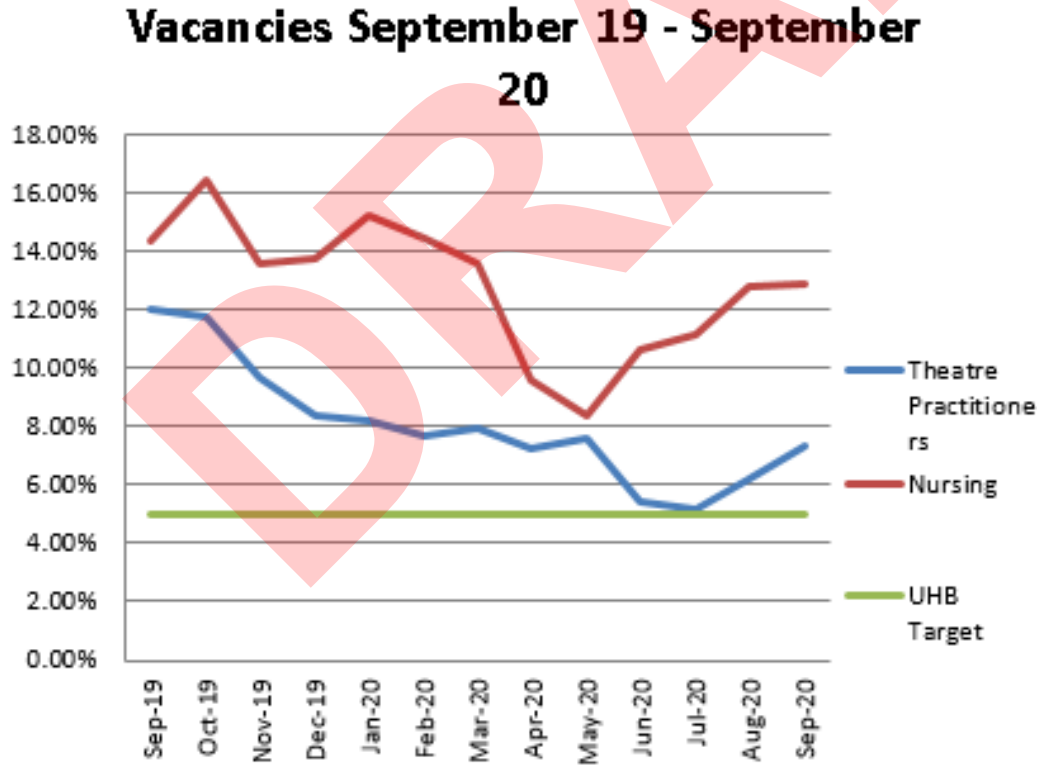
Key Performance Indicator	Cumulative 12 month as of September 20	Comparison with Previous Month (August 20)	Comparison with Previous Year (September 19)	2020-2021 target
Vacancy Rate (WTE)	7.27%	8.38%	7.16%	5.00%
Voluntary Turnover Rate (WTE)	6.86%	5.94%	5.60%	7.00%
Sickness Absence Rate	4.73%	6.21%	4.99%	4.47%
PADR Rate	25.93%	26.63%	49.11%	85.00%
Statutory and Mandatory	67.65%	68.10%	68.59%	100.00%
Medical Appraisal	64.88%	67.93%	84.62%	81.55%

Recruitment

Registered Nurse and ODP recruitment has been a significant challenge due to the COVID pandemic. The Clinical Board hold regular recruitment meetings underpinned by a robust action plan which has driven several different initiatives such as:

- Dedicated supported 4 week supernumerary time for all new registered staff joining a ward.
- Keeping in touch days where UHB staff contact staff who have been appointed but may not be commencing employment for a few months e.g. Student Nurses/ODPs who are a few months off qualifying, and invite them in to talk to them about new initiatives and give them opportunity to meet with staff in the team they are joining.
- Student Streamlining awareness events
- Overseas recruitment for inpatient and perioperative areas

The main schedule of work for the Surgical the Clinical Board to progress with over the next 12 months is the Peri operative care workforce plan to modernize and streamline out Nursing and ODP workforce. A robust plan has already been developed and we are looking to source a project manager to help support this project going forward to support the Lead Nurse for Perioperative Care.



Whilst historically the staffing position for theatres was of concern at nearly 12% (Graph 1) this has reduced exponentially over the last 6 months to just over 8% whoever this does not reflect the difficulties that the COVID pandemic has brought to the perioperative environment as Green/ Amber and red areas need to be staffed independently from the same resources.

The situation for the wards shows a similar picture showing a decrease from 12% in September 2019 to 7 % in September 2020 however this does not take into account the uncommissioned additional capacity areas that surgery Clinical Board are staffing for the Health Boards such as ward C7 .

The Surgery Clinical Board want to recognise the amazing resilience that the staff from Surgery Clinical Board have shown over the pandemic with only 2 inpatient areas within Surgery Clinical Board not having the purpose or the location of their ward changed.

Highlights

- Staffing of C7 as COVID ward by SCB during both first and second wave
- Green, Amber and red zones were created in UHW and UHL Theatres.
- The Anaesthetic Practitioners provided a 24 hour a day MERIT team who would attend COVID intubations in UHW and UHL
- Trauma take and full trauma teams moving to UHL
- Trauma clinic moving to UHL
- TACU moving to UHL
- B6 opening as medical ward to help with medical pressures – June 2020
- 14 wte staff volunteering to work in DHH hospital
- 25 wte RN staff released to support additional capacity areas – Nov 2020
- Dental Nurses supporting many areas across UHB
- T&O Consultants setting up turning team for Critical Care
- SHO and HO supporting UHB COVID rota – roles backfilled by Consultants
- Breast team supporting medical wards in UHL until Nov 2020
- Cardiothoracic theatres moving from UHW to UHL
- The CAVOC theatres and recovery area was cleared to provide a further 12 potential ITU spaces
- A 7 day week emergency service was created in Childrens hospital for Wales theatres
- Recovery Staff received additional training to be part of the 'Treat & Transfer' team who would transfer COVID+ patients from UHL to UHW
- New PACU and recovery unit on award A3link is due to be up and running by December 2020.

Retention

Whilst we have a very comprehensive work plans and action plans to try and address nurse retention such as holding celebration events, surgery star awards, employee engagement events and trying to instil a feeling of being part of a bigger team such as via dedicated Facebook pages, it is still proving to be inadequate and further pressures from the COVID pandemic have exaggerated this in 2020.

Staff engagement

A significant amount of work has been carried out in the Clinical Board over the last 12 months to make this agenda a priority. The following are some of the highlights of the good work being done or being planned:

- OD work ongoing in Theatres and HSDU to improve engagement
- Promoting the Health Board values and behaviours, including values based recruitment
- Surgery Stars Celebration Event
- Team Development
- Succession Planning
- Talent Management
- Leadership & Development Programme ongoing in Theatres and HSDU
- Keeping in touch days for New Starters
- Clinical Skills days for Nurses
- Professional Nursing Forums
- Registered and un-registered engagement groups
- Student Streamlining engagement sessions

Sickness absence

Whilst sickness absence is not at the UHB target levels all Directorates appear to be managing their sickness well despite the COVID pandemic

Sickness Rates

	Sept 19	Sept 20
General Surgery	4.08%	3.86%
Ophthamology	2.62%	1.69%
Theatres	5.82%	5.73%
T&O	5.72%	5.67%
Urology	4.71%	8.16%
ENT and Dental	2.98%	2.35%
Management	0.00%	0.00%

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

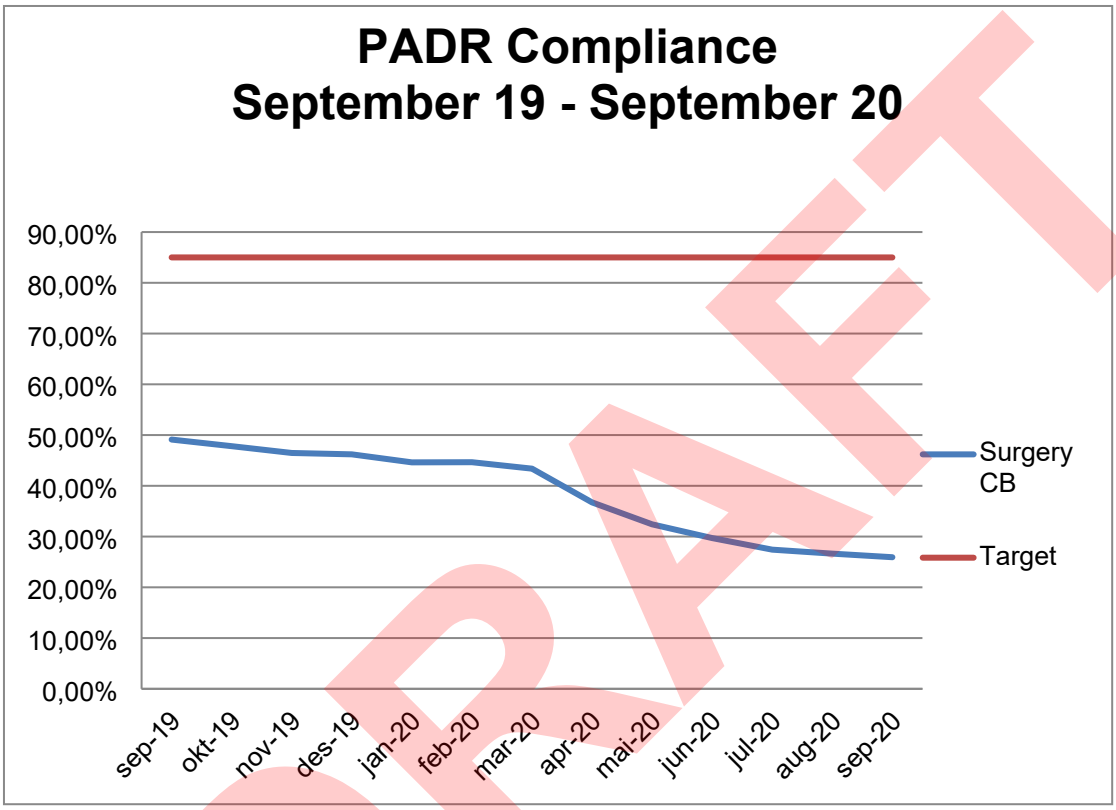
- Support for managers with both short and long term absence via:
  Bespoke training by the Workforce & OD Team
  Sickness Absence Surgeries with Line Managers, to discuss individual cases
- Compliance Against the Policy:
  Audit programme, focussing on hot spot areas to check;

- Health & Wellbeing Promotion via sickness surgeries and training
- Redeployment and return to work opportunities for staff

PADR compliance

PADR compliance has decreased to under 30% in Sept 2020 with a marked deterioration since March 2020 due to the COVID pressures.

Surgery Clinical Board - non-medical PADR Compliance



Actions to enable sustained improvement:

- Managers are able to access training in how to retrieve their latest reports via the ESR team.
- CB continue to meet with Senior Nurses and Clinical Leaders from Theatres in UHW to give a clear message regarding improvement. The same will happen with Senior Nurses and Clinical Leaders in UHL.
- Encouragement to use ESR database, not department database as the ESR data is what is reported upon
- Unfortunately enabling work hasn't delivered the level of improvement that the Clinical Board anticipated over the COVID pandemic period

Award winners

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

HSJ Awards- Shortlisted – Transformation of glaucoma eye care services
BMJ 2020 – Environmental Sustainability and Climate action team of the year

Staff Recognition Awards 2020
Ophthalmology Macular Team (Quality, Sustainability and Efficiency Award Winner)
Beat Flu Campaign Team (Health at Work and Well Being Award Runner Up)
Barbara Jones (Staff Recognition Research & Development Award Runner Up)

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **NOTE** the progress made by the Clinical Board to date
- **APPROVE** the content of this report and the assurance given by the Surgery 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								

Report Title:	**HEALTH AND CARE STANDARDS**								
Meeting:	Quality Safety and Experience Committee						**Meeting Date:**	15.12.20	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Executive Nurse Director								
Report Author (Title):	Patient Safety and Quality Assurance Manager								

Background and current situation:

The current set of Health and Care Standards came into force on 1 April 2015 and incorporate 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.

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.

In December 2019 an update was provided on the progress that had been made on the actions taken forward from the self-assessment earlier in 2019. Updates were provided from the groups and committees aligned to the Health and Care Standards in December 2019.

In 2020 a self-assessment against the standards was stood down in view of the Covid-19 pandemic. This paper will report the progress that has been made on the amber and red actions previously presented in December 2019.

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

There has been progress in some areas but the impact of the Covid-19 pandemic has thwarted progress in several areas. Two of the standards reported in red are due to the lack of resources as impeding progress i.e. Standard 2.5 Nutrition and Hydration report a lack of a funded dietitian impacting upon the service provided in the Emergency Unit. This will be taken forward by the Director of Therapies and Health Sciences.

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. Discussions are underway to ensure that appropriate resource is available for full participation in national clinical audit and this will form part of a business case to support implementation of the revised QSE Framework when agreed.

The 2021/22 approach is currently uncertain in view of the ongoing Covid-19 pressures and the full impact of the second wave is not yet fully understood. It is anticipated that if the Heath and Care Standards are to take place for 2021/22 the process will remain the same as the previous years 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 2021 QSE Committee.

The overall approach and timescales for 2021/22 may be reviewed to balance the pre-requisite for assessment and assurance against the Health and Care standards with the anticipated ongoing pressures on health care service due to the Covid-19 pandemic. An update position will be provided to the Committee in February 2021.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

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 was completed and the results were presented to the Committee in December 2019. We now have an update on the progress of actions that were RAG rated as amber or red. This is outlined in Appendix 2.

Recommendation:

The committee are asked to:

- **Note** the progress made against the actions identified for each of the Health and Care Standards.

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

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	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

Health and Care Standard Update on actions from Corporate Assessments (2019/2020) Update December 2020

Standard	Action	Update 2019	Update 2020	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.	No data is available currently. Data has previously been reported from UHB IT reporting System, the local Public Health Team has been unable to access this data since the move to Global Link. Work is ongoing with IM&T to find a solution unfortunately there have been delays as a result of COVID	**A**
	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.	Dietetic services continue to accept referrals for people with raised BMI from across the UHB and have also now introduced self-referral, encouraging people to self-refer rather than rely on medical referral. Posters are distributed around the UHB and there is a section on the new www.keepingmewell.com website	**A**

			The health board is expanding its weight management services in early 2021 linked to the healthy weight healthy wales strategy and will have dedicated maternity services and children's services going forward.	
2.2 Preventing Pressure Damage	2. Input into the UHB Total Bed Management contract	2. Taken out of scope of group – to be taken forward by Deputy END.	It has been agreed that no further work will be undertaken in relation to the Bed Management Contract for the foreseeable future.	**R**
	3. Developing a standardised approach to formulary ordering and management	3. Progressing	Awaiting an update for the progression of implementing a standardised approach.	**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 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.	Datix changes have been made during the course of 2020 to assist pressure damage incident reporting. In particular, new dashboards have been developed to support management of pressure damage incidents at scrutiny panels. PCIC Clinical Board has led the way with scrutiny panels, supported by the Patient Safety Team. The work has been presented to the Pressure Damage Group with encouragement to other Clinical	**A**

			Boards to adopt a similar scrutiny process. Patient Safety Team and Safeguarding Department have collaborated to align processes into one flowchart. This will be presented to the Safeguarding Steering Group in December 2020 and rolled out across the Health Board. This will facilitate timely management of referrals to Safeguarding and Serious Incident reporting. During 2020, Serious Incident processes have significantly changed due to COVID-19. Reporting to the Delivery Unit is now in place.	
	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.	Scrutiny panels have been rolled out within localities, and SoP is in development and to be presented at the next PPD group meeting. As indicated above, changes have been made on Datix to support the reporting and management of pressure damage incidents in 2020. It must be noted that a new RL DATIX system is being implemented across NHS Wales in 2021 (Once For Wales Concerns Management System) which will see further changes required for	**A**

			all Health Boards. This is in development.	
	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.	An improvement project did not proceed in 2020 due to the COVID-19 pandemic. The Patient Safety Team intends to take this forwards in 2021 and has asked for expressions of interest from clinical areas at the Pressure Damage Group and Tissue Viability Nurses pressure damage study day in November 2020.	**R**
	10. Review of our heel off-loading products as no standardisation across Wales	10. Audit results shared and objectives need developing	Awaiting an update on the progress of a standardised approach across Wales.	**A**
2.3 Falls prevention	3. Evaluation of the Pace setter funded model for the Community		Work has been ongoing, Awaiting progress update of the evaluation of this model.	**A**
	5. Follow up audit of call bells	5. To be undertaken early 2020	Awaiting update on audit.	**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	Health and Safety have capacity to provide training for the use of the hover jack on an ad hoc basis. This is not part of the mandatory training package.	**A**

			Hover jacks are available at both UHL and UHW sites. Awaiting an update on the work to development of a sustainable solution.	
	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	This work will be taken up by the new falls lead when they take up their post in January	**A**
	8. Set up of an inpatient falls alliance	8.This will be taken forward by falls delivery group from January 2020	Alliance meetings have been paused due to COVID. The Alliance are developing the triangle model, Improvement and implantation team have been facilitating this. Discussions are ongoing to ensure there is a focus on inpatients falls as well as community.	**A**
	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	Awaiting feedback on success of the bid submitted.	**A**
2.4 IPC and Decontamination	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-	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	Due to Covid-19 educational sessions have been put on hold. However, Corporate Induction has recently recommenced E- learning remains available for healthcare staff to access	**A**

	learning module, and purchase of appropriate equipment.			
	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	Under review	**A**
	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.	No change from previous	**R**
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)	Two ward audits are planned to be undertaken in January 2021. Previous audit was postponed due to Covid pressures.	**A**
	2. Ward managers take up the role of supporting the implementation of the bed plan on the ward	Dependent on action 1	As previous	

	through raising awareness of the benefits of using the tool and auditing its use on the ward			A
	3. Review the role of the qualified nurse in overseeing the meal service and develop a role profile	Dependent on action 2	As previous	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 e,g mental health AAU	New descriptors are being used across the HB, level 1 fluids is a recommendation that continues to lack sufficient associated compliant products.	A
	5. Development of a suite of models of delivery for nutrition training offer in the light of reduction in nurse induction time	5. Meeting has been undertaken with Cardiff University regards curriculum nutrition content for undergraduate nurses, Newsletter updates have been developed, online updates available. Further training to be planned with practice development nurses	Completed and more training available on an All Wales basis.	C
	6. Address concerns highlighted in the CHC visit and HIW report around nutrition and hydration at front door following. No funded dietetic	6.Immediate concerns addressed but remains no funded dietetic service at front door	No changes to situation – no funded dietetic service at the front door	R

	service in the Emergency Unit			
	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	The system has been embedded at UHL, a trail in now planned for Children's Hospital for Wales followed by UHW	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.	The model ward has been rolled out on three medical wards funded for 12 months – A1L, C6 and E8. Report to be shared with the CHC	A
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.	PSN was published by WG in November 2020 and has now been used across the UHB to inform current build/refurb projects. The risk assessment tool will be used for existing UHB storage alongside the medicines audit tool	C
	3. Specific support to patients/carers in presence of sensory loss	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 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	Work is ongoing to support visually impaired patients with medicines labels. Dementia friends training is progressing for all new starters	A
	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	The project did not start due to pandemic and is currently on hold	A

2.7 Safeguarding Children and Adults at Risk	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.	There has been a delay in this work commencing however it will begin in February 2021 and it is proposed to be finished by July 2021.	**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	This is completed and up and running.	**C**
	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	This audit has been delayed and is scheduled to commence in March 2021.	**A**
2.8 Blood Management	3. The UHB to look towards the implementation of electronic blood tracking and electronic fating of blood products at the patient bedside.	3. No progress	The electronic system (Blood Trak) automates the documentation of vein to vein transfusion so minimises human error. This system his would be a significant quality improvement but there is significant cost associated with this system which is around £325k. It was agreed that without a clear cost-benefit analysis that proceeding with a capital purchase is not indicated at this time.	**A**

			By way of assurance, a recent accreditation assessment by the QPIDS program (quality in primary immunodeficiency services) found that 'the management and tracking of blood products by Blood Bank in Cardiff and Vale UHB is exemplary'. Additionally, we monitor and follow-up every unit of blood to ensure we have evidence of traceability. Traceability is one of the key metrics reviewed at the monthly Blood Transfusion Quality meeting.	
2.9 Medical Devices	1. Revision of UHB Medical Equipment Management Policy in line with the pending revised MHRA guidance	1. Awaiting publication of MHRA revised guidance therefore not able to progress until this happens (publication is anticipated in time to meet planned timescales)	Publication of MHRA revised guidance delayed due to change in legislative timetable as a result of impact of COVID-19 (full implementation of EU MDR 2017 delayed until after end of Brexit Transition Period, therefore, existing UK law on medical devices plus that currently going through UK Parliament will apply from 01.01.21). UHB Medical Equipment Management Policy and related procedures updated as an interim measure with further review due by 31.12.20.	**A**

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.	We have appointed to a patient safety and learning post and this person will be taking forward the falls work stream. Will be in post January 2020.	**C**
	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.	This work will be incorporated within the revised quality safety and improvement framework.	**C**
	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 new chair has been appointed to the new NatSSips group. It is anticipated that we will refocus on these safety standards in 2021.	**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	Recently received a demonstration for an electronic audit system and are perusing a purchase.	**A**
	7. Continued increase in compliance with patient safety solutions	7.Some progress towards compliance with safety standards but individual components remain outstanding	Good progress had been made and are our current compliance is **XXXX** we have declared compliance with some historical outstanding notices.	**A**
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.	Further work is planned for 2020/21 to ensure Commercial Trial income and grant income is also managed transparently	

		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 centres to ensure reinvestment in R&D. Processes to ensure adequate oversight of new cost centres is ongoing.	through established cost centres to ensure reinvestment in R&D. Processes to ensure adequate oversight of new cost centres is ongoing.	**A**
	2. Progress with the vision of a Joint R&D Office with Cardiff University	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.	Awaiting update on progress of the Transforming services work stream.	**A**
	3. Continue to develop capacity and capability in R&D, Audit and improvement skills	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	Awaiting update on the progress of increasing capacity for R&D work	**A**

		by the Senior Nurse, Research Education and Training.		
	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	5. The Clinical Board has been tasked with identifying the required resource to facilitate these audits	Capacity of the UHB to participate in all the National Clinical Audits is ongoing, discussions are underway to ensure that appropriate resource is available for full participation in national clinical audit.	R
	6. To further develop governance arrangement for reporting Clinical Board level clinical audits.	6. A Governance framework is being developed as part of the QSI framework and will incorporate this detail	A Clinical Effectiveness Committee has been established which will oversee and monitor more closely the Health Board.	A
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.	Work is ongoing, awaiting update of progress.	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	Awaiting update on progress	A

		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.		
	3. Key assurance indicators need to be developed to support the above audits and reviews	3. See point 2.	Dependent on point 2	**A**
4.1 Dignified Care	3. Evaluation of mouth care provision	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.	Has been included in the ward inspections for the last 12 months, which provides a baseline of which areas use the mouth care tool. Will be part of the ward accreditation standards for 202. Perfect ward platform will be used to inform which wards have met bronze, silver or gold mouth care standards.	**C**
	5. Continue to build on work undertaken to improve environment of care for patients with cognitive impairments	5. Local examples of charity bids, estates requests, and refurbishments are evident in the improvement of ward environments.	The implementation of 'The Perfect Ward' as part of the HB accreditation programme is expected to demonstrate the extent to which ward environments support people with dementia and cognitive impairment.	**A**
4.2 Patient Information	1. All CBs to ensure that at least 75% of their medical staff have undertaken MCA training.	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.	Overall compliance is 25.7% and remains an area for improvement.	**R**

	2. All CBs to undertake an audit of mental capacity assessments and report their findings at a CB quality and safety/audit meeting.	In progress	Outstanding	**A**
5.1 Timely Access	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	The Covid pandemic has had an unprecedented impact on the delivery of health services, substantially reducing activity across the majority of planned care services. The UHB has done a great deal of work, including building new facilities and redesigning models of care, to maintain some level of planned care services. This has allowed the UHB to continue to provide all 'Essential Services' (as defined by Welsh Government) throughout the pandemic but nonetheless the number of patients waiting has increased and, in particular, the UHB has seen an increase in the number of patients waiting beyond the national targets. At the end of October the overall RTT waiting list had grown by 4.3% but the number of patients waiting over 36 weeks had grown to 35,978 (an increase of 33,881 since February). The number of	**R**

			patients waiting over 8 weeks for a diagnostic also increased sharply from 63 in February to over 10,000 in May. This has begun to improve since June but remains over 9000.	
	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.	The Specialist CAMHS service was repatriated into Cardiff and Vale University Health Board, from the 1st April 2019. Work has since been ongoing to improve performance and to support overall system change. Covid 19 has had an impact on service delivery and progress towards the development of new models, but has also facilitated new methods of supporting children, young people and families through telephone contact (TC) and video conferencing (VC). Throughout the pandemic CAMHS services have been maintained. In terms of delivery against the Part 1 Welsh Government Target, significant work was undertaken prior to lockdown to deal with a backlog of cases and deliver performance improvements. **The service has met the 80% Part 1 Target consistently since May**	**G**

			2020, against a backdrop of 0% compliance 12-months previously**.** An SBAR providing a more detailed update on the service went to the S&D committee in September.	
	5. Continued improvement in the performance of emergency services	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 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.	The emergence of Covid has of course had a major impact on the delivery of emergency services. Initially the overall number of people attending the EU department and admitted to hospital reduced substantially as the number of patients with Covid increased sharply. Attendances and admissions have been steadily increasing through the winter towards, but not yet back at, normal levels. Performance over this period has been volatile. On August 5th the UHB introduced CAV 24/7, a novel service which patients contact prior to attending EU. This has led to around a third of EU attendances now being scheduled, reducing delays and helping to keep patients and staff safer. This model is now being rolled out across Wales.	**A**

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.	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.	All patients are now referred via a single point of access, to ensure that where suitable they are offered support via community resource teams. The SPOC team also work with many wards within the hospital to make sure that every opportunity is given to the patient to discuss what matters to them.	**A**
	5. Evaluate the opportunities within the new St David's model aimed at prevention of deconditioning and encourage active reablement		Work has been ongoing throughout the year to visit the model of care provided at St David's to ensure that each patients is provided with the opportunity for rabblement and rehabilitation despite the impact of COVID this work is continuing.	**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.	Funding continues to support the services provided via Mental Health Matters, we have now also commissioned the Harmoni Suite (funded by the integrated care fund) which is hoped will provide opportunity to patients who require an alternativ4 venue which can access therapy and activity provided by mental health matters and LPOP. Age connect also continues to provide discharge support officers within the hospital. Mental health matters and age connect	**A**

			performance and activities are monitored quarterly via the integrated care fund partnership arrangement.	
	9. Explore further opportunities to involve patients with planning care and discharge planning	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 any discharge arrangements. The recent National Dementia audit indicated an improvement in discharge planning arrangements from previous years.	We have recently undertaken discharge procedure audit which has identified that in the majority of cases that families have been involved in planning discharge. Training has been provided to ensure staff understand the importance of patients and families being involved in their care planning and discharge. SPOC officers and discharge support officers along with the discharge liaison nurses actively engage with patient's family and careers to ensure that their voices are heard during the discharge process.	**A**
6.3 Listening and Learning from Feedback	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	Dental are taking this piece of work forward.	**A**
	3. Broaden Feedback to the ward areas in Medicine and individuals so that key messages and experiences are shared; Development	3. Ward based reports shared but further work on developing a triangulated report is underway	From April service user experience system will allow more detailed area specific feedback An Organisational learning committee will be set up for 2021,	**A**

	of Sister/Charge feedback session from Serious incidents and RCA so that they in turn can share this with their ward staff		ToR are currently being developed.	
	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	PKB feedback is shared and auctioned as appropriate	**A**
	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	Meetings have been held using virtual platforms.	**C**
7.1 Workforce	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	We have reduced the number of our LOCAL Employment Policies to 6. These set out our organisational commitments and what we are aiming to achieve. They are supported by a number of Procedures which describe the processes to follow, roles & responsibilities, and any entitlements or obligations. This will mean less duplication, more	**C**

			transparency and information which is easier to understand. The new policies and the supporting procedures are: **Recruitment & Selection Policy** – Recruitment, DBS, Relocation Expenses, Professional Registration & Fixed Term Contract Procedures **Adaptable Workforce Policy** – Retirement, Working Times, Flexible Working, Occasional Home/Remote Working, Redeployment, Annual Leave & Loyalty Award Procedures, **Learning, Education & Development (LED) Policy** – Mandatory Training, Study Leave, PADR & Academic Malpractice Procedures **Equality, Diversity and Human Rights Policy** with the Supporting Trans Staff Procedure **Employee Health and Wellbeing Policy** – Management of Stress, Management of Alcohol/Substance Abuse, Domestic Abuse and Industrial Injuries Procedures **Maternity, Adoption, Paternity & Shared Parental Leave Policy** with Procedures for each of these elements plus Maternity Risk Assessment and Combining	

			Breastfeeding and Returning to work. There are also a small number of stand-alone documents covering issues like death in service, payroll over/underpayment, new and changed jobs and professional abuse The ALL-WALES POLICES remain unchanged and continue to apply to us and all other Health Boards in Wales Within Cardiff and Vale University Health Board (the UHB), employment policies are developed and reviewed in partnership via the Employment Policies Sub Group (EPSG) and, where appropriate, though the Local Negotiating Committee (LNC). The development of such policies involves a comprehensive consultation process before final submission for approval by the Strategy and Delivery Committee. The authority to approve general employment procedures and guidelines has been delegated to the EPSG.	

			All-Wales Policies are developed and agreed in partnership by the Welsh Partnership Forum.	
	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.	Meetings were established with The Wallich and conversations have taken place as to the possibility of some collaborative working alongside that of Llamau. We have continued to work with Elite with a focus on exploring our Disability Confident Employer status. We have also in initial discussions about offering work placements through Project Search. Work with various schools around potential employment opportunities began in the school calendar year 2019/20 but has been postponed because of the pandemic.	**A**

Report Title:	**Board Assurance Framework – Patient Safety**								
Meeting:	Quality, Safety & Experience Committee						**Meeting Date:**	15th December 2020	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	**Director of Corporate Goverance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

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

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

The Board Assurance Framework has now been presented to the Board since November 2018 after discussion with the relevant Executive Directors. It provides the Board with information on the key risks impacting upon the delivery of the Strategic Objectives of Cardiff and Vale University Health Board.

The attached Patient Safety risk is considered to be a key risk to the achievement of the organisation's Strategic Objectives. There are also a number of risks on the Corporate Risk Register (see Private agenda) which relate to Patient Safety.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

There are currently nine key risks on the BAF, agreed by the Board, which are impacting upon the Strategic Objectives of Cardiff and Vale Health Board. Patient Safety is one of those key risks and specifically identifies that Patient Safety may be compromised due to:

- National shortage of COVID treatment capacity;
- Some elective services not currently available;
- Sub optimal workforce skill mix or staffing ratios;
- Patients not choosing to ask for medical help;
- Patients are contracting COVID whilst in a hospital setting.

It is good practice for Committees of the Board to also review risks on the BAF which relate to them. The role of the Committee in relation to the risk is to review it, check that the controls are in place and working and agree any further actions required in order to mitigate the risk. The Committee can then provide further assurance to the Board that the risk is being managed or mitigated as much as possible at the current time. The Executive Director Leads for this risk are the Executive Medical Director, the Executive Nurse Director and the Executive Director of Therapies and Health Sciences.

Recommendation:

The Quality, Safety and Experience Committee is asked to:

Review the attached risk in relation to Patient Safety to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.

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

Equality and Health Impact Assessment Completed:	Not Applicable

Patient Safety (Lead Directors Stuart Walker, Ruth Walker and Fiona Jenkins)

Risk	Patient safety may be compromised because of: Future national shortage of COVID treatment capacity (Beds, critical care, drugs, workforce, oxygen, other equipment – ventilators/renal replacement/CPAP) in the event of a second COVID surge Or because some elective services are not currently available for non-COVID patients Or because of sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care to a larger number of patients in relation to a further COVID surge, alongside increasing demand for non-COVID unscheduled care and urgent scheduled care and winter pressures and activity. Or because patients are choosing not to ask for medical help, despite genuine illness, related to PH messaging and awareness of the COVID crisis Or because patients are contracting COVID 19 whilst in a hospital setting.		
Date added:	March 23.03.2020		
Cause	Patients not able to access the appropriate care because demand is outstripping supply, or patients fail to seek appropriate care in a timely way. Presentation of COVID 19 virus in inpatient settings due to patients presenting who are asymptomatic but are positive Possible lack of PPE, poor IPC or inappropriate management		
Impact	Worsening of patient outcomes and experience, higher death rate.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25**
Current Controls	• Plans developed to continue with expanded critical care and COVID bed capacity within footprint of hospitals, taken alongside patient cohorting in 'non-COVID' areas. • Plans developed and deployed to optimise internal acute and critical care capacity with external options having been utilised for significant internal and external surge/field hospital capacity. • Internal estates and facilities team deployed to provide infrastructure enhancements to enable internal capacity plan • Principality stadium no longer available with further surge capacity available in Lakeside facility from late November • National/local procurement processes for under-supplied resources • Maintaining Training/Education of all staff groups in relation to delivery of care to COVID patients • Use of Spire Hospital as a dedicated facility for urgent cancer work - ongoing		

	• Ongoing training and simulations for staff working in unfamiliar areas. • Recruitment of additional staff • Cancer patients treatment being reviewed and prioritised where appropriate • Restrictive visiting arrangements • Outbreak management plans and delivery
Current Assurances	• Internal capacity expansion plans commissioned and reviewed regularly at Operational and Strategic Group to ensure right phasing • Operational Group meeting daily to ensure clinical staff remain engaged in managing phased expansion/area utilisation. • Establishment of workforce hubs to ensure that staff are deployed on a competency basis • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives • Audit of IPC and Audit outcomes • Reporting of IPC Outbreak meetings into ME • IPC Daily Cell Meeting &Weekly PPE Cell Meeting • Expert and independent advice in outbreak meetings

Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15**
Gap in Controls	.		
Gap in Assurances			

Actions	**Lead**	**By when**	**Update since September 20**
1. Reconfiguration of COVID/Non-COVID capacity delivery in light of new pandemic modelling projections – ongoing process.	Steve Curry	31.03.21	Ongoing discussion currently and gearing plans developed. Plan in place which is continually been reviewed in relation to demand and capacity – see separate risk on BAF: **the risk of inadequate capacity to manage future COVID 19 peaks and planned work safety**
2. Reconfiguration of COVID/Non-COVID workforce skill mix and staffing numbers in light of new pandemic modelling projections	Workforce groups	31.03.21	Discussions continuing staffing mix being reviewed in line with action 1 above.
3. Internal COVID 19 outbreaks being reported to Quality, Safety and Experience Committee with lessons learnt been fed back into the organisation.	Ruth Walker	24.09.20	**Complete & ongoing**

4. Learning from COVID 19 outbreaks at CTM and AB Health Boards and being utilised in management of outbreaks		Ruth Walker	From mid October	**New action**
5. Genotype testing which shows whether outbreaks are linked and core case		Ruth Walker	From mid October	**New action**
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**		**10**

Report Title:	**Quality, Safety and Experience Workshop – feedback report**						
Meeting:	**Quality, Safety and Experience**				**Meeting Date:**	15.12.20	
Status:	**For Discussion**	√	**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Executive Nurse Director Executive Medical Director						
Report Author (Title):	**Assistant Director Patient Safety and Quality**						

Background and current situation:

On World Patient Safety Day 2020 (17th September), a virtual Quality, Safety and Experience (QSE) Workshop was held to engage with senior clinicians and managers across the organisation in order to start the discussion to identify our QSE priorities for the next 5 years. A total of 66 people attended the workshop for part or all of the day.

The backdrop to the day was the new Health and Social Care (Quality and Engagement) (Wales) Act which will be implemented in 2021. This will place quality considerations and a duty of candour at the heart of all that NHS bodies in Wales. It will also strengthen the voice of citizens and the governance arrangements.

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

- A period of engagement will now take place with a wider UHB audience of clinical and non-clinical staff
- There will be an review of the current organisation committee and group structures to support QSE
- A Quality, Safety and Experience Framework for 2021-2026 will be presented to the April 20-21 QSE Committee

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

What approach did we take?

Prior to the workshop, a short safety culture survey was sent out to all delegates. They were also provided with some pre-reading material – The Patient Safe Future –a Blueprint for action[1] and Safety Culture Discussion Cards[2]. Themes from the survey and the pre-reading material were identified and facilitated virtual groups were set up to discuss each theme and feedback to the main virtual room. The key theses identified were:

- Organisational Safety Culture
- Leadership and the prioritisation of quality, safety and experience
- Patient experience and involvement in quality, safety and experience
- Patient safety learning and communication
- Staff engagement and involvement in safety, quality and experience
- Patient safety, quality and experience data and insight

[1] Patient Safety Learning, 2019
[2] NHS Education for Scotland 2018

- Professionalism of patient safety, quality and experience

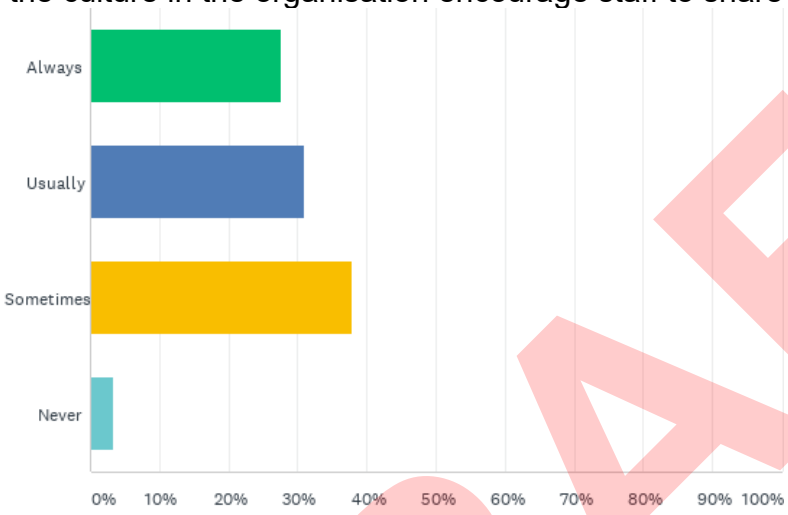
Presentations from Dr Chris Turner[3], from Professor Paul Bowie [4] Programme Director (Safety and Improvement) NHS Education for Scotland and from Professor Jonathon Gray, Director of Transformation and Digital [5], were used to engage staff in the discussion throughout the day. Following the workshop, an evaluation survey was sent out to staff.

What did staff tell us?

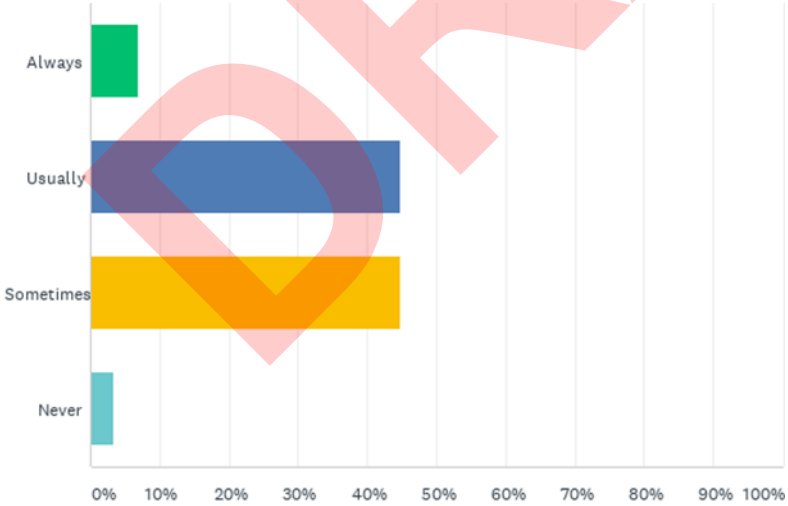
The Safety Culture Survey

29 delegates responded to the pre-workshop patient safety culture survey. Results to the questions were as follows:

Does the culture in the organisation encourage staff to share learning from their mistakes?



Do staff ask patients 'what matters to them'?

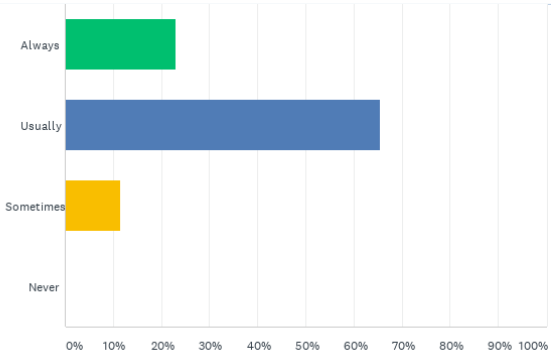


Do staff report any safety concerns in the organisation?

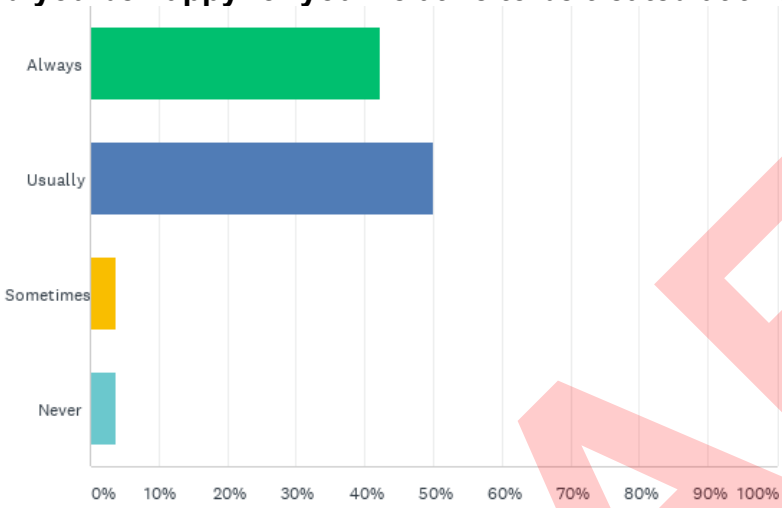
[3] Civility saves lives - when rudeness in teams turns deadly https://www.youtube.com/watch?v=4RUIhjwCDO0

[4] A Team-Based Learning Approach to Safety Culture Programme Director (Safety and Improvement) NHS Education for Scotland

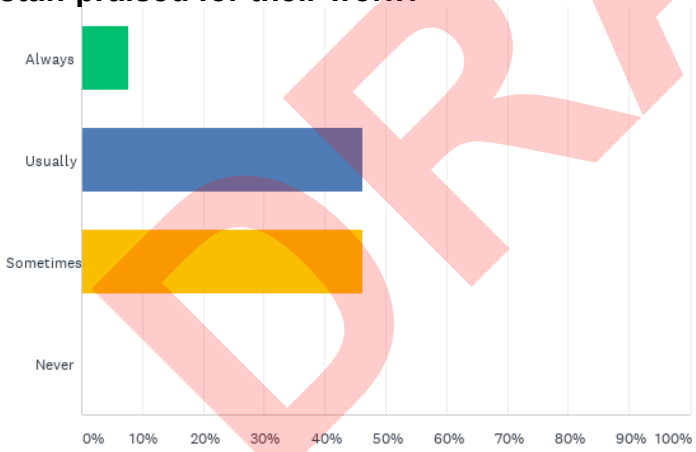
[5] obstacles and solutions to realising our full QSEI potential



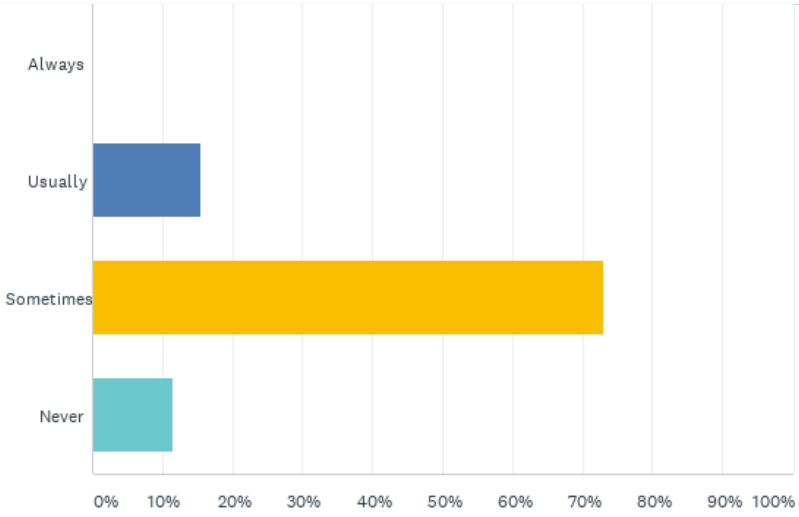
Would you be happy for your relative to be treated at this Health Board?



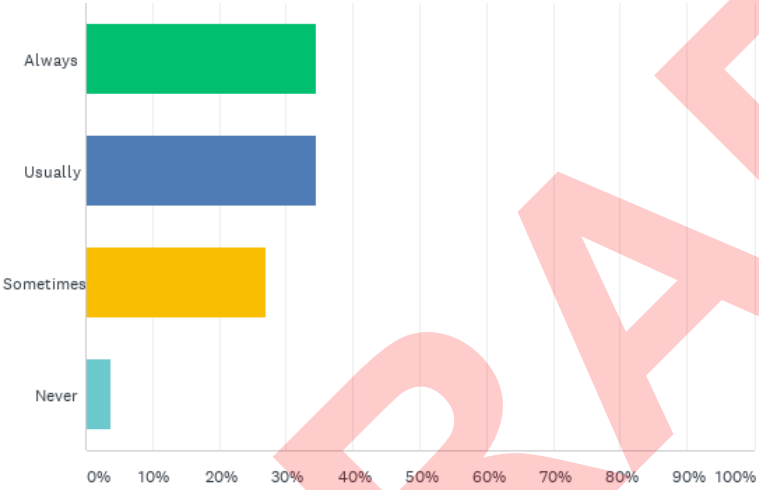
Are staff praised for their work?



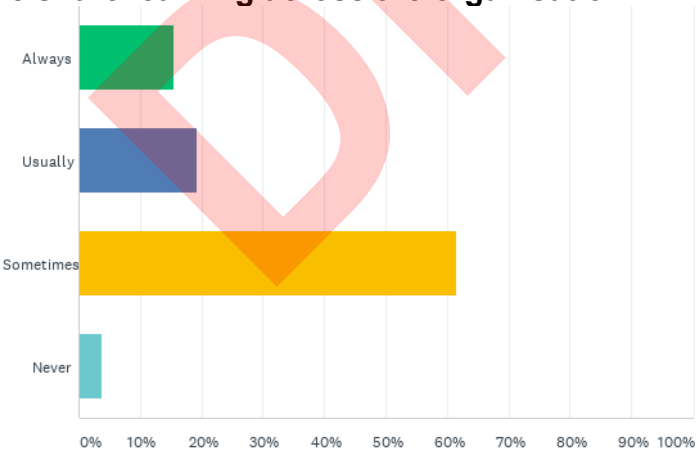
Do we blame staff when things go wrong?



Do you feel that patient safety/experience is reinforced as the priority in this area of the organisation?



Do we share learning across the organisation?



There was an opportunity to provide qualitative feedback and staff told us that:

- We need to train people in safety and improvement skills and be careful how we monitor safety so we don't have an unintended consequence
- ‘It’s everybody's business’
- This questionnaire is clinically biased; my role oversees patient safety and patient

experience without being clinical and it would be helpful if it could be recognised that not everyone involved in this area of work is directly clinical

- The organisation has an open and transparent culture compared to many. More work to be done. Needs more dedicated resource to reflect the size and the complexity of the organisation.
- Our QS&E agendas can work well at higher levels in the organisation but needs more support at lower, local, team or ward levels to ensure that directorate/board Q&S meetings are getting real data
- These should be the centre of all we do. The corporate teams are small for the size of the organisation. We need to move from reacting to events to proactively improving and preventing them.
- We try very hard but resources are very small for the PST and PE team. I think differing CB have different levels of support from the team
- Nursing is the gatekeeper of patient safety and experience but performance and management led structures risk disengaging nurses and losing that voice
- 'Can sometimes appear dr and nurses only - it needs to include all staff'
- Very pleased with anticipated change of focus and hopefully culture
- Is certainly an additional difficulty that this is such a large organisation with such a high bed occupancy
- I absolutely believe in a safety culture and will fully support any efforts of to drive this initiative on. I believe that, despite pockets of excellence, there is a lot of work to do in some quarters of the organisation in terms of developing a culture of trust, openness and willingness to collaborate

Keynote speakers that informed the discussions and subsequent outputs

Professor Paul Bowie

Safety culture or safety climate? Measuring climate is measuring mood in the moment and metaphorically could be seen as the tip of the iceberg. Measuring culture is like measuring 'personality'. It is deep rooted – like the 91% of an iceberg that can't be seen. It is what people do or say when nobody is watching.

Attributes of a safe organisation

- Commitment to safety
- Reinforce near misses
- Long term strategy
- Monitor and act on job induced stress and poor working conditions
- Regularly assess safety culture

A positive culture means we are open to learn from failure, there is no blame and people can report concerns. Less than 10% of incidents/near misses/concerns are formally reported.
Staff sickness and outcomes can't be associated with safety climate and staff feel 'done to' (based on the GP Safety Climate Tools NES).

EUROCONTROL is an international organisation working to achieve safe and seamless air traffic management across Europe. It has developed a safety culture that we should learn from. It is an exemplar of a no blame culture.

NHS Education Scotland has developed safety culture discussion cards with 8 key themes that get people talking.

In a complex system it is extremely difficult to carry out 'best practice'. There is limited evidence that culture surveys impact change.

We need protected learning time to discuss how work is done every day and establish and integrated approach to quality and safety.

Often finance and performance are separated from quality and safety.

We still have a blame culture. We should understand systems thinking to deviate from blame.

Structures around Q&S should be professionalised. We need risk assessors and safety advisors.

Professor Jonathan Grey

Success

Optimism – joy and heart

We should have a vibrant sharing and networking forum

Strong leadership

Always keep the patient perspective

Measure and learn

Habits to create

- Informative comparison
- National learning and exchange
- Bold ambition
- optimism

General open room discussion.

Delegates felt that there is increasing scrutiny of QSE especially from external agencies. We were asked whether there is MDT learning from investigations.

A delegate told us that the staff know the risks and can point us to sources of potential harm but we need to make the systems for them to do this much easier. Datix is felt to be cumbersome and time consuming.

Even very experienced staff can make mistakes; we need to ask how many times do staff actually 'save the day?'. There is always too much focus on a single incident –we need to stop looking down and in and start looking up and out. We need to apply systems thinking and take on board multiple perspectives as to why an incident happened. Pharmacists intercept potential harm all of the time – we need simple mechanisms in place to record this this type of data.

Feedback from the Facilitated workshops

Organisational Safety Culture
We were told that the ethos of the UHB is one being open and honest; it is improving all the time, although there are still some challenges. Not all staff would feel free to raise concerns as they do not want to be critical of their colleagues. We need to use Exit interviews to assess whether Quality and Safety issues contribute to the reasons why people are leaving. Staff do not get feedback therefore may become demotivated to report. There needs to be a balance between the methods by which we learn.

What does good look like?

- Regular forum sessions to update staff multi professional about whole system practice incidents and good practice
- Improve the way in which we feedback to people who raise concerns
- Triangulating education / wellbeing / inclusion = Belonging so people feel safe to speak up and supported
- Create an environment where we learn from each other as a whole system
- An Integrated approach with partners and external stakeholders

In the afternoon, the group concluded that overall priorities for the organisation include better systems for closing the loop, having open door policies and regular learning events. There needs to be education and training in QSE for leaders at all levels; we need to agree key safety messages. We need emotionally intelligent leaders who can delegate their power to their teams and give people permission to act.

Leadership and the prioritisation of quality, safety and experience

We were told that that there has been a shift in prioritisation of safety but we can't 'do it' for people – we need to 'support and facilitate' not 'do for'.
The new risk register is improved.

Covid has had a massive impact. The decrease in patients has meant that quality systems have been used more e.g. Ask and Act domestic violence screening tool; we can't now go back to how it used to be. The challenge is how do we do that with less time. Not all quality aspects improved with covid though. During covid there was a big focus on quality for staff and patients e.g. PPE, space, virtual services. A safety issue has driven service transformation. E.g. CAV 247 which was clinically led. Covid has shifted the responsibility and has driven transformation.

Staff felt that our Executive team really do care about patient safety. The approach to QSE can be professionally siloed and is often seen as 'nurse- centric'. Frontline staff do not always understand their role in QSE and are too keen to escalate issues to more senior staff.
We need to see the achievement of targets as being intrinsically linked with quality – timeliness of access to care, for instance, is a recognised domain of quality.

Staff feel that the UHB genuinely cares about patient safety, some staff have been taken aback by how patient centric it is when shadowing etc. especially at Executive level. Staff do however, get frustrated with some of our IT systems that do not enable us to properly report what we are doing for the quality and safety agenda. How accurate is our data?
We need to demystify QSE.

What does good look like?

- Performance, quality and finance are intrinsically linked
- Better engagement at all levels across CB's with a true multidisciplinary approach
- Breakdown silos between professions – more shadowing across professions
- Breakdown silos between Clinical Boards - an integrated approach rather than disparate teams
- Happy staff = happy patients = happy relatives
- A greater understanding and acceptance of the challenges across clinical areas especially outside an acute setting
- More focus on staff safety as well as patients
- Peer groups for Q&S leads so less isolated

In the afternoon, this group told us that that priorities for the organisation include changing the language we use about safety; using a bottom up approach and improving the way we communicate with staff. We need to create a 'Fellowship for Quality' and support and engage frontline staff.

Patient experience and involvement in quality, safety and experience

Patient and staff stories are really powerful, providing a tool for reflection. The timeliness of addressing concerns was raised and delegates felt it was difficult for staff to admit a breach of duty. We need to inspire our workforce.

What does good look like?

- Early resolution and admission of harm
- Increased communication/de-escalation/face-to-face meetings with patients and families
- Immediate sharing of learning
- RCA investigations need early and ongoing communication with the family. They need feedback and a timely conclusion.
- Use of digital stories
- Greater stakeholder/service user involvement in QSE groups

In the afternoon, this group told us that that priorities for the organisation include communication with patients and staff, stakeholder engagement with a range of fora (e.g. Youth Board); greater use of patient stories; investment in equipment, systems and in staff time.

Patient safety learning and communication

Delegates felt that communication in relation to QSE is weak as an organisation; there is fantastic training taking place but there needs to be a clear outline of what is on offer. There needs to be a pathway for communication e.g. Newsletters and/or videos, podcasts.

We need to create a culture where reporting incidents happens without any one person being blamed. Staff should feel safe and be empowered to raise issues and share learning. This lack of communication can lead to staff feeling fearful.

Delegates felt that there needed to be an MDT approach to entering data on Datix and it was felt that at the moment, this is primarily a nursing role. Training should be delivered using an MDT approach. All education delivered should have the experts from specific teams to deliver the content.

What does good look like?

- Build on the good practice from the Lessons Learned Forum and enhance this, so that lessons learned are distributed widely. This approach could be adopted in other areas within Clinical Boards?
- Greater education and opportunities to learn from each other
- Newsletters and videos as a means of communicating safety messages and learning
- Greater use of induction processes to emphasise safety messages
- A curriculum for QSE across the organisation – culture, systems learning, psychology of blame - a clear pathway for staff – from Preceptorship to Senior Leader
- Clear messages – everyone speaking the same language
- Making time to learn is key
- Multi ways of communicating across the organisation
- Good means we had failure but we have put steps in place to improve things

In the afternoon, this group told us that that priorities for the organisation include a lessons learned forum, mapping out of our processes and approach to RCA, improving our approach to staff wellbeing. Then more we value staff the better the quality of care. Coaching, supervision and training is vital. We must protect junior doctors more –they move around a lot and can 'disappear under the radar'. Everyone however, is equal when it comes to QSE.

Staff engagement and involvement in safety, quality and experience

Delegates asked whether we have a culture where staff can challenge? It was felt that this became more polarised depending on your seniority within the organisation. It can be particularly hard in areas such as GP Practices and small teams where there are close personal working relationships between staff.

There was also confusion about who to go to. Line management can be blurred and it was felt that it is difficult to approach a different profession (e.g. how does a nurse report a consultant?)
During the investigation of a never event the junior workforce was not listened to.
We need to be more sensitive to low grade disruption and to bullying and appoint leaders who reflect the values of the organisation. Leaders lead and listen.
The Safety Valve was seen as positive as were the establishment of Health and Wellbeing leads. Creation of a safe and confidential environment is important.
Delegates questioned whether we provide enough support to staff involved in incidents –there is not enough investment in psychological support and in signposting to appropriate services.
Debriefing was felt to be helpful but only when done properly, noting that for some people it can be more harmful as they re-visit the incident.
There is information available but you need to know how to navigate to access it. Information is disseminated but it gets forgotten or is not read as we are bombarded with so much. It can be difficult to sort the wheat from the chaff.

What does good look like?

- Support in place to ensure junior staff feel confident to challenge senior colleagues
- Appointment of leaders who demonstrate the organisational values
- Building QSE into the appraisal process
- Greater support for staff involved in harmful incidents; investment in psychology services. Have a tiered approach and a fast track to CBT for those who need it.
- Appropriate de-briefing processes embedded

- Organisational understanding of sickness related to trauma following incidents
- Have local health and safety/wellbeing leads
- Appoint staff safety champions
- Ensure there is quick and easy access to information for staff.

In the afternoon, this group told us that that priorities for the organisation include appropriate de-brief and support especially as part of post- incident management. Post-trauma incident management should become as good as it can be and there should be access to appropriate emotional and psychological support. We also need to support/mentor junior doctors to understand processes more. There should be standardisation of communication between primary and secondary care and better working together especially in terms of staffing and pressures in the system. Compliance with appraisal process and reporting issues should become second nature.

Patient safety, quality and experience data and insight
Although it was felt that there is a good reporting culture, delegates felt that Datix is seen as punitive. We need to focus more on what went well.

What does good look like?
- Easy to use systems
- Standardised data collection which is meaningful and accurate; less time navigating multiple systems
- 'Bottom up' approach to the use of data
- Changing the language around QSE and incident reporting (incidents are learning events)

In the afternoon, this group told us that that priorities for the organisation include making sure that data is 'timely, meaningful and relatable'. Again it was felt that we need to change the language in relation to QSE. The new Quality Act can provide a platform to refresh this. We need to simplify systems and share data more. Think about Greatex rather than Datix.

Professionalism of patient safety, quality and experience

What does good look like?
- Greater investment in QSE structures
- Support for staff from the bottom up
- Actively protecting time for QSE
- Making QSE more relevant to clinicians
- Achieving the right MDT balance in QSE conversations
- Using all data sources e.g. how are we learning from our National Audit data?

In the afternoon, this group told us that that priorities for the organisation include the fact that we need to give everyone a platform to be heard. The least experienced staff can tell us what is not going right. Our QSE structures are set up in 'silos' and we are data rich but information poor. We need to be braver – we need to remove hierarchical structures.

Evaluation of the workshop by staff who attended.

29 delegates responded. 21% reported the workshop to have been extremely useful, 59% very useful and 20% somewhat useful. No delegates reported that the workshop had not been useful.

Comments included:

'A great forum to share and learn from others- great speakers put the day in context. Staff were very engaged and enthusiastic to improve our systems and processes '

'The day was structured well incorporating excellent presentations and time to reflect and participate with useful discussion within the workshop groups and wider group'

'Expert speakers' ability; to ask questions directly to medical director & nursing director; break out workshops useful'

'The UHB and multi-disciplinary representation, honest and frank discussions, wide sharing of good practice and patient safety concerns. It was focused in terms of specific actions which will be taken forward, therefore even though a day is a lot of time out, I left feeling it was worthwhile. I found Paul Bowie's presentation excellent.'

The full survey results can be made available.

Conclusions

There was excellent engagement from all delegates and the workshop and approach that we took has been well evaluated. Key messages to now build on:

We need to:

- be brave but be simple
- engage everybody – patients, staff and stakeholders and be able to hear their voice. We need all of the data and all of the systems to support that.
- establish a range of regular learning events and share understanding and learning about team dynamics more
- establish better training and accreditation for QSE – safety curriculums and MDT engagement
- improve leadership in QSE at all levels ensuring that ALL of our staff have a platform that ensures their voice is heard.
- Agree a common language about QSE with our staff; one that embraces the positive as well as the negative
- think about the ways in which we value and appreciate staff recognising the positive contribution that they make and how we support and encourage them to grow.

The Institute of Health Improvement, recently published their National Plan[6], a collaboration among 27 national organizations committed to advancing patient safety. You can read the report here. This centres on four foundational and interdependent areas, which the National Steering Committee prioritized as essential to create total systems safety.

- **Culture, Leadership, and Governance:** The imperative for leaders, governance bodies, and policymakers to demonstrate and foster our deeply held professional commitments to safety as a core value and promote the development of cultures of safety.
- **Patient and Family Engagement:** The spread of authentic patient and family engagement; the practice of co-designing and co-producing care with patients, families, and care partners

[6] Safer together: A National Action plan to advance patient safety.

to ensure their meaningful partnership in all aspects of care design, delivery, and operations.

- **Workforce Safety:** Ensuring the safety and resiliency of the organization and the workforce is a necessary precondition to advancing patient safety; we need to work toward a unified, total systems-based perspective and approach to eliminate harm to both patients and the workforce.
- **Learning System:** Establishing networked and continuous learning; forging learning systems within and across health care organizations at the local, regional, and national levels to encourage widespread sharing, learning, and improvement.

The NHS Patient Safety Strategy[7] (see here) sets out three key aims:
• improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)

• equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)

• designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

These current international publications support the approach and output from the QSE workshop:

Patient Experience

A recent study by the National Patients Association concluded that there is scope for a fresh approach. Patient experience has been measured and evaluated by the system for its own purposes. This traditional approach understands patient experience in the system's terms. It uses patient experience as a measure of performance, and looks only at the experience of receiving care. This falls short of considering the experience of someone living their life with a health or care need. The traditional approach can still be useful. But there are two major problems with it in practice. Firstly, it is not clear that the data and other evidence it has generated capture the experiences of patients in a meaningful way. It tends to be made up of quantitative scores under abstract headings, which patients would find hard to relate to their real-life experience. It is also not clear that it provides a meaningful measure of NHS performance. included both 'social' factors, looking beyond the medical, and more patient-focused factors that were still nonetheless healthcare focused, The results suggest that achieving a more patient-oriented understanding of patient experience can best be achieved while still keeping a focus on health and care issues, but framing them in a way that captures what patients experience, rather than what services provide. The literature also suggests that different aspects of patient experience, not usually captured using the traditional approach, are uncovered when different methodologies are used. This includes using social media, and surveys that are co-designed with patients. The results also suggest quite strongly that the nature of a patient's illness should be taken into account when evaluating their experience: A link to the paper can be found here.

In June 2018 the Patient experience improvement framework was published by NHS Improvement[8] The framework enables organisations to carry out an organisational diagnostic to establish how far patient experience is embedded in its leadership, culture and operational processes. It is divided into six sections, each sub-divided and listing the characteristics and processes of organisations that are effective in continuously improving the experience of

[7] See of organisations that are effective in continuously improving the
[8]

patients. These include:

- leadership
- organisational culture
- collecting feedback: capacity and capability to effectively collect feedback
- analysis and triangulation: the use of quality intelligence systems to make sense of feedback and to triangulate it with other quality measures
- reporting and publication: patient feedback to drive quality improvement and learning: the ability to use feedback effectively and systematically for quality improvement and organisational learning

It includes an assessment tool from Board to ward and includes the section of what does good look like this is a validated tool that could be used to measure Patient experience.
Please find the link to the framework here

Next steps:

- Further engagement with a wider audience of clinical and non-clinical staff across the organisation; organisation wide safety culture survey throughout January and February 2021
- Engagement with patients and families
- Engagement with key external stakeholders and partners
- Agreement of a 5 year Framework for Quality, Safety and Experience to be approved at the April 2021 QSE Committee.

Recommendation:

The Quality, Safety and Experience Committee is asked to **NOTE** the feedback from the QSE workshop and also to **AGREE** next steps

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								

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 8TH JULY 2020

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Alicia Christopher	Operational Support Service Manager
Matthew Temby	Clinical Board Director of Operations
Lesley Harris	Professional Head of Radiography UHL
Robert Bracchi	Medical Advisor to AWTTC
Vicky Cummings	Haematology Quality Manager
Bolette Jones	Head of Media Resources
Maria Jones	Sister, Outpatients
Timothy Banner	Head of Patient Services, Pharmacy
Mathew King	Head of Podiatry
Rebecca Rowlands	Public Health Wales
Sian Jones	Assistant Head of Workforce and OD
Aimee Cox	Safeguarding Team
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Jo Fleming	Quality Lead, Radiology
Suzie Cheesman	Patient Safety Facilitator
Judyth Jenkins	Head of Dietetics
Emma Cooke	Head of Physiotherapy

Apologies:

Meriel Jenney	Clinical Board Director
Alun Roderick	Laboratory Service Manager, Haematology
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Paul Williams	Clinical Scientist, Medical Physics
Nigel Roberts	Laboratory Service Manager, Biochemistry

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 20/214 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting which was held via Skype. It was agreed that the next meeting will be held using Microsoft Teams.

CDTQSE 20/215 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 20/216 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 10th June 2020 were **APPROVED.**

CDTQSE 20/217 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 20/112 Contractors Policy

Jonathan Davies is still seconded. Sue Bailey will follow up on the issues with the policy with him when he returns to his role.

Action: Sue Bailey

CDTQSE 20/118 Prevention of Diabetes

Scott Cawley to discuss with Meriel Jenney engagement with Primary Care on the prudent model for the prevention of diabetes.

Action: Scott Cawley/Meriel Jenney

CDTQSE 20/137 Risk Registers

Directorates who have not yet sent their risk registers to Helen Jenkins on the new template were reminded to submit them.

Action: Directorates

CDTQSE 20/193 Piped Filtered Water

Sue Bailey has collated a list of areas that are still ordering water bottles for dispensers and passed this to Estates.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 20/218 Patient Story

There was no patient story presented at today's meeting.

CDTQSE 20/219 Feedback from UHB QSE Committee

The minutes of the UHB QSE Committee held on 14th April 2020 were circulated for information.

The minutes noted the temporary extra capacity arrangements for the mortuary that had been put in place in April.

CDTQSE 20/220 Health and Care Standards

The self-assessment process has been suspended in light of Covid.

CDTQSE 20/221 Risk Register

A Clinical Board Risk Register in the new template format is being produced.

CDTQSE 20/222 Exception Report

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 20/223 Initiatives to Promote Health and Wellbeing

Sue Bailey thanked Maria Jones, Flu Champion and all the staff providing support in issuing the flu vaccinations for helping this Clinical Board to achieve the Clinical Board with the highest uptake of the flu vaccination again last season. She also congratulated Emelye Allmark in Radiology who won an award as Flu Star Champion.

Maria Jones noted that more flu champions will be required this year and would welcome volunteers to become Champions.

Sue Bailey is concerned that staff are becoming fatigued as Covid starts to decline. She urged staff to utilise their annual leave to have a break from work. It has been recognised across all Clinical Boards that there needs to be an understanding of where there are particular areas of stress and fatigue in directorates. Alicia Christopher will circulate an email to services today to ask services to highlight where there are issues in their services.

Action: Alicia Christopher/Directorates

Information on how staff can access antibody testing for Covid 19 has been circulated. Judyth Jenkins enquired whether students on placement can access the testing. Sue Bailey will clarify and feedback.

Action: Sue Bailey

Some staff who contracted Covid have found the experience traumatic and it was queried whether there is a route for them to access a fast track employee wellbeing service. Sue Bailey will make enquiries and if necessary Matt Temby will escalate this requirement to the UHB.

Action: Sue Bailey/Matt Temby

SAFE CARE

CDT QSE 20/224 Concerns and Compliments Report

In June 2020, the Clinical Board received 9 concerns, 22% of which were addressed within early resolution timeframes. 6 compliments were received.

Laboratory Medicine is reporting an amber status. 3 concerns and 1 compliment were received.

Physiotherapy is reporting an amber status. The department received 2 concerns.

Radiology is also reporting an amber status. The department received 4 concerns, 2 of which were dealt with by early resolution.

Good performance was noted in Outpatients and Patient Administration which received 1 compliment. Occupational Therapy received 1 compliment and Medical Illustration received 3 compliments.

It was reported that Sue Bailey and Helen Jenkins are undertaking a weekly review of concerns with the concerns team.

CDTQSE 20/225 Ombudsman Reports

Nothing to report.

CDTQSE 20/226 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 20/227 Patient Safety Incidents

SI Report

The Clinical Board is currently reporting 5 SIs:

In110043 - dispensing error in Pharmacy relating to an incorrect dose of Phenobarbital. The closure form has been sent to Welsh Government.

In106742 - Kell positive issued to a female of potential child bearing age. The closure form has been submitted to Welsh Government.

In103765 – there was a delay in an outsourcing provider reporting a CT scan where there was a significant finding. The closure form has been submitted to Welsh Government.

In101759 - data confidentiality breach involving loss of a laptop. The closure form has been submitted to Welsh Government.

In82274 - relates to a patient who died following a choking episode. The first draft of the RCA has been completed and further comments have been suggested from the Patient Safety Team. A second draft is now in progress.

CDTQSE 20/228 New SI's

A new SI has been reported in Primary Care relating to a second Phenobarbital concentration incident to the same child. On this occasion an under-dose was issued. Sue Bailey suggested a patient safety notice is issued. Suzie Cheesman will discuss with the Medicines Safety Group.

Action: Suzie Cheesman

Matt Temby suggested whether there should be an individual check or extra measure put in place on each prescription of Phenobarbital as it is being dispensed. Pharmacy to give this some thought.

Action: Tim Banner

CDTQSE 20/229 RCA/Improvement Plans

Nothing to report.

CDTQSE 20/230 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 20/231 Regulation 28 Reports

Nothing to report.

CDTQSE 20/232 Patient Safety Alerts

Nothing to report.

CDTQSE 20/233 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 20/234 Medical Device Risks/Equipment and Diagnostic Systems

Tony Powell was not present.

CDTQSE 20/235 IP&C/Decontamination Issues

A concern has been raised around the decontamination of wheelchairs. A paper has been submitted to Clive Morgan and Mark Campbell to look at the feasibility of procuring a wheelchair washer.

CDTQSE 20/236 Point of Care Testing

Nothing to report.

CDTQSE 20/237 Key Patient Safety Risks

Safeguarding

Aimee Cox reported that Safeguarding training was suspended but level 2 is now running. The team are looking at providing virtual training or face to face training for small numbers. Any new staff members should attend Level 2 face to face training.

Staff in the team have been working over weekends during the Covid period. The team are piloting Ask and Act to everyone attending A&E and this has highlighted an increase in disclosures.

Guidance on case conferences and supervision has been circulated.

The referral process for child or vulnerable adult concerns are still to come through to the team who have ongoing Links with MASH.

The violence prevention team located in A&E have continued to work during the Covid period. Evidence suggests that knife crime has been on the increase.

It was requested that staff with any safeguarding concerns to ring the team rather than notifying them through Paris system.

Wales Safeguarding Procedures link on Safeguarding is available on the Safeguarding intranet page.

An audit on children and young people nursed on adult wards has been completed and will be presented to the Safeguarding Group next week.

Sue Bailey noted that a lot of information is circulated weekly via email. She asked if the information is available on their intranet site so staff can be signposted to their intranet page.

It was also requested for Aimee Cox to summarise the report she presented today in bullet points for circulation to the directorates.

Action: Aimee Cox

Safeguarding Mandatory Training compliance was circulated. There has been an increase in compliance at level 2. Violence against women has reduced but is still close to the target of 85%.

Mental Capacity Act

Nothing to report.

CDTQSE 20/238 Health and Safety Issues

Concerns were raised that pigeons were roosting on the windows outside of the Podiatry Department. Pest Control have been in attendance to address the problem.

CDTQSE 20/239 Regulatory Compliance and Accreditation

Vicky Cummings reported that UKAS has cleared all the findings from their surveillance visit to Haematology and the department is now fully accredited.

Sue Bailey reported that the MHRA have de-escalated Pharmacy UHL and Radiopharmacy from their Inspection Action Group and the departments are now under normal surveillance.

She also noted that the Health Safety Executive received a concern on the management of staff that tested positive in one of this Clinical Board's services. The department involved provided robust evidence to assure the HSE that the concerns were unfounded and that there was good management of the staff in place.

CDTQSE 20/240 Policies, Procedures and Guidance

Treatment Escalation Plan

Circulated for information.

Covid 19 Guidance

The latest updated list of key guidance and documents on Covid-19 was circulated.

Procedures Policy and Procedure

The policy and procedure are currently out to consultation.

Standard Operating Procedure for Running a Virtual Group Consultation in Physiotherapy

It was noted that an excellent document has been produced by Physiotherapy and this was **APPROVED** by the Group.

Emma Cooke consented for other areas in the Clinical Board to utilise the procedure to fit their services.

EFFECTIVE CARE

CDTQSE 20/241 Clinical Audit

Nothing to report.

CDTQSE 20/242 Research and Development

Grace Carolan-Rees Clinical Board R&D lead is retiring. Sion O'Keefe thanked her on behalf of the Clinical Board for her commitment to R&D. Replacement arrangements are being discussed

CDTQSE 20/243 Service Improvement Initiatives

Sion O'Keefe reported that a vast amount of service improvements have been put in place across the Clinical Board during the Covid period, with the most significant changes relating to the switch to digital technologies. There have been good examples of virtual consultations being set up for patients to access services. He will be in contact with services that are keen to explore this but are not yet up and running. He noted that he is also working with colleagues in the Digital Team around in-boarding arrangements for patients.

It was noted that no further resource for hardware for Attend Anywhere will be available.

Discussions are being held in the Clinical Board on practical ways of using Microsoft Teams and the benefits of the package. Cellular Pathology are assisting the Clinical Board in leading on this with support being provided by IM&T. Alicia Christopher has received requests from services to set up teams and will look to roll these out on a service by service basis.

SBAR Radiology Education

Lesley Harris presented an SBAR for in-house training for Radiographers and Clinical Technologists which has been produced in conjunction with the LED department. The directorate is looking for approval for this course to be delivered. Staff undertaking this training would need to understand that it is not transferable across Health Boards as the training is not accredited.

The Sub-Committee **APPROVED** the proposal. This will improve education and increase the numbers of staff trained quickly and more cost effectively.

CDTQSE 20/244 NICE Guidance

Nothing to report.

CDTQSE 20/245 Information Governance/Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 20/246 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 20/247 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

Nothing to report.

CDTQSE 20/248 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 20/249 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 20/250 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 20/251 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Reduced activity due to Covid has significantly impacted on waiting list targets. Services have been running but based on clinical priority.

Communication will be circulated this week on the challenge of trying to see more Outpatients.

CDTQSE 20/252 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 20/253 National User Experience Framework

There have been no User Experience Framework reports being produced during the Covid period.

STAFF AND RESOURCES

CDTQSE 20/254 Staff Awards and Recognition

Dietetics has been shortlisted in HSJ Patient Safety Awards in recognition of a video produced on patients newly diagnosed with coeliac disease.

CDTQSE 20/255 Monitoring of Mandatory Training and PADRs

Sian Jones presented the Clinical Board's data for May 2020:

Turnover – 3%

PADR compliance rate - 44.77%. Directorates have provided the Clinical Board with assurance that they will prioritise increasing their compliance rates.

Job planning – 10.9% but it was noted that there are system issues.

Sickness rate - 4.9%.

Mandatory training compliance rate - 84.4%.

Fire training compliance - 73.68%. Sue Bailey is able to provide a group virtual training session for fire training if requested.

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

There were no items to receive.

ANY OTHER BUSINESS

Vicky Cummings reported that she has been informed that there is a possibility of moving from the Q-Pulse QMS system to I-Passport. Sue Bailey advised that the UHB needs to evaluate the new system to ensure that it will meet its needs and the Q-Pulse licence has therefore been renewed for a further 12 months. I-Passport will be open to other areas that do not currently have a QMS in place. Mathew King commented that Podiatry is interested in implementing a QMS system.

DATE AND TIME OF NEXT MEETING

12th August 2020 at 2pm – arrangements to be confirmed.

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 12TH AUGUST 2020

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Meriel Jenney	Clinical Board Director
Alicia Christopher	Operational Support Service Manager
Scott Gable	Laboratory Service Manager, Cellular Pathology
Emma Cooke	Head of Physiotherapy
Ruth Alexander	Podiatry Representative (for Mathew King)
Louise Long	Microbiology Representative
Lesley Harris	Professional Head of Radiography UHL
Robert Bracchi	Medical Advisor to AWTTC
Bolette Jones	Head of Media Resources
Maria Jones	Sister, Outpatients
Timothy Banner	Head of Patient Services, Pharmacy
Jo Fleming	Quality and Safety Lead, Radiology
Suzie Cheesman	Patient Safety Facilitator
Judyth Jenkins	Head of Dietetics

Apologies:

Matthew Temby	Clinical Board Director of Operations
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Mathew King	Head of Podiatry
Alun Roderick	Laboratory Service Manager, Haematology
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Jonathan Davies	Health and Safety Adviser
Paul Williams	Clinical Scientist, Medical Physics
Nigel Roberts	Laboratory Service Manager, Biochemistry

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 20/256 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting which was held via Microsoft Teams.

CDTQSE 20/257 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 20/258 Approval of the Minutes of the Last Meeting

It was noted that Emma Cooke was in attendance at the last meeting.

Page 7, Sue Bailey clarified that the MHRA de-escalation related to Pharmacy UHL as opposed to Pharmacy as a whole.

Action: Helen Jenkins

CDTQSE 20/259 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 20/112 Contractors Policy

Sue Bailey to discuss issues raised with the policy with Jonathan Davies, however he is still on secondment. This action will remain open until he returns to his Health and Safety post.

Action: Sue Bailey/Jonathan Davies

CDTQSE 20/137 Risk Registers

There are still a number of risk registers not yet received from directorates.

Action: Directorates

CDTQSE 20/223 Staff Health and Wellbeing

Directorates have been reporting back to the Clinical Board issues with staff health and wellbeing, Radiology noted in particular that staff are suffering from fatigue but there are no actions requiring escalation from the Clinical Board. There are some services that have yet to respond and Alicia Christopher will follow this up.

Action: Alicia Christopher

Sue Bailey noted that there is wellbeing support available for staff who are traumatised by significant Covid reactions. The Employee Wellbeing Service is available and within the Chief Executive Connect today it was reported that the Samaritans are offering support to staff.

www.hhp.wales.co.uk is offering support for health care professionals and students. This if funded by Welsh Government and Cardiff University. The website has links to a huge amount of resource.

CDTQSE 20/223 Testing of Students on Placements

Sue Bailey has been informed that students will be tested as a cohort of their own. Services are requested to keep requests for staff to be tested separate from students.

CDTQSE 20/228 Phenobarbital Incident

This incident is being reported as an SI to Welsh Government but is being reported in relation to Primary Care and not this Clinical Board. An SI meeting has been set up and Suzie Cheesman will request for a safety notice to be issued.

Tim Banner reported that the incident has been discussed with the Children and Women Clinical Board Lead Pharmacist and also discussed at Corporate Medicines Management Group. A discussion was held around the actions that Primary Care can take to prevent this error from occurring again. GPs are enthusiastic to take this forward but noted the practicalities around this will be challenging. From this Clinical Board's perspective all actions have been taken, but noted that corporately there is further work to be undertaken.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 20/260 Patient Story

There was no patient story presented at today's meeting.

Karen Lewis was due to attend to provide an update on learning from claims cases but was not present.

CDTQSE 20/261 Feedback from UHB QSE Committee

The next meeting of the UHB QSE Committee is 18th August.

CDTQSE 20/262 Health and Care Standards

The self-assessment process has been suspended in light of Covid.

CDTQSE 20/263 Risk Register

A Clinical Board Risk Register in the new template format is being produced.

CDTQSE 20/264 Exception Report

AWTTC has submitted their risk register to the Clinical Board. There is a risk recorded relating to a Spira, a national database which was not viewable by staff in Cardiff and Vale Health Board. IT could not identify the cause of the problem and there is potential for this to occur again. Sue Bailey will send Meriel Jenney the email trails relating to this issue and will discuss with her options for escalating the issue outside of the meeting.

Action: Sue Bailey/Meriel Jenney

Biochemistry has escalated an issue of spurious results from a blood gas analyser which was over-reporting results. 2 patients in Critical Care were affected and work is underway to identify whether there are any clinical concerns or impact from this. It is not yet clarified if there is any patient harm.

A CT scan sent to Everlight for external reporting was simultaneously reported in-house with discrepant reports. An investigation is to be undertaken and further feedback will be presented at the next meeting.

Action: Sue Bailey

A potential IRMER has been reported relating to the same request form received twice for a CT pelvis for a patient. Awaiting the dose estimate to identify if this is reportable.

A staff incident was reported where an individual was not wearing a lead jacket in theatre. Information has been sent to the Radiation Protection Service for a dose report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 20/265 Initiatives to Promote Health and Wellbeing

The Patient Safety Day this year will be held on 17th September 2020 and will focus on staff wellbeing.

SAFE CARE

CDT QSE 20/266 Concerns and Compliments Report

In July 2020, the Clinical Board reported an amber/green status. 13 concerns were received with 23% resolved within early resolution timeframes. 3 compliments were received.

Departments reporting an amber status are Physiotherapy which received 2 concerns and Speech and Language Therapy which received 1 concern.

Areas showing good concerns management were Occupational Therapy which received 0 concerns and 1 compliment. Podiatry which received 1 concern but also 1 compliment and Radiology which received 3 concerns, 33% resolved by early resolution and 1 compliment.

There is an emerging theme of concerns from patients expressing frustration around difficulties arranging appointments and waiting times. Patients are not knowing how long they are likely to have to wait. A generic solution needs to be considered of how to inform patients of how long they are likely to wait, particularly as the backlog has grown. Lesley Harris will raise the issue at the next Radiology

Directorate Management Team meeting. This issue also needs to be placed as an agenda item for all directorate teams.

Action: All

Emma Cooke reported that Physiotherapy has received feedback from informal complainants that waiting times is a theme for services across the whole Health Board.

Meriel Jenney noted that communication has been written from Radiology to go out to GPs for discussion with their patients. Lesley Harris to check if this communication has been sent out.

Action: Lesley Harris

CDTQSE 20/267 Ombudsman Reports

Nothing to report.

CDTQSE 20/268 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 20/269 Patient Safety Incidents

SI Report

The Clinical Board is currently reporting 5 SIs:

In110043 - dispensing error in Pharmacy relating to an incorrect dose of Phenobarbital. The closure form has been sent to Welsh Government.

In106742 - Kell positive issued to a female of potential child bearing age. The closure form has been submitted to Welsh Government.

In103765 - WG has closed this incident this week.

In101759 - data confidentiality breach involving loss of a laptop. The closure form has been submitted to Welsh Government.

In82274 - relates to a patient who died following a choking episode. The inquest date was scheduled for April but was postponed. Awaiting a revised date.

CDTQSE 20/270 New SI's

Nothing further to report.

CDTQSE 20/271 RCA/Improvement Plans

A Learning From Events report has been received concerning the Lupus incident. A patient was misdiagnosed with antiphospholipid syndrome based on its lupus

result and commenced on warfarin as a consequence for 3 months. As a result the patient alleged that there were side effects. The reasons that the error occurred were due to the use of an incorrect reference range. The report has been shared with Haematology for learning purposes.

CDTQSE 20/272 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 20/273 Regulation 28 Reports

Nothing to report.

CDTQSE 20/274 Patient Safety Alerts

ISN 2020/005 Paracetamol 1000mg in 100ml solution for Infusion – Change of Brand, Packaging and Risk of Selection Error

The notice has been received and circulated for awareness across the Clinical Board.

CDTQSE 20/275 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 20/276 Medical Device Risks/Equipment and Diagnostic Systems

Tony Powell was not present but submitted a report.

Patient Safety Notice PSN051 - Intraosseous Injector has been circulated across the Health Board reminding areas that the battery is to be checked as part of the resus trolley checklist.

The gas cylinder replacement proposal has not been progressed. The UHB still has a number of old type cylinders and regulators in use, and the proposal was to move towards the new type cylinders with a mechanism to cross charge Clinical Boards with a proportion of their usage. Finance need to action devolving the budget for gases to other directorates to move forward with this scheme. Sue Bailey will discuss this outside of the meeting with Darrell Baker.

Action: Sue Bailey

An update was provided on the Patient Controlled Analgesic (PCA) pump replacement. The MTC is now funding 30 of the 115 needed. There is no progress on the purchase of the outstanding replacements and the risk of failure of current pumps is more likely. The new 30 purchased pumps are going to be implemented across the UHL site, and when the rest purchased the UHW site will be replaced.

The rollout of the defibrillator replacements is almost complete.

Decommissioning of the Dragons Heart Hospital is underway. Sue Bailey acknowledged the hard work of Clinical Engineering who are managing the decommissioning of the kit.

CDTQSE 20/277 IP&C/Decontamination Issues

The road at the rear of B Bock and Medical Physics building is in need of a regular clean but there is a need to be mindful that this does not cause any issues for Radiopharmacy production when this is being cleaned.

Physiotherapy staff are experiencing challenges with current masks and arranging for on-call staff to be fit tested. There are seven staff who do not fit test any masks currently in use and the department is trying to access hoods. Hoods are a finite resource that requires support from the Clinical Board. Sue Bailey stated that the Clinical Board is willing to support this request and she will send Emma Cooke the necessary form for completion.

Action: Sue Bailey/Emma Cooke

There are decontamination process issues relating to wheelchairs and issues around the 72 hour quarantine period for the kit. Sue Bailey will raise the issues at the UHB Decontamination Group on Friday.

Action: Sue Bailey

CDTQSE 20/278 Point of Care Testing

Nothing to report.

CDTQSE 20/279 Key Patient Safety Risks

Safeguarding

Maria Jones provided feedback from the UHB Safeguarding Group. A discussion was held around the amount of large documents being requested for circulation via email without hyperlinks. The Clinical Board will need to consider how it manages this issue.

A Safeguarding App has been developed which contains all safeguarding procedures.

It was noted that there has been an increase in disclosures during the Covid period as patients are attending unaccompanied. There has been a decline in the number of referrals coming from general areas as services were closed.

The pressure damage reporting procedure has changed and departments are to revert back to the pre-covid procedure.

It is anticipated that the Yellow Ribbon Campaign will go ahead in November and also for the Safeguarding Week in November to take place.

The Alcohol Abstinence Monitoring Procedure was circulated for information.

Mental Capacity Act

Nothing to report.

CDTQSE 20/280 Health and Safety Issues

The Clinical Board Health and Safety group is being held tomorrow.

CDTQSE 20/281 Regulatory Compliance and Accreditation

The Clinical Board Regulatory Compliance and Accreditation Group met last week.

Scott Gable reported that Cellular Pathology has maintained UKAS accreditation. This is positive news given the challenges around undergoing accreditation during the Covid period.

CDTQSE 20/282 Policies, Procedures and Guidance

Standard Operating Procedure for Running a Virtual Group Consultation in Physiotherapy

The procedure was approved by the Group at the previous meeting. Small amendments were made to the document following the meeting and Sue Bailey has taken Chair's Action outside of the meeting to ratify the amendments and final version of the procedure.

The Ultrasound Governance Policy and Procedure is out to consultation and can be reviewed via the intranet.

EFFECTIVE CARE

CDTQSE 20/283 Clinical Audit

Internal audit will be undertaking an audit of ultrasound governance across the UHB. A meeting is scheduled with the Internal Audit team to set the scope of the audit. Following the meeting this will be shared across Clinical Boards to advise them of the audit and what will be audited. The standards within the Ultrasound Governance Policy and Procedure will be used as the measuring tool for the audit.

CDTQSE 20/284 Research and Development

Grace Carolan-Rees has retired and a replacement for the R&D Lead for the Clinical Board is needed. Any interest in the role to speak to Meriel Jenney.

CDTQSE 20/285 Service Improvement Initiatives

It was noted in CEO Connects this week that applications are open for Bevan Exemplars.

CDTQSE 20/286 NICE Guidance

Guidance for self-solation for patients coming in for Planned Care was noted. It is recommended that as a minimum, there is a standard of 3 days from the date of Covid test to the date of operation.

In terms of diagnostics, it is recommended that patients socially distance and comply with good hand hygiene for 2 weeks prior to diagnostics. Radiology staff will be asking patients to wear face masks and hand sanitisers will be available throughout the department. This will allow the number of patients in the waiting rooms to be increased and to allow patients to distance 1 metre apart rather than 2 metres.

CDTQSE 20/287 Information Governance/Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 20/288 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 20/289 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

Nothing to report.

CDTQSE 20/290 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 20/291 Equality and Diversity

It was reported that the Executive Directors will be taking a leadership role across the 9 protected characteristics of the Equality Act. The Chief Executive will be leading on race.

TIMELY CARE

CDTQSE 20/292 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 20/293 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

For 3rd August Radiology was reporting a backlog of 7360 patients over 8 weeks.

Physiotherapy is reporting 53 breaches over 14 weeks. These all relate to patients for the Back in Action service which is currently not running. This service will commence in September.

1033 breaches are reported in Podiatry and there is a plan to reduce to 0 by September

Dietetics is reporting 9 breaches for Type 2 diabetes patients and 209 weight management patients.

Occupational Therapy – 0 breaches.

Speech and Language Therapy – 8 breaches.

It is likely that the metrics for waiting times is likely to change but it is not yet determined how performance will be reported going forward.

Meriel Jenny would like an update of how services are communicating with Primary Care and patients in terms of their waiting times and how they can mitigate safety risks to patients. Departments to also share their thoughts on how waiting list figures should be reported for their individual services. It was agreed that a significant proportion of the next meeting will be devoted to these discussions.

Action: All

Meriel Jenney will enquire at the next Clinical Board Directors Meeting what approaches the other Clinical Boards are considering.

Action: Meriel Jenney

CDTQSE 20/294 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 20/295 National User Experience Framework

An email was circulated today to departments requesting their feedback on how they are managing the patient experience.

STAFF AND RESOURCES

CDTQSE 20/296 Staff Awards and Recognition

The Clinical Board is seeking nominations for its Staff Recognition Scheme. For August nominations are sought for an individual who has made an outstanding contribution. This is to recognise someone who has gone the extra mile to support the UHB during the Covid period or an individual who has worked hard to deliver a service beyond their current role.

For September, nominations are sought for a team that has made an outstanding contribution.

CDTQSE 20/297 Monitoring of Mandatory Training and PADRs

At the end of June the Clinical Board is reporting 84.1% compliance against mandatory training.

Fire training compliance is 73.88%.

PADR compliance rate is 41.96%. Training for undertaking Values and Behaviours based PADRs has been stood down. Managers are therefore requested to continue to undertake PADRs using the former PADR style until they are able to attend the values based appraisals training. The Clinical Board has requested assurance from directorates that they have plans in place to increase PADR compliance in their areas.

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

There were no items to receive.

ANY OTHER BUSINESS

Nothing further to report.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 9th September 2020 at 2pm via Microsoft Teams.

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

MINUTES OF THE MEETING HELD ON 9TH SEPTEMBER 2020

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Matthew Temby	Clinical Board Director of Operations
Alicia Christopher	Operational Support Service Manager
Scott Gable	Laboratory Service Manager, Cellular Pathology
Emma Cooke	Head of Physiotherapy
Mathew King	Head of Service, Podiatry
Lesley Harris	Professional Head of Radiography UHL
Robert Bracchi	Medical Advisor to AWTTC
Christopher Tetley	Head of Clinical Photography (for Bolette Jones)
Maria Jones	Sister, Outpatients
Timothy Banner	Head of Patient Services, Pharmacy
Jo Fleming	Quality and Safety Lead, Radiology
Judyth Jenkins	Head of Dietetics
Seetal Sall	Point of Care Testing Manager
Alun Roderick	Laboratory Service Manager, Haematology
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Nia Came	Head of Adult Speech and Language Therapy

Apologies:

Meriel Jenney	Clinical Board Director
Bolette Jones	Head of Media Resources
Suzie Cheesman	Patient Safety Facilitator
Louise Long	Microbiology Representative
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Paul Williams	Clinical Scientist, Medical Physics
Nigel Roberts	Laboratory Service Manager, Biochemistry

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 20/298 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting which was held via Microsoft Teams.

CDTQSE 20/299 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 20/300 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 12th August 2020 were **APPROVED.**

CDTQSE 20/301 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 20/112 Contractor Policy

Sue Bailey to discuss with the Clinical Board Health and Safety Adviser when he returns to post the issues raised relating to the Contractors Policy.

Action: Sue Bailey

CDTQSE 20/137 Risk Register

Outstanding risk registers to be submitted to Helen Jenkins.

Action: Directorates

It was noted that a Clinical Board risk register has been collated into the new template.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 20/302 Patient Story

There was no patient story presented at today's meeting.

Attend Anywhere Presentation

Anne Owens delivered a presentation on Attend Anywhere virtual consultation platform. The pilot commenced in April 2020 in response to the Covid 19 lockdown. Attend Anywhere was the platform of choice due to its good governance arrangements and security. It was deemed to be user friendly for both clinicians and patients.

Clinical Diagnostics and Therapeutics Clinical Board commenced utilising Attend Anywhere on 22nd April and have undertaken 458 consultations. This equates to 96 consultation hours. It has 10 waiting rooms set up, 7 of which are being utilised. 97 staff members have been trained on the platform and 47 of these staff have participated in consultations. It was noted that Podiatry is reporting the highest usage of Attend Anywhere within the Clinical Board.

Across the UHB in totality 4024 consultations have been undertaken.

Implementation leads are established within Clinical Boards to embed Attend Anywhere into practice. Standardised template letters and text wording for patients have been produced. FAQs and user guides are available on the intranet for staff. Staff are encouraged to look at the intranet site for new materials. Social Media and media campaigns have been informing patients on how to access the waiting rooms.

In terms of outcomes so far, Attend Anywhere has ensured a level of continuity of service to patients throughout lockdown. It has provided an opportunity for services to review pathways of care and consider what services could be undertaken via video. It has also provided an opportunity for new and innovative ways of working e.g. orthotic fitting, observing children in their own environment and patients having care in their own home environment are feeling more empowered.

Video consultation will be the way forward for the future. Services will be migrated away from platforms with less governance and encouraged to move forward with Attend Anywhere. However the decision whether consultations are suitable in a virtual environment will always be led by the clinician.

Mathew King asked if there are any developments planned for group sessions. This is an area that Podiatry would be keen to expand into. Anne Owens advised that group sessions within Attend Anywhere currently do not function well. There are plans to look at implementing group work via Microsoft Teams however this requires roll out of Microsoft 365.

Emma Cooke advised that Physiotherapy whilst utilising video consultations are unable to move to Attend Anywhere as it is not synced to their appointment system for invites. Sion O'Keefe noted that work is underway in Medical Records around automation utilising Comms 2. He suggested that it is worthwhile undertaking a collective assessment of what is needed going forward within the services of the Clinical Board to move forward with Attend Anywhere.

CDTQSE 20/303 Feedback from UHB QSE Committee

The minutes of the meeting held on 8th September 2020 are not yet available.

CDTQSE 20/304 Health and Care Standards

Self-assessments are not currently being undertaken.

CDTQSE 20/305 Risk Register

Nothing further to report.

CDTQSE 20/306 Exception Report

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 20/307 Initiatives to Promote Health and Wellbeing

Flu vaccines are expected to be available from 21st September and patient facing staff are to be prioritised. There is no update on when the Covid vaccinations will be available. However a mechanism for recording the date of when staff receive their flu vaccinations will need to be identified as there needs to be a 3 week gap between receiving the flu vaccination and the Covid vaccine. Directorates need to consider their priority list of staff. It was noted that staff who are not frontline workers will still be offered the vaccination.

Action: Directorates

The Clinical Board has received nominations for flu champions. Social distancing considerations will be important this year and suitable venues are being considered. It is highly unlikely that drop in sessions will be held this year.

SAFE CARE

CDT QSE 20/308 Concerns and Compliments Report

In August 2020 the Clinical Board reported an Amber status. It received 16 concerns, with 25% resolved within early resolution timeframes and 11 compliments. There were 4 breaches against response dates due in August.

Outpatient/Patient Administration reported a Red status in August. The directorate received 3 concerns with 33% resolved within early resolution timeframes. It reported 1 breach in response times and 0 compliments.

Radiology is reporting an Amber Status. The department received 5 concerns with 20% resolved by early resolution. It reported 1 breach in response times and 2 compliments.

Physiotherapy is reporting an Amber Status. The department received 4 concerns with 25% resolved by early resolution. It reported 2 breaches against response times but received 4 compliments.

Good concerns management was noted in Laboratory Medicine. The directorate is reporting a green status. It received 2 concerns with 50% managed in early resolution timeframes. There were 0 breaches in response times and the directorate received 1 compliment.

Medical Illustration is reporting a Green status. The directorate received 0 concerns and 2 compliments.

Medical Physics is also reporting a Green status. The department received 0 concerns and 1 compliment.

In terms of themes, of the 16 concerns received 9 related to difficulties arranging appointments and 5 relating to waiting times.

CDTQSE 20/309 Ombudsman Reports

An Ombudsman Report was circulated for information relating to a perceived delay in a pathology report relating to a biopsy sample. It was noted that the Ombudsman did not uphold the complaint.

CDTQSE 20/310 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 20/311 Patient Safety Incidents

SI Report

The Clinical Board is reporting 4 Open SIs:

In122136 relates to the incident in Cardiac Theatre which was discussed at the last meeting.

In106742 relates to the Blood Bank. The closure form was submitted to Welsh Government in April and has not yet been closed.

In101759 relates to the stolen laptop in Outpatients. The closure form has been submitted to Welsh Government but has not yet been closed.

In82274 – this incident is awaiting an inquest that has not yet taken place.

CDTQSE 20/312 New SI's

Nothing to report.

CDTQSE 20/313 RCA/Improvement Plans

Nothing to report.

CDTQSE 20/314 WG Closure Forms – Sign Off

No closure forms were received.

CDTQSE 20/315 Regulation 28 Reports

Nothing to report.

CDTQSE 20/316 Patient Safety Alerts

There were no Patient Safety Alerts to report.

CDTQSE 20/317 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 20/318 Medical Device Risks/Equipment and Diagnostic Systems

Medical Devices Regulations that were due to come into force earlier this year were delayed due to Covid. The EU has now delayed the implementation of the Regulations until 2021 which will therefore not be implemented in UK law. It was noted that it is therefore likely that the MHRA will develop its own medical device regulations.

Matt Temby reported that the UHB has been in the process of progressing with a business case to replace the Radiopharmacy Unit with a new build. The completion date has now been delayed until August 2022 and the decision has been taken to cease all work on the business case. Discussions have been held with the Executive Directors and it has been agreed that a risk assessment will be undertaken on the current facility and a paper will be submitted to Management Executive to highlight the full risk of this decision. The paper will also recommend the need to inform the MHRA. It has been agreed that there will be a 2-3 week period to undertake a thorough risk assessment process and identify the risks prior to informing the Regulator.

CDTQSE 20/319 IP&C/Decontamination Issues

Nothing to report.

CDTQSE 20/310 Point of Care Testing

Seetal Sall reported that the Point of Care Testing service is due to take receipt of a device and will be the first to evaluate a new multi analyser point of care device to detect Covid antibodies and antigen. Moving forward test by test this can be upscaled for multifunctional pathways. The service will produce a protocol in conjunction with an R&D lead who will be working with the team to undertake this evaluation.

The local Point of Care Testing team are also looking to introduce point of care flu testing in the Emergency department utilising a device that has been implemented in other Health Boards in Wales. Matt Temby enquired if MEAU at UHL will also be part of this. It was advised that the department has been considered and is under discussion.

The Point of Care Testing Group is to be re-established and the terms of reference have been sent to Sue Bailey to review. Sue Bailey will discuss with Seetal Sall outside of the meeting.

Management of Point of Care Testing consumables have previously been via the Pharmacy ordering system however a new system is being introduced in Pharmacy that will only manage drugs. Tim Banner advised that a process needs to be put in place.

CDTQSE 20/311 Key Patient Safety Risks

Safeguarding

A high volume of large emails relating to safeguarding information circulated from the Safeguarding team has raised concerns with closing email mailboxes. The Clinical Board is therefore considering sharing this information through Microsoft Teams.

Mental Capacity Act

Nothing to report.

CDTQSE 20/312 Health and Safety Issues

Nothing to report.

CDTQSE 20/313 Regulatory Compliance and Accreditation

There were no issues to escalate from the Clinical Board Regulatory Compliance Group. Good progress is being made in general and Sue Bailey will share the metrics at the next meeting.

Action: Sue Bailey

CDTQSE 20/314 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 20/315 Clinical Audit

Nothing to report.

CDTQSE 20/2316 Research and Development

The R&D Group has not met for some time due to Covid and also due to the retirement of the Clinical Board R&D Lead. Discussions are ongoing for a replacement and a job description will be circulated shortly.

An R&D Performance meeting with the Medical Director and UHB R&D Lead is being held next week.

CDTQSE 20/317 Service Improvement Initiatives

Sion O'Keefe reported that an Outpatient Programme Board has been implemented in the UHB with Meriel Jenney and Anna Kuczynska jointly chairing the group. The aim of the Group is to transform Outpatient Services and will initially focus on how to maximise throughput of outpatients whilst minimising the risk of transmission of

Covid. The group is supported by the I&I Team and the approach will be communicating with patients and how they can be seen safely. There will need to be changes to systems and environments.

CDTQSE 20/318 NICE Guidance

Nothing to report.

CDTQSE 20/319 Information Governance/Data Quality

ICO Regulations which have been relaxed during Covid will be more tightly enforced going forward.

DIGNIFIED CARE

CDTQSE 20/320 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 20/321 Initiatives to Improve Services for People with:

Dementia

Sue Bailey attended the UHB Dementia Group where a discussion was held on the provision of digital stories for patients on what they can expect when they arrive at hospital services. Sue Bailey will provide further information at the next meeting. Seetal Sall can provide Sue Bailey with information linked to the Madeleine Project.

Action: Seetal Sall

Sensory Loss

Keithley Wilkinson, Equality Advisor is collating details of any initiatives or service improvement work for patients with sensory loss. If any services have put in place improvements for patients with sensory loss to inform Sue Bailey

Matt Temby enquired if any services have implemented clear masks for patients with sensory loss. Nia Came reported that Speech and Language Therapy Services on an All Wales level are looking into implementing clear face masks. She agreed to ask Procurement if they can source some boxes.

Action: Nia Came

CDTQSE 20/323 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 20/324 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 20/325 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 20/326 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

It was noted that Therapies have utilised alternative methods to manage their waiting lists.

It was recognised that there are challenges for services where virtual consultations are not suitable such as Radiology, where demand is increasing.

Mathew King advised that patients are within their rights to record their virtual consultations with their clinicians, however they are not allowed to share the recordings. Sion O'Keefe will follow this up with Anne Owens to form part of a checklist for Attend Anywhere.

Action: Sion O'Keefe

Matt Temby stated that the work in Therapies on their progress with waiting times and the work to address the turnaround times in Cellular Pathology has been acknowledged by the Executive Team. Whilst there is a backlog in Radiology the Executives also recognise the work being undertaken by the department to hold their diagnostic position.

Alicia Christopher is collating information on what services are open and currently closed. Directorates are asked to respond using the template circulated.

Judyth Jenkins enquired whether the destruction of records can be undertaken. The UHB response is that at present records must be retained. They can be stored in the UHB storage facility and Sion O'Keefe will provide her with further details.

Action: Sion O'Keefe

CDTQSE 20/327 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 20/328 National User Experience Framework

User Experience Reports are not currently available.

STAFF AND RESOURCES

CDTQSE 20/329 Staff Awards and Recognition

Good quality nominations were received for the Clinical Board Staff Recognition Scheme in August for an individual making outstanding contribution.

The Clinical Board are undertaking informal visits to staff. Alicia Christopher and Sue Bailey visited teams in Rookwood this week.

CDTQSE 20/330 Monitoring of Mandatory Training and PADRs

There are no issues with Mandatory training compliance. Directorates are working on plans for improving their PADR compliance.

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

The Clinical Board Regulatory Compliance Group Minutes September 2020 were **RECEIVED.**

The Biochemistry Quality Group Minutes for August 2020 were **RECEIVED.**

ANY OTHER BUSINESS

Nothing further to report.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 14th October 2020 at 2pm via Microsoft Teams.

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 14TH OCTOBER 2020

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Matthew Temby	Clinical Board Director of Operations
Alun Roderick	Laboratory Service Manager, Haematology
Alicia Christopher	Operational Support Service Manager
Scott Gable	Laboratory Service Manager, Cellular Pathology
Cath Marshall	Physiotherapy (for Emma Cooke)
Jo Fleming	Quality and Safety Lead, Radiology
Judyth Jenkins	Head of Dietetics
Mathew King	Head of Service, Podiatry
Robert Bracchi	Medical Advisor to AWTTC
Maria Jones	Sister, Outpatients
Nia Came	Head of Adult Speech and Language Therapy
Nigel Roberts	Laboratory Service Manager, Biochemistry
Seetal Sall	Point of Care Testing Manager
Suzie Cheesman	Patient Safety Facilitator
Bolette Jones	Head of Media Resources
Paul Williams	Clinical Scientist, Medical Physics

Apologies:

Meriel Jenney	Clinical Board Director
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Lesley Harris	Professional Head of Radiography UHL
Emma Cooke	Head of Physiotherapy
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Alison Bax	Professional Head of Radiography UHW
Andrew Goringe	Laboratory Director, Haematology

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 20/331 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting which was held via Microsoft Teams.

CDTQSE 20/332 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 20/333 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 9th September 2020 were **APPROVED.**

CDTQSE 20/334 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:

CDT QSE 20/112 Contractors Policy

Sue Bailey to discuss with the Clinical Board Health and Safety Adviser when he returns from secondment, the issues raised relating to the Contractors Policy.

Action: Sue Bailey

CDTQSE 20/137 Risk Registers

Risk registers have not yet been received from Haematology, Pharmacy and Speech and Language Therapy. The departments to submit their risk registers to Helen Jenkins.

Action: Alun Roderick/Nia Came/Tim Banner

CDTQSE 20/321 Clear Face Masks

Sue Bailey has the contact information should any departments wish to trial clear face masks.

CDTQSE 20/326 Attend Anywhere

Sion O'Keefe to inform Anne Owens of the need to include patient rights relating to the recording of their virtual consultations in the checklist for Attend Anywhere.

Action: Sion O'Keefe

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 20/335 Patient Story – Learning from Legal Cases

Karen Lewis, Claims Manager was in attendance to provide shared learning from legal cases.

CN UHW 3887- the first case she presented involved a claimant who was admitted with a combination of ailments. The patient had a laparoscopy for suspected

appendicitis. The patient was discharged with further tests arranged but returned after having a Mirena coil removed with severe abdominal pain and clinical peritonitis. A large mass was found when the patient was taken for laparotomy. The patient returned to UHW following rigors and problems with the stoma having completed a course of antibiotics. A CT scan showed signs of pelvic inflammatory disease. The patient was admitted again with a small bowel obstruction which resolved with medical management over a few days.

It is alleged that there was a failure to carry out adequate reading of the CT scan report and making a wrong diagnosis of epiploic appendicitis resulting in the incorrect treatment prolonging pain and suffering. This claim is in the early stages of investigation. No decision has been made.

CN UHW 3191 - the second case presented related to a patient, who as a result of a pulmonary embolism, was referred to the Haematology Department in order to investigate whether there were any underlying causes. The Claimant had three lupus anticoagulation tests and the results were all positive. The Claimant was then commenced on long term Warfarin therapy. A repeat lupus anticoagulant test returned negative and further repeat testing was arranged. The Claimant was advised that an internal investigation had been undertaken and it was revealed that the two previous lupus anticoagulant positive results were incorrect and have been re-tested and was shown to be negative.

There was an investigation to ensure that the machinery used to interpret the Claimant's result was not at fault, the internal investigation, however, found that the fault was as a result of human error and not as a result of the machinery which was used in the process.

A lot of good practice was acknowledged in this investigation. The quality of the RCA and the speed of actions to contact clinicians and patients was commended in the Expert's report.

The Health Board had been advised to make and admission of breach of duty in respect of the lupus anticoagulant results being reported incorrectly. Initially the Health Board made a denial with regard to causation. However, on the basis of the advice sought from Counsel and, in light of Expert opinion the Health Board were advised that it would appear that causation in respect of the Claimant's psychiatric injury could not be defended. The Health Board admitted breach of duty and that as a result of this the Claimant received 15 days of unnecessary warfarin therapy and one dose of clexane. This case has now been settled.

CN UHW 3356 - A low value claim case was noted where a patient came into A&E and received a CT scan. He was discharged from the hospital and was advised that he had suffered a soft tissue injury. A subsequent scan a few weeks later revealed a fracture in the cervical spine. The claimant alleged that there was a breach of duty when the Health Board failed to report and treat the fracture to his back.

The Health Board obtained independent expert evidence from a Consultant Radiologist. The Defendant's expert carried out a review of the imaging and the radiology reports in this matter. The expert concludes that the first CT scan

demonstrated no evidence of an acute vertebral fracture and the report of the cervical spine CT with the consultant addendum is of a satisfactory standard.

The Claimant further claims that a multi-fragmentary fracture of the medial left clavicle was either missed or was not correctly treated following the fracture being identified. The investigation confirmed that a medial left clavicle fracture was identified following Consultant review of the CT scan. It was accepted that there was a delay in diagnosing and treating the clavicle fracture as unfortunately, the clavicle fracture was not identified by the clinical team until weeks later.

It was accepted that had the clavicle fracture been identified following the first CT scan, the Claimant would have been treated earlier by way of a broad arm sling for comfort and would have avoided a period of additional pain.

The Health board were advised to admit liability for a delay in diagnosing a fracture of the left clavicle but deny liability for the delay in diagnosing the cervical fracture. A low value offer was made with further advice obtained.

In terms of learning and actions, all radiology reports are made available at the point of final validation on the Clinical Portal. A printed copy is then sent to EU for further resilience and to inform their follow-up procedure. The Clinical Team have access to electronic access to the full Radiology reports. All reports by trainee Radiology are reviewed by a Consultant Radiologist.

CN UHW 3530 - The next case discussed involved a patient who attended the EU department at UHW complaining of left hip/knee pain. X-rays were taken of the left hip and femur. The EU doctor who examined the claimant reviewed the radiology and concluded that there was no fracture but there was calcific deposition around the joint. The claimant was diagnosed with calcific bursitis and was discharged with pain killers. The radiology was formally reported as showing no fracture. The patient was referred to Trauma and Orthopaedics due to an 8 week history of pain in her hip requiring her to walk with crutches and being unable to work. The claimant was seen by the Consultant Orthopaedic Surgeon.

The Orthopaedic Consultant Surgeon reviewed the radiology. Updated radiographs showed marked further deterioration. There was concern that the claimant had developed a soft tissue reaction secondary to the large amount of titanium debris. Revision surgery was required but it was noted that it would be challenging due to the condition of the hip. The claimant went on to have a total hip replacement.

The outcome following the claimant's revision surgery was significantly adversely affected by the delay in diagnosis.

The Expert concluded that there was a failure to identify a ceramic head failure. There was a significant delay between the claimant being seen by a relevant Orthopaedic Specialist and this delay was accepted. Breach of Duty has been accepted the case will be settled.

In terms of learning, the Radiology Educational Supervisors to discuss the case with the treating clinician to ensure lessons are learned. The case was shared and

discussed at the Radiology Discrepancy meeting and is being considered by the Clinical Diagnostics and Therapeutics Clinical Board for updated assurance.

CN UHW 3476 - The next case discussed involved a patient who attended A&E with a persistent cough and foul taste in the mouth. An x-ray was reported as normal. A further x-ray of the chest and abdomen was undertaken a few months later revealing a shadow within the upper left zone and noted a lesion was present. The patient underwent an upper left lobectomy and the tumour was completely excised.

An allegation of breach of duty of care arising from an alleged failure to report the presence of a 1.5 cm of opacity in the x-ray. The Claimant's solicitors now allege that there was a failure to compare the x-ray taken in 2015 with a pre-existing x-ray from 2014. It is alleged this comparison would have allowed the reporter to note an increase in the size and density of the opacity thus making a primary lung cancer most likely diagnosis. The Claimant also alleges that the x-ray of August 2014 showed a suspicion of an abnormality which was worthy of comment even at that stage.

During a case conference there were supportive expert reports on how this was investigated but could not be certain that the consultant had not referred to a previous x-ray so the case was not supported. It was deemed a note taking issue rather than practice.

There was no issues identified with the system that had been undertaken to review and report on x-rays/scans However, the Consultant confirmed that this matter would be considered by the wider team in order that they may review this case and be aware of the outcome.

CN UHW 3734 - the next case involved a patient who attended her GP regarding a 2 months history of right sided neck swelling and was referred to the UHW hospital for a neck ultrasound. The ultrasound was undertaken and the claimant was informed that it was a harmless branchial cyst that did not require treatment. The patient was referred to the ENT unit when the lump had grown in size. On examination it was suspected that she had a right sided tonsil cancer with secondary spread to neck lymph nodes. Biopsies and CT scans showed positive for squamous cell cancer in the tonsil. She was told that the diagnosis initially made was incorrect and that she should have been referred to an ENT specialist at the time. She underwent chemotherapy and radiotherapy at Velindre Hospital. She developed hearing impairment and had to use hearing aids. She also suffered severe throat pain which made swallowing difficult and had to use a nasogastric tube for feeding.

The allegations are that there was a failure to recommend for specialist assessment before making a diagnosis which fell below reasonable standard of head and neck specialist radiologists. It was alleged that the ultrasound report by the Consultant Radiologist was not completed conclusively and was not reasonable to conclude that the lump was a branchial cyst without any safety-netting. This case was reviewed internally and confirmed that the ultrasound scan showed a lymph node suspicious for malignant metastatic disease. This is a case for discussion and future learning.

CN UHW 3548 - the final case discussed involved a patient who suffered a stroke in 2008 at which time she was aged 65. In 2009 she was diagnosed as suffering with an 8.5 mm right sided acoustic neuroma. The Claimant chose conservative treatment in the form of MRI scans to monitor the acoustic neuroma. An allegation was made on the failure to report a brain aneurysm later identified on scans. The claimant felt that had she known about this earlier her treatment options would have been different.

The Health Board admitted that there was failure to report the presence of a brain aneurysm. It was agreed that it is difficult to identify an intracranial aneurysm. There was no causative effect from this and if identified then it would have been monitored not treated at that stage.

It is accepted that there is a need to ensure that sufficient information is given to the patient including all treatment options. There needs to be a proactive approach in instilling the need to consider all treatment options open to the patient and in the recording of this information and discussions with the patient. There was good evidence in the documentation that informed consent had been completed.

It was noted that reading and acknowledgement of reports is a common theme from claims and concerns. Matt Temby and Sue Bailey will discuss with Meriel Jenney how to review consent issues and review of diagnostic images outside of Radiology.

Action: Matt Temby/Sue Bailey/Meriel Jenney

CDTQSE 20/336 Feedback from UHB QSE Committee

The minutes of the meeting held on 8th September 2020 are not yet available.

CDTQSE 20/337 Health and Care Standards

The self-assessment process is currently stood down.

CDTQSE 20/338 Risk Register

In Haematology the traceability risk assessment is being revised along with the WLIMS risk assessment.

The provision of cardiac services at UHL risk assessment has been completed.

CDTQSE 20/339 Exception Report

Robert Bracchi reported that the Clinical Pharmacologist team are undertaking consultations by telephone but have not been invited to participate in Attend Anywhere at UHL. It was noted that the potential for a virtual village in UHL is being progressed with the facility with the appropriate connections to conduct virtual consultations. Matt Temby will advise when this is in place.

Podiatry rooms in the Vale have not yet been handed back from Primary Care and therefore there is no Podiatry service available in the Vale. All Vale patients are having to attend CRI. Mathew King will contact Lisa Dunsford.

Action: Mathew King

Cath Marshall reported MSK services are delivering out of 2 sites, CRI and Barry and physical space and access to IT to support virtual consultations is an issue. On the Physiotherapy risk register. Matt Temby reported that a short term solution has been identified. There is available space in UHL Core Outpatients for a period of time and Emma Cooke is liaising with Tracey Wooster.

Sue Bailey reported that MSK Radiology forms were inadvertently left on a desk and not passed for booking. This led to a delay in some patients being delayed in being booked with appointments USC patients were not included in this and were not at risk. No harm has been identified to patients due to the delay. E-vetting module is now being held in Radis system to prevent a reoccurrence of this incident.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 20/340 Initiatives to Promote Health and Wellbeing of Patients and Staff

Maria Jones reported that every season there is discrepancy between the amount of vaccines that are taken out and the consent forms that are returned to Occupational Health. This week there is a pause on issuing further vaccines and Flu Champions have been asked to utilise the vaccines that are circulating within their Clinical Boards and prioritise patient facing staff. Therapists are being prioritised in this Clinical Board. Sue Bailey noted the huge efforts that have been made to date by the Flu Champions in this Clinical Board to get staff vaccinated and the Clinical Board thanked them for their hard work. Maria Jones also linked with Flu Leads in other Clinical Boards to work together to vaccinate staff on the other sites.

Staff are asked to remember the date of their vaccine in the event of the Covid vaccine becoming available. It was noted that Sion O'Keefe is working towards supporting a plan for when the vaccine becomes available. Pharmacy also undertaking a lot of preparatory work.

SAFE CARE

CDT QSE 20/341 Concerns and Compliments Report

In September 2020, the Clinical Board is reporting a Red status. It received 15 concerns and there was 1 breach in response times. 5 compliments were received.

The main area of concern is Physiotherapy which received 4 concerns and reported 1 breach in response times. However 25% of the concerns were resolved in early resolution timeframes and the department received 1 compliment.

Areas of good concerns management are Radiology which although received 4 concerns, it resolved 50% of these within early resolution timeframes. The department also received 1 compliment.

Occupational Therapy received 2 compliments.

Medical Illustration received 1 compliment.

CDTQSE 20/342 Ombudsman Reports

Nothing to report.

CDTQSE 20/343 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 20/344 Patient Safety Incidents

SI Report

The Clinical Board is reporting 4 Open SIs. 2 of these are where the closure forms are with Welsh Government. An update was provided on the 2 SIs currently in progress:

In82274 relates to a Speech and Language Therapy incident relating to a choking episode. The RCA is complete and the Clinical Board has been advised to move to closure with Welsh Government.

In122136 relates to a Cardiac theatre case - this is currently under investigation.

CDTQSE 20/345 New SI's

The Clinical Board has been involved in a paediatric major trauma case involving Radiology where there were delays in a child being transferred to Bristol. This incident involved a number of directorates.

An IRMER breach was reported in relation to images not archived for two patients. Awaiting feedback on the cause of the incident.

An incident occurred yesterday relating to a request form with an incorrect addressograph. This is likely to be reported as an IRMER incident.

CDTQSE 20/346 RCA/Improvement Plans

Nothing to report.

CDTQSE 20/347 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 20/348 Regulation 28 Reports

Nothing to report.

CDTQSE 20/349 Patient Safety Alerts

Internal Safety Alert 20/009 Expired Blood Sample Tubes

The alert relates to the Welsh Blood Service. Biochemistry is running a random audit of sample tubes coming in for reassurance that the department is not subject to the same problem.

CDTQSE 20/350 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 20/351 Medical Device Risks/Equipment and Diagnostic Systems

Tony Powell was not present but circulated the Medical Device Safety Officer Report.

There is a serious failure issue with T34 palliative care infusion pump with the possibility of the battery not lasting long enough in use. This is an All Wales issue and a patient safety notice will be circulated.

Gas cylinder replacement proposal requires finance to look at portioning budgets across Clinical Boards in order to progress this.

Patient controlled analgesic pump replacement is progressing with MTC funding 30 of the 115 needed and funding is being sought for the remainder. The 30 will be utilised at UHL and UHW will receive a stock of new pumps when they are purchased.

The development of the Lakeside Wing has implications on the routine workload of Clinical Engineering team. Equipment will be transferred week of 2nd November from existing stock.

Some Arjo hoists and plinths in place across the UHB has been deemed obsolete which will potentially cause issues in the future if parts cannot be sourced.

Problems have been reported across Wales relating to supplies of reagents from Roche Diagnostics. The issue does not affect Cardiff and Vale. Swansea Bay have reached the point where they may need support. The UHB is considering what support it can be provide regionally. Biochemistry has a full stock of Abbott reagent and can provide some assistance.

Medical equipment in Cellpath is reaching end of life and due to limited access to capital funding is looking at a managed service contract as a possibility.

Radiology received a notice on Lifeguard patient x-ray trolleys advising not to move them using the safety sides. The department is in contact with Clinical Engineering to get these fixed.

CDTQSE 20/352 IP&C/Decontamination Issues

Matt Temby reported that there is an ongoing IPC issue in UHL on East 6.

An alert system will be instigated for this Clinical Board whereby if an outbreak is identified through the Local Coordination Centres then this will be communicated through the QSE route and circulated out to all directorates. Peripatetic staff within this Clinical Board working on wards with a Covid outbreak will need to undertake decontamination processes at the end of the day to lower the risk of cross contamination. Staff will need to collaborate across departments to minimise the number of staff on the ward at the same time.

It was noted that visor usage is now increasing and a stock issue was reported on wards yesterday. The advice on the utilisation of visors had not changed however the application of the advice has been variable on wards as Covid levels had decreased over the summer. Matt Temby will check that the stock issues are in hand. He will escalate the need to refresh communication at UHL wards and request for standardised information on PPE and Covid guidance.

Action: Matt Temby

He stated that he is supportive of individual departments ordering a supply of PPE stock in the event of there being a shortage on the wards.

It was noted that information on visors will be forthcoming from IPC.

An E-coli bacteraerium was reported in August. Radiology have produced an action plan and will re-audit this.

CDTQSE 20/353 Point of Care Testing

It was reported that there is agreement for a formalised Clinical Lead to work with Specialist Clinical Board and the laboratory.

CDTQSE 20/354 Key Patient Safety Risks

Safeguarding

The next UHB Safeguarding meeting will be held in December.

The Clinical Board has created an information hub for documents relating to safeguarding on Microsoft Teams

Mental Capacity Act

Nothing to report.

CDTQSE 20/355 Health and Safety Issues

The Clinical Board Health and Safety Group is being held next week.

CDTQSE 20/356 Regulatory Compliance and Accreditation

Sue Bailey reported that in general there is good, ongoing compliance. Key risks to escalate relate to staffing in laboratories and the impact on quality metrics. A plan is in place to address the issues.

The MHRA is concerned on the slippage of quality metrics at St Marys that was noted in their latest quarterly submission. The plan is to improve the metrics by the end of October.

The loss of senior staff in Radiology has also been raised as a concern.

Plans to advise the Regulators of the refurbishment plans in the Mortuary and Radiopharmacy may potentially trigger inspections of the facilities.

An in depth risk assessment has been undertaken in Radiopharmacy following the delay in the new build. As part of this, the team has identified a way to alter air changes in the clean room that are now above standard and this can be sustained.

CDTQSE 20/357 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 20/358 Clinical Audit

Sue Bailey has met with Angharad Oyler new Head of Patient Safety and Quality and they are keen to revitalise clinical audit.

Nominations are being sought for the Clinical Audit Heroes Awards.

CDTQSE 20/359 Research and Development

Nothing to report.

CDTQSE 20/360 Service Improvement Initiatives

Nothing to report.

CDTQSE 20/361 NICE Guidance

Nothing to report.

CDTQSE 20/362 Information Governance/Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 20/363 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 20/364 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

CDTQSE 20/365 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 20/366 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 20/367 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 20/368 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Matt Temby noted the excellent work in Therapies team to return to near normal services and achieving normal performance targets.

Radiology continues to improve in performance and he thanked the team for their efforts.

Sue Bailey also noted the good turnaround times in Laboratory Medicine.

CDTQSE 20/369 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 20/370 National User Experience Framework

Patent Experience data is currently not being collated.

STAFF AND RESOURCES

CDTQSE 20/371 Staff Awards and Recognition

Excellent nominations are being made to the Clinical Board Staff Recognition Scheme. The category for the Clinical Board Staff Recognition Scheme in October is the 'Making it Better' Award.

The Clinical Board is considering how to organise a wider staff celebration event given the challenges around social distancing.

The AHP Awards are being held this week.

Alice Richards, Physiotherapist was nominated for a Queens Honours Award and was awarded the British Empire Medal. This to acknowledge her work in the Home Ventilation Team for procuring the right equipment for Covid and ensuring staff are trained up for Covid cases. The Clinical Board formally congratulated her on the award.

CDTQSE 20/372 Monitoring of Mandatory Training and PADRs

Mandatory training compliance is above 80% and the Clinical Board is close to achieving the UHB target of 85%.

PADR plans are in place to improve compliance.

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

The Biochemistry Quality Group Minutes for August 2020 were **RECEIVED.**

ANY OTHER BUSINESS

Sue Bailey attended the Environmental Management Steering Group which focuses on what can be done to minimise the UHB's environment impact. A refit programme has been implemented in Estates looking at LED lighting and there is a boiler upgrade at UHL. Upgrading ventilation plans are in place for Barry Hospital

and UHL. The UHB electricity bill has fallen by 1.8% and water usage by 1.3%. This £1.5m scheme realises savings of £0.75m a year and 7 tonnes of carbon. The UHB generated 16% less waste than the previous year.

The Cycle to Work scheme and Park and Ride scheme at UHW are still running. The UHL service is suspended. Electric vehicle charging points have been implemented at Woodlands House.

It was noted that Capital and Estates would like Clinical Boards to audit environmental issues and take ownership of the issues.

Cath Marshall raised concerns on parking at UHL. Vehicles are parking on double yellow lines and double parking. Matt Temby advised there is no current plan to switch back to Parking Eye. He will raise the issues with Peter Welsh.

Action: Matt Temby

It was also noted that a large proportion of car parking will be allocated to construction at CRI which is likely to generate complaints from staff and patients.

Patient Safety Day was held on 17th September and lots of resources have been added to the intranet page. Suzie Cheesman will circulate the link.

Action: Suzie Cheesman

A Quality and Safety workshop was held on the same day with discussions around engagement on the quality and safety framework going forward.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 11th November 2020 at 2pm via Microsoft Teams.

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 5th June 2020
SKYPE MEETING

MINUTES

Attendance:
Ceri Phillips (CP), Interim Director of Nursing (Chair)
Hywel Roberts (HR), Consultant, Critical Care and Q&S Medical Lead
Hywel Pullen (HP), Head of Finance
Richard Skone (RS), Clinical Board Director
Maria Roberts (MR), Patient Safety Facilitator
Keith Wilson (KW), Consultant, Haematology
Rachel Barry (RB), Lead Nurse, Neurosciences
Colin Gibson (CG), Clinical Engineer, ALAS
Claire Mahoney (CMah), Clinical Nurse Specialist IP&C
Richard Parry (RP), Q&S Facilitator
Lisa Higginson (LH), Senior Nurse, N&T
Mary Harness (MH), Senior Nurse, Haematology
Sian Williams (SW), Interim Lead Nurse, Cardiothoracics
Tom Hughes (TH), Clinical Director, Neurology
Beverly Oughton (BO), Interim lead Nurse, Critical Care
Thomas Holmes (TH), Consultant, Critical Care
Steve Gage (SG), Pharmacist Lead
Jonathan Davies (JD), H&S Lead
Cath Wood, Interim Head of Operations SPs CB

Present:
Gemma Williams (GW), Personal Assistant, Specialist Services (Note Taker)

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions CP welcomed everyone to the Skype meeting.	
1.2	Apologies for absence Due to the request for one representative per Directorate the apologies were not noted formally however received from; Gareth Jenkins, Chris Williams, Orla Morgan, Carol Evans, Judith Burnett, Suzie Cheesman and Richard Wheeler.	
1.3	To review the Minutes of the previous meeting 28th February 2020 The minutes were agreed as an accurate record. The matters arising were not discussed individually as some of the items are on the agenda but CP asked for any issues to be raised.	
1.4	Directorate Update Verbal presentation 5 minutes each regarding how the first wave of COVID has affected them: Cardiothoracics SW gave an update on the last 10 weeks. Reduction in activity - quiet in terms of patient admissions. Prioritising urgent	

patients to bring in and ensuring that they manage the patients that need device/TAVI access quickly before the peak. They were required quite quickly to make further capacity to support Critical Care. CCU relocated to the Polytrauma unit and closed 10 beds on C3. Initially some Cardiac Surgery continued but a number of cases became COVID positive following surgery and resulted in 5 patients (4 Cardiac and 1 Thoracic surgical) sadly passing away. Following this they had to make a decision that Cardiac Surgery would stop in the short term. SI meetings held by Ruth Walker have taken place and a detailed review into all cases have been completed. It was noted 4 of the 5 patients had been in contact with each other and it appears the index case was a transfer from ABUHB. There has been significant ward configuration for Cardiac during COVID. C5 (38 bedder) became a Medicine ward for Covid. Cardiothoracic patients/ Cardiology were amalgamated onto B1. They have been managing a small throughput of patients in thoracic surgery via side rooms. Manage small volumes of Cardiac patients by utilising a different approach with CITU closed: Utilising one theatre and a patient pod. Patients are self-isolating before they come in - looking where we can deliver thoracic and cardiac surgery in more increased numbers. Received Exec approval that temporarily Cardiothoracic Surgery will be moved to the green zone in UHL in order to deliver a safer, more robust pathway moving forward to increase activity. Elective activity is slowly starting up again in moderation – Virtual follow up outpatient appointments have been implemented. All the teams have worked really hard to maintain a level of service. Some staff have supported the Dragon Heart Hospital and CNS's have been supporting the staffing of ward areas. There has been a number of staff COVID positive across Cardiothoracic but currently this has been managed well.

<u>Critical Care</u>

Bo updated the group. The key issue for Critical Care was increasing capacity. They expanded into Cardiac ITU and also into the Coronary Care Unit (which they are still in). Also had to do a lot of work recruiting additional staff - had anticipated high numbers of support staff – they had 68 members of staff. LED and Cardiac University helped in terms of training these nurses for us. There were peaks in capacity and periods of time where they doubled up level 3 patients. There have been 85 positive Covid patients in ITU. 47 discharged and 44 discharged home so very proud of these outcomes. 13 patients still in ITU. The mortality rate was 35% at the peak which is better than the national average. There have been issues during the process, such as PPE and staff related issues like pressure damage from the PPE and heat on the unit. Staff have been through a really challenging time. In the beginning of April at the height of COVID there were 42 nurses Covid positive and this week there have been 8 members of staff who have tested as Covid positive within the Nurse, admin and medical team. There are 4 members of staff in isolation and 4 staff shielding. All of the MDT has pulled together as a team. People are now however starting to feel tired and emotional and showing evidence of stress. .

THo noted that the most important issue was the mood of the staff in the fall out and that the biggest risk was the nursing staff and how they are feeling. CP agreed that the way staff are feeling is really important and that we need to look at how we move this forward in terms of a potential second wave and look at the resources available to support staff moving forward. TH noted that we need to listen to staff and see what can be done. Different cohorts will have different needs. BO informed the group that staff have been asked to complete questionnaires on survey monkey asking all staff to feedback on what has gone right and what hasn't - awaiting results of the survey.

RS reiterated that we do need to recognise the wellbeing of staff and look at how we can address these issues. It is recognised by Executives as well. Need to apply same energy to this as that which was applied to the Dragon Heart Hospital.

People are exhausted - they do need to take their annual leave. Need to continue to make plans for the new normal and listen to suggestions made.

Neurosciences

RB updated the group. 2 aspects for Neurosciences - Rookwood and UHW. The first cases of Covid were at Rookwood which was unexpected. This came fairly early on. In the February Q&S meeting it was mentioned then that Neurosciences were likely to be least affected so everyone was caught unaware. There were 12 patients on the Neuro Rehab Unit affected – these patients are particularly vulnerable and complex. Not all required transfer to UHW as some patients were not suitable for transfer. The vast majority were nursed through the process at Rookwood. All except one were nursed back to health. It was felt that the virus passed through neuro rehab in the same way as care homes. In terms of UHW there were unfortunately a couple of poor outcomes in relation to neurosurgical patients at the beginning of the outbreak, which highlighted the need to screen all patients. We have now changed a lot of processes and are screening patients coming in as elective admissions. All elective patients are being screened pre-operatively. In total 136 staff have been tested and 18% tested have been positive. 3 staff members have been seriously unwell but thankfully are now recovering. 16 staff across a number of disciplines are shielding and this has added challenges to the service but it has been manageable. There have been significant changes to the way the directorate works. Consultant Neurologists have contributed significantly to the COVID Rota and the neuro surgery rota has been run entirely on Consultants and Registrars. Ward C4 closed in mid-April and the patients were transferred to B4 as admissions in both neurosurgery and neurology declined. This has caused a lot of anxiety for staff and continues to be a significant challenge moving forward. Neurosciences have supported a huge variety of areas for example the DHH medical wards and Critical Care. Moving forward our focus is now largely on how we restore services and how we shape them in a different way. The Neuro Day Unit had to move into the Neuroscience OP suite in Suite 16 as it had previously been on Ward C4. It remains in suite 16 and we are looking to increase capacity by running a longer treatment day. We are continuing to manage our long term patients e.g. MS patients and there has been some benchmarking over the last week which has shown that we have continued to support these patients well in comparison but this has largely been phone call appointments. We are also developing a pathway for the green zone for neurosurgery this will enable a level of activity to be transferred to a green zone for more urgent elective patients. As part of this we are working to release staff to support this and develop a pathway.

TH thanked RS and the rest of the Core team for their support and time re C4 North. People in general found it to be a creative and part of their careers and had a beneficial effect. Now some anxiety has resurfaced. Having Stroke on C4 has the potential to build a platform for a neuro stoke combined service. CP noted that it has been an extremely challenging time.

Haematology

KW updated the group. In the beginning there was a single rota as they had to support the Covid effort which meant that the sub speciality doctors did everything on a green or amber basis. The Registrars were disassembled and out on a rolling rota. The Registrars were working 12 - 13 hour shifts and on call over-night so thinned out the rota significantly. Good will and comradery was great. From an Estates point of view – they turned off their positive pressure and patients at the moment have no benefit of positive pressure or hepofiltration. Mitigated this risk by enhanced antifungal prophylaxis so will pay a financial penalty but saving lives as a consequence. Also had meetings with Public Health Wales and arranged an algorithm for patients. Screening from the start. They didn't want their patients going through A&E so they became their own centre for

unscheduled care. Now re-established a new norm and running a double green and amber rota between general Haematology and BMT. Grateful to neuro for donating half of their ward for unscheduled care which has helped keep their elective areas green and a non-covid positive area. To make this all happen they closed the day unit at UHL and at UHW operated a 7 day rota. Patients who are extremely immuno-compromised are being seen in Spire clinic and other patients that don't need to come in are having telephone consultations/interviews. Some positives – very quick in getting a lot of people into home working. Able to rearrange work space to comply with social distancing. Non-medical staff working longer 4 day weeks alternating between home and in the office. There has been a lot of good will. They are finding people are now tired. MH noted that they are very fortunate in that their patient group self-isolate anyway. There have been very few deaths as a consequence. Amongst the staff there has been 1 Medic, 7 Nurses and 0 admin infected so very fortunate. There was a lot of adrenaline amongst the staff to start however things are getting a bit more difficult now and looking at how to move forward. They are starting the antibody testing within Haematology now which they are looking to assess the impact of this in terms of emotionally and will then feedback at a future meeting. CP noted that IT and the use of laptops has made a huge difference. Social distancing is key moving forward which is really challenging. New guidance now available in terms of staff shielding which HR are working through.

N&T

LH updated the group. N&T is split into 2 areas - Nephrology and Transplant. LH gave an update on Nephrology first. They quickly realised they would have to run business as usual during Covid – specifically those that need haemodialysis etc. Those patients that would have received a shielding letter but still need to come to the hospital for dialysis 3 times a week. This has meant working closing with independent service providers to protect patients as much as possible. Difficult with the change in PPE guidance early on. Emma Lane in Procurement supported them in supplying them with appropriate PPE. Due to the nature of patients and B5 being the only in patient area offering dialysis in South East Wales the directorate needed to provide care to Covid positive patients within their footprint which meant dividing B5 into a Covid and non-covid end. They haven't had any patient to patient Covid transmission. They have now started to run some small nephrology clinics. Acutely aware they will have some negative outcomes re CKD patients as a result of Covid. Transplant and renal surgery were one of the first Centres to stop transplanting fairly early on and surgical colleagues should be commended in their decision so could re-allocate staff accordingly to support us. Transplant registrars went to UHL which meant the Transplant service has been run predominantly by the Consultant Surgeons who stepped into Registrar roles. They streamlined their transplant clinic so that they only ever have 10 patients at any one time. This has allowed us to remodel our clinic's moving forward and the use of technology to support is currently taking place. N&T don't fit the green zone criteria so they are working on making T5 as green as possible and currently working through staff testing. It is important to acknowledge, like every other team people have worked extremely hard and made some difficult complex decisions. We are now seeing some fatigue in staff and are looking at how we can support long term.

ALAS

CG updated the group. Focused on a community based urgent need service. Also a lot of people were very reluctant to use ALAS services. Staff were rostered to maintain social distancing and manage the risk. There have been some positives, in that it has given staff time to look at how to do things differently moving forward. There is much more collaborate working now - Some staff have been or were deployed elsewhere such as DHH etc. A number of staff tested positive but there has been no evidence of transmission through the workplace.

	CP thanked everyone for spending the time pulling this information together, noting it felt really beneficial and important to share everyone's experience and the fantastic work that has been implemented/ achieved. Discussion took place in how can this work now shape things moving forward to work to the new normal and not go back.	
PART 2: SAFE CARE		
2.1	<u>Open SIs</u> MR updated the group. 6 open SIs for the Clinical Board: • In101022 - This case relates to a potassium administration error where the patient's heart went into ventricular fibrillation. The patient is now thought to be doing well. The closure form for this patient is on the agenda. • In101282 – This case relates to a man who had his cardiac surgery delayed. There will be a quarterly meeting with WHSSC coming up where they will want an update on this case so MR asked for some help from the Cardiac Directorate. MR and Cardiac to get together outside of the meeting. • In103031 – this case relates to a lady who was receiving Continuous Veno-venous Haemofiltration therapy and the return line and the vascath became disconnected. • In103961 – this case relates to a man who died unexpectedly after a TAVI procedure. The draft investigation report has been compiled and MR will now needs to be picked up again. • In106895 – this patient was known to Neurosciences – MR noted that she needs information from Neuro as there is a WHSSC meeting on Monday. Comments also needed from Medicine. • In108123 – this case relates to a man who died on the Cardiothoracic waiting list. Issue with getting some information from Aneurin Bevan when he transferred to us so waiting on this information. MR noted that the patients that died in March and April were reported to Welsh Government in May as SIs but that they were downgraded to a "no surprises." They are however being investigated as it is recognised that this needs to be done. Last week Stuart Walker had a letter from Chris Jones, Chief Medical Officer, in relation to these deaths and the learning. In the process of compiling this information. <u>Open Inquests</u> The Health Board has 134 Open Inquests - 30 of which are open with our Clinical Board. In March, the Coroner stopped all inquest cases due to be heard and it looks like they are being resumed activity in July so there will be several months' worth of cases to reschedule which will be a logistical challenge. Most of the cases are being dealt with by Tracey Skyrme from the Bereavement Services. Some queries for Tracey. It was noted that it is important that the Directorates tap into the new work stream developed by Dr Raj Krishna re Establishment of UHB mortality review group. Dr Krishna has requested a medic and senior/lead nurse from SPs to sit on this group. CP requested a nomination for a Medic and a Lead Nurse to join the group. Directorates to take this message back to their areas. Richard Wheeler, CD for Cardiothoracics has expressed an interest from a medical point of view but keen to hear from all directorates. CP requested the nominations to be sent to her by Friday 12th June 2020 <u>Risk Registers</u> CP noted that she will be looking at the Risk Registers going forward and asked the Directorates to check whether risks have changed during Covid. Directorates to revisit their risks and GW/CP to add onto the next meeting agenda.	**Dirs** **Dirs** **CP/GW**

2.2	Closure Forms for Serious Incidents: • In101022 Cardiac ITU medication error and improvement plan • In113097 B5 Injurious fall CP asked the group if they were happy to sign off the closure forms. The forms were signed off subject to any comments outside of the meeting for those that hadn't had chance to review the forms as yet. Any suggested amendments to be sent to MR by close of play today. Assume happy if don't hear and proceed to close. MR re In101022 noted that it needs to be brought back later in the year for assurance that learning has been embedded and that there has been significant practice changes. The B5 falls case (In1130897) is a recurrent issue across the Health Board (lying and standing blood pressures) so this will be picked up with the Falls and Delivery Group and discussed in the September Q&S meeting. GW to note.	**ALL** **GW**
2.3	Healthcare Associated Infections • Clinical Board HCAI Review to end of April 2020 • Specialist HCAI report CM updated the group on the HCAI reports. CM referred to the IP&C report for Specialist embedded in the papers for detail. CM noted the IP&C achievements made in relation to last year's health care infection targets. Unfortunately the Board didn't achieve the C.Difficile target however as a Board we were only 4 cases over and actually several were the same patient which is something to consider going forward. The Board didn't achieve the Staphaureus target by 2 cases but the 56 reduction is to be celebrated along with the reductions on E.coli, Pseudomonas and Klebsiella. Another highlight was bringing the MDRO outbreak at Rookwood to a close during Covid - staff are to be congratulated on how they managed the situation. Currently there are a few patients C.Difficile positive - 4 in Rookwood, Ward 7 which are all typed the same. There had been some contact with AB Health Board but can't determine transmission between these patients. There is an IP&C audit this week and another meeting will be held this week to follow this up. 2 cases of C.difficile in TCT a meeting is currently being arranged to review both cases. 3 cases of Klebsiella in Critical Care during the height of Covid. SW raised a query with regards to what is the correct process if a patient becomes systematic i.e. has a temperature post procedure as they have no access to available side rooms. Consultants are therefore concerned that they may have to move patients to a query Covid ward without actually knowing that they have it which may expose the patient unnecessarily. KW noted that their patients were also at risk within Haematology and said that they follow the procedure that if the patient has any new symptoms they stay where they are on the ward until the test result is known so that you are not putting the patient at further risk as the most infectious period has gone. KW will email the current flow chart from JACIE they use to CP. CM will raise concerns within the team and then update the Board once it has been discussed. SG referred to a presentation circulated yesterday from Eleri Davies which advises isolating patients immediately. To be aware. SG requested that Directorates inform their Directorate Pharmacist of any proposals to re-purpose or move wards - involve your Directorate Pharmacist in the planning stages and during any moves to ensure medicines availability. Particularly important for Critical Care medicines. As non-Covid activity re-starts we need to assess the impact on the medicines supply route. Ward managers should be mindful of the responsibility for security of medicines at ward level at all times, but particularly when wards are closing or moving.	**KW** **CM** **Dirs**

2.4	Health Care Standard 2.9 Medical Devices CG noted that he had circulated an email yesterday on medical devices and therefore would just provide a brief summary. Medical device regulations have been delayed due to Covid so the urgency for this work has reduced in the interim. The UHB however is taking this work very seriously. CG urged Directorates to get in touch for any medical device issues and any that have arisen due to Covid. CG shared an index of information on the clinical engineering Covid folder which contains a lot of information with regards to learning. CP requested that the group review what has been sent out by CG and link in with him and arrange a meeting if needed.	**Dirs**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee MR updated the last meeting took place in mid-April and one is planned in mid-June. A key point raised from the April meeting was the paper on mortality reviews and learning from deaths which leads into the work and establishment of the UHB Mortality review working group that was discussed in point 2:1.	
3.2	Documentation Audit CP that the last meeting referred to a Documentation audit that needed to take place which was stood down in light of Covid. In terms of moving forward and new wards being established CP suggested that this audit is now completed around July time - Lead and Senior nurses to take this forward.	**Lead and Senior Nurses**
3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups Neuro Risk Register RB informed the group that they had reviewed their risk register within Neuro and have built in a line to reflect the changes Covid has had on their services. RB will share this with GW to circulate with the group. Staff rest Rooms BO raised concern that they are going to have significant issues with staff rest rooms in terms of coffee room space and the track and trace system which requires staff to be 2 metres apart for social distancing. Keeping staff 2 metres apart will be a significant challenge. Do staff need to be in work and can they work from different sites. CP noted that we will need to look at individual Directorates and for them to feed into the Clinical Board any specific areas of concern.	**RB./GW**
3.4	Cardiac Surgery The Cardiac move to UHL to be added to the agenda for the next meeting and for SW and Richard Wheeler to provide an update.	**GW**
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	For information: • PSN052 • PSN051 • PSA 011 • Internal safety notice 2020/May/003 • Internal safety notice 2020/March/002 • PSA 010 • Coronavirus Newsletter For information - please review and take forward if anything relevant to your	

	areas.	**Dirs**
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business Mortality review group TOR MR noted that an All Wales toolkit is being developed for staff who have acquired Covid potentially in the workplace. The staff one looks too be signed off soon and working with LED and Workforce to look how to take this forward. More to come. Antibody Testing SW referred to the use of antibody testing and asked if this is available to all staff. Haematology work closely with Immunology so they are first to pilot it. It's a pilot working with Stuart Walker to see if it is feasible for the UHB. HR noted that Critical Care are also taking part in the pilot. Not rolled out to all as yet. Clinical Board Updates RS provided a short summary of updates; • Cardiac is moving to UHL and they are looking at either the 22nd or 29th June for this to happen; in line with the UHL green zones opening. • DHH has been stood down and keeping as an "if needed" until September/October time. • Spire meeting yesterday because we have made such good use of it they are looking at using it for quite a while. • OPs looking at 25% capacity of throughput (taking into account social distancing etc). RS has sent around the WG guidance on how to get OPs up and running again. Please can everyone review. • Still issues with the Junior Rota - everyone needs to be aware what they are doing. Two options; bespoke rota within the Directorate or join the medical rota which needs cover all of the time. • Concern re a Covid second wave. RS raised concern that even if the wave is smaller than the first wave, with the potential for extra work it will have a bigger impact. Moving into plans going forward for a second smaller wave.	**ALL**
PART 6: DATE OF NEXT MEETING		
6.1	Revised dates to be confirmed. Lecture theatre and Skype access to be arranged going forward and new dates will be circulated.	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 26th June 2020
Lecture Theatre 1 (Corridor behind Y Gegin)

Attendees:

Ceri Phillips (CP), Interim Director of Nursing (Chair)
Maria Roberts (MRR), Q&S Facilitator (and note taker)
Hywel Roberts (HR), Consultant in Critical Care and Medical Lead
Clare Mahoney (cMah), Infection Control Lead
Sarah Matthews (SM), Senior Nurse, N&T
Angela Jones (AJ), Resuscitation Service
Colin Gibson (CG), REU/ALAS
Richard Parry (RP), Q&S Facilitator
Steve Gage (SG), Pharmacist
Tessa Northmore (TN), Senior Nurse, Neurosciences
Gemma Ellis (GE), Consultant Nurse, Critical Care
Mary Harness (MH), Senior Nurse, Haematology
Gareth Jenkins (GJ), Service Manager, Haematology
Joanne Bagshawe (JB), Senior Nurse,
Sian Williams (SW), Senior Nurse, Cardiothoracics
Judith Burnett (JB), Senior Nurse, Critical Care
Bev Oughton (BO), Interim Lead Nurse, Critical Care
Claire Main (CM), General Manager, Critical Care and Major Trauma

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions	
1.2	Apologies for absence (some noted due to no Skype access) Lisa Higginson, Tom Holmes, Clare Rowntree, Rachel Barry, Catherine Wood, Richard Skone and Hywel Pullen.	
1.3	To review the Minutes of the previous meeting 5th June 2020 The minutes were an accurate record subject to; item 2.3 HCAI - Steve Gage noted that page 6 needs to be amended to; SG requested that Directorates inform their Directorate Pharmacist of any proposals to re-purpose or move wards - involve your Directorate Pharmacist in the planning stages and during any moves to ensure medicines availability. Particularly important for Critical Care medicines. As non-Covid activity re-starts we need to assess the impact on the medicines supply route. Ward managers should be mindful of the responsibility for security of medicines at ward level at all times, but particularly when wards are closing or moving. Matters Arising Item 2.1 • Open Inquests – Dr Krishna has requested a nomination for a medic and a Lead Nurse to join the UHB Mortality and Review Group. CP received	**GW**

	several nominations from the Directorates and the following will be attending the meeting as representatives for the Clinical Board: ○ Dr Richard Wheeler ○ Caroline Burford, ITU Consultant ○ Gemma Ellis ○ Lisa Higginson • Risk Registers – Directorates were previously asked to revisit risks. On agenda to be discussed. Item 2.2 • Closure Forms for Serious Incidents – the forms were signed off subject to any amendments made outside of the meeting. No amendments requested outside of the meeting. • GW will arrange for the B5 case (In1130897) to be discussed at the September Q&S meeting recurrent issue across the Health Board. Will be picked up by the Falls and Delivery Group. Item 2.3 • Healthcare Associated Infections – KW emailed the current flowchart they use from JACIE if a patient becomes symptomatic post procedure to CP. CMah raised the concerns within her team and then updated the Board. The updates were shared. • Directorates will continue to work closely with ward Pharmacists in order to protect the medicines supply chain. Item 2.4 • Health Care Standard 2.9 Medical Devices – CP previously requested that the group review what has been sent out by CG and link in with him and arrange a meeting if needed. Item 3.2 • Documentation audit – CP suggested that the audit is completed around July time at the last meeting. Lead and Senior Nurses were asked to take this forward. SG noted that there is some reference in the tool to outdated practice e.g. we now use MTED – SG has flagged this with Keith Wilson. MH to discuss with KW to ensure the tool is representative of current practice and then review it with SG. Agreed to hold completing the audit until we can use the up to date tool. Item 3.3 • Exception reports and escalation of key QSE issues from Directorate QSE groups - RB has shared the neuro updated risk register with the group which has the added line to reflect the changes covid has had on their services. Item 3.4 • Cardiac Surgery – SW updated the group as per below (Item 4.1). • Papers for information – to review and take forward if anything relevant to your areas. Item 5.1 • Clinical Board Updates – Everyone was previously asked to review the WG guidance on how to get OPs up and running again.	**GW** **MH/KW/SG**
1.4	<u>Cardiac move to UHL</u> SW updated the group. All of the CT surgery moving next week to the green zone at UHL. They have stopped elective activity at UHW this week to move. A Project Manager is now	

	in place. Review taking place of SOPs. Establishing teams on Microsoft as part of planning. Using RAG ratings – one red remains. Masons are doing the move. First patients in on 28.6.20. Whilst the work is being undertaken to create a new CITU the use of theatres PODs to create CITU capacity will be used W4 will be used for ward beds in the initial phase. Patients will be self-isolating and swabbed pre-op. 2 patients per day using Theatre and CAVOC Theatre. By mid-July ITU should be ready. Charles Radcliffe- ward beds will be temporarily used for phase 2. W6 and Bethan coming on line mid-August. 11 ward cubicles will be available. There will be emergency patients so they will need to be swabbed and isolated. CP noted that it was a huge move and the amount of work was remarkable in the timeframe. MMR referred to an IP&C meeting that took place yesterday at UHL re: increased COVID cases in East side. Currently the advice was this will not affect the move/ or commencing of surgery but this will be monitored closely. SG referred to the routine testing of staff. Haematology have carried out a pilot. The Welsh Government view is about progressing venous antibody testing. Sue Bailey is leading on this. PCIC Communications hub will likely be the ones to do it. Further updates will be sent once received. To agenda on next Q&S meeting.	**CP/GW**
PART 2: SAFE CARE		
2.1	<u>MT Update</u> Catherine Wood was not available to provide an update – CP gave a brief summary update to the group. Ongoing updates will be needed. MTC was due to start in April with the Polytrauma ward on A4. This was held due to covid and there is now a push to move this forward. Considered to be an essential service. By September there will hopefully be a decision (possibly 15th July) in date of progression and secured area in UHW. SG noted that there was no dedicated Pharmacist. CM noted that there are 20% staff gaps which they are working through. CP noted that there is space available – concerns for whole pathway of patients through their trauma journey and the environment available. Agreed to agenda for next Q&S.	**GW/CP**
2.2	<u>Open Serious Incidents</u> MRR updated the group. In106895 (SW) – will be closed once the improvement plan is done. Hopefully by Tuesday. CP noted that she has reviewed all of the SIs with all directorates/re IOs and there is a plan in place to move forward. MRR noted Ruth Walker is expecting SIs to be closed especially where they've been open a while. Need to ensure investigation, improvement plan and closure.	
2.3	<u>Healthcare Associated Infections</u> • Clinical Board HCAI Review to end of April 2020 • Specialist HCAI report CMah referred to the embedded report: - No new MRSA bacteraemia for 6 months which is good news. - Discussions re screening of dialysis patients – very costly but balanced against cost of treating of bacteraemia. SM noted that it has been identified that there is variance between what units are doing and screening. They are doing different things with regards to what labs they send to, which might have different costs. KW noted that the contract wording needs to be very clear. SM noted that there is a meeting being set up to review this. - PPE breach on ITU re filter – a change in re-usable masks led to some self - isolation of staff. CM updated the group of the robust monitoring and plans in place to support PPE provision and staff support.	

	- CITU had high legionella counts – Estates have taken over the flushing. Also C3N who are awaiting more input from Estates to resolve the flushing regimes. If you repurpose areas and they are empty we need to ensure flushing regimes are in place. Risk of knock on effect to other services if not undertaken. Group agreed to share within directorates e.g. The Rookwood shower issues are being dealt with by Estates. HR noted that ward moves need to be identified with Estates. HR noted that there are lots of MSSA and Klebsiella and asked if these were Covid patients. CMah will review. HR noted that they had identified Klebsiella in Covid patients who were very susceptible to positive infections. HR also noted that IP&C measures and PPE in place is hard to maintain. KW raised a query regarding validation of the filter in masks. CMah noted that there were manufacturing differences and that you can change the shape of the mask on your face leading to different outcomes in fit tests. Seems to be some difference in interpretation of fit testing instructions. This has been escalated to Exec level and H&S for help. - B5 x 3 patients positive COVID. IPC working collaboratively with Renal. All measures in place and being closely monitored. At this stage this has not been declared as an outbreak. Discussion took place re: patient not adhering to required precautions etc. Advice given to SM to support at this time. Discussion took place around the role of PHW in enforcement action if necessary for non-compliant patient. - C3N staff break area and fit testing there – needs reconsidering due to legionella count.	**Dirs** **CMah**
2.4	<u>Health Care Standard 2.9 Medical Devices/equipment issues</u> CG noted that the UHB doesn't have a grasp on the breadth of medical equipment in place. Huge scope. Trying a different approach via CEDAR. Delay in new regulations buys us some time. Significant issue as we could be prosecuted. CEDAR will have structured interviews with MDSO and Q&S leads in Specialist Clinical Board to start with who will direct them on to other people who can help with what we know and what we don't know. HR noted that they have an equipment group and can identify big ticket items but asked how far down the tree do they need to go. CG noted that it is very difficult to track and trace items under £5k which aren't necessarily coming in via Procurement and that is the issue – we don't have control over entry routes. HR noted that there is no SPA time currently. Maybe by the next rota in September the 5 staff (techs x 3 and 1 stock controller) can help CEDAR initially.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u> None.	
3.2	<u>Risk Registers</u> Directorates were asked to review their Risk Registers within their DMTs. To feedback any updates by beginning of July for CB submission to UHB. Tom Holmes has reviewed the risk register and process within Critical Care. Discuss with Cardiff Uni re Datix and risk registers. Richard Parry aware of this. MMR noted that it would be useful to know if this is about the All Wales Datix system that is coming. Agreed RP to contact TH to discuss further.	**Dirs** **RP**
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Haematology</u> MH noted that office space was very difficult with regards to social distancing	

	and not enough room. Air handling/JACIE issue. GJ liaising with Estates. ALAS CG noted that waste disposal was an issue. Advised to switch from tiger to orange bags but refusal to remove it. CP will help pick this up. N&T SM noted that they are aiming to move towards re-starting transplantation – patients will go into a holding area and await outcomes of swabs. ITU BO noted that there were office space issues for ITU.	**CP**
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	For information: Treatment Escalation Plan Ge/AJ updated the document had now been approved and to go to all Clinical Board Q&S meetings. . AJ noted that this was discussed in March due to Covid and there were some anxieties around the roll out speed. Ruth Walker had some concerns re the senior clinician role as this could be nurses. HR asked what Critical Care involvement has taken place. GE updated Chris Hingston has been involved. HR noted that he had not seen this until a few days ago and was concerned regarding the level 3 section – wards can assess re escalation to Critical Care but it isn't for wards to decide re level 3 care. HR updated TH will coordinate feedback. GE asked AJ if they can determine how well they are being completed. AJ noted that they are reviewing this. KW noted that the wording at the top and bottom seems to be a sign off by the same person – duplication. AJ noted that it links to the DNA CPR policy. KW felt it was not helpful how it is set out. SM noted that they introduced a form in N&T as they didn't know about this. MMR asked if there will be a formal review. Email from Raj stating that the deadline for comments was 17.7.2020. Need to ensure all Directorates across the UHB have a response.	**THo** **Dirs**
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business	
PART 6: DATE OF THE NEXT MEETING		
6.1	Friday 17th July 2020 8-9am Lecture Theatre 1, UHW (corridor behind Y Gegin)	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 17th July 2020
Lecture Theatre 1 (Corridor behind Y Gegin)

Attendees:

Ceri Phillips (CP), Interim Director of Nursing (Chair)
Richard Skone (RS), Clinical Board Director
Catherine Wood (CW), Director of Operations
Clare Mahoney (cMah), Infection Control Lead
Colin Gibson (CG), REU/ALAS
Steve Gage (SG), Pharmacist
Lisa Higginson (LH), Senior Nurse, N&T
Gemma Ellis (GE), Consultant Nurse, Critical Care
Tom Holmes (TH), SpR, Anaesthetics
Kevin Nichols (KN), Service Manager, Cardiothoracics
Daniel Jones (DJ), Deputy General Manager, Critical Care and Major Trauma
Suzie Chessman (SC), Q&S Facilitator
Judith Burnett (JB), Senior Nurse, Critical Care
Bev Oughton (BO), Interim Lead Nurse, Critical Care
Tessa Northmore (TN), Senior Nurse, Neurosciences
Sian Williams (SW), Interim Lead Nurse, Cardiothoracics
Lisa Davies (LD), Directorate Manager, N&T
Mary Harness (MH), Senior Nurse, Haematology
Claire Main (CMain), General Manager, Critical Care and Major Trauma
Angela Jones (AJ), Resuscitation Service

Present:

Gemma Williams (GW), PA for the Specialist Clinical Board (Note taker)

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions The group introduced themselves one by one within the lecture theatre and on skype.	
1.2	Apologies for absence Hywel Pullen, Maria Roberts, Gareth Jenkins, Keith Wilson, Hywel Roberts and Sarah Matthews.	
1.3	To review the Minutes of the previous meeting 26th June 2020 The minutes were agreed as an accurate record. Matters Arising Item 1.3 • GW confirmed that she made the amendment to the minutes requested by Steve Gage for item 2.3 HCAI. • GW confirmed that she had saved the B5 falls incident in the Q&S folder to be discussed in the September meeting. • Documentation audit – the documentation audit tool has now been amended and is attached on the agenda under item 4 for information. The audit was	

	initially set early this year but postponed. Looked at completing in July but documentation audit did not have MTED included so MH and Keith Wilson have adjusted it. Directorates were asked to complete the audit in July and feed into the august meeting.	**Dirs**
	Item 1.4 • Antibody testing is on the agenda to be discussed.	
	Item 2.1 • MT Update – on the agenda to be discussed.	
	Item 2.3 • HCAI – If any clinical areas are repurposed and they are empty Directorates need to ensure that flushing regimes are in place. A reminder to all to take this forward. CMah also noted that if they are mixer taps they need to flush the hot and the cold. • High numbers of MSSA and Klebsiella – CMah was going to review if they were Covid patients.	**Dirs**
	Item 3.2 • Risk Registers – Ongoing item. Agenda for the August meeting. Directorates to send their updated risks to Richard Parry by the first week of August. • Tom Holmes to discuss Datix and risk registers with Cardiff Uni – RP to contact Tom Holmes to discuss further.	**GW Dirs** **RP**
	Item 3.3 • ALAS waste disposal issue – CP picked this up after the meeting and this is now resolved.	
	Item 4.1 • Treatment Escalation Plan – Tom Holmes very supportive of the form but raised in previous meeting that he would share with intensivists for input. CP confirmed this feedback has been received and will share with AJ who is leading on this work.	**CP**
1.4	<u>MTC/ PTU Update</u> CW updated the group. They were originally proposing to go live with MT back in April and they had a readiness visit in the middle of March against trauma quality standards and parts of the patient pathway. Over the last couple of months MT has been suspended in light of the pandemic but as we reach quarter 2 it has been defined as an essential service and the Health Board is now obliged to implement it. Now looking at September for a go live date. A number of pieces of work have been carried out to assess the readiness to make sure it is achievable. With regards to the EU department, the primary thing to be ready was have their trauma lead in place 24 hrs a day. Capital works were also needed around the resus bays. Theatres has been more difficult as there is now green theatres, amber theatres and red theatres which is logistically challenging. Theatres have confirmed they are ready to go but sessional commitment will be slightly different than previously thought. The Critical Care footprint has expanded in light of the pandemic which means that they can now fit in the 3 additional beds which is positive. There will be a cohorted polytrauma unit. There was originally going to be a bespoke polytrauma unit on A4 but unfortunately now we have have no access to this as it is currently occupied by CCU and potentially in the future maybe a green zone, so will now be using C3. Some risks associated with this such as capital time lines, cubicle work and making the physical space fit for purpose. Suboptimal therapy space for	

	noting. In March 81% of workforce was in place and as of September 80% of the workforce available to us which is remarkable. CW thanked the team for keeping the staff engaged and their training up to date. The new go live date is the 14th September and the ministerial announcement is likely to be today. Repatriation from MTC is a double edged sword - can support other specialities but if it doesn't work well there is a significant risk to C&V as an organisation. Repatriation has huge support from the Chief Executive. Work is ongoing with regards to internal repatriation. Caroline Bird and her team are looking at this. CM noted that the detail of the polytrauma unit is what they need to work through. CW noted that there was a meeting with Steve Curry today at 10am with regards to next steps and implementing the project – a project implementation team will be set up. CW noted that she was happy to share the governance structure with the group. The first workshop is on Monday. CP noted that in terms of staffing, to get to the workforce level they have achieved, is a huge credit to the team and also the other Directorates for supporting the staff and their development needs. SG noted that there is still an unresolved issue in that there is no pharmacist in place for the polytrauma unit. CM noted that they met a week and half ago to discuss this and that there are also risks in Critical Care as well.	**CW** **CP**
PART 2: SAFE CARE		
2.1	<u>Open Serious Incidents</u> SC updated the group. There are currently 7 open SIs. 5 that are over-due with WG. SC gave a short update on each case: • In106895 – a gentleman came in for neurosurgery, was treated and discharged, however his diabetes diagnosis was missed and not picked up. The RCA has been completed and approved. The improvement plan is currently being completed then will progress to completing the closure form. TN noted that it was discussed yesterday in their Q&S and that she will pick this up. • In103961 – This relates to a gentleman who had a TAVI procedure and had issues post op. The RCA is with Maria Roberts for finishing and awaiting date for inquest. • In101282 - Cardiac waiting list death from September last year. The RCA was completed a while ago but it needs to be approved. KN is leading on this and the RCA to be discussed/ approved in next week DMT. Once agreed KN will progress improvement plan and closure form. • In103031 – a lady was receiving Continuous Veno-venous Haemodialfiltration therapy and the filter became disconnected. This is not looking like the cause of death but there is a meeting with Richard Parry and SC to progress this. • In108123 - Another cardiac waiting list death reported in January 2020. Following review it would appear that the 41 weeks of the cardiology pathway in Aneurin Bevan were excluded from the waiting time when transferred to Cardiff. RP and Lisa Evans IO. SC is still trying to get cause of death from the Gwent. A number of questions have been sent to the Royal Gwent to comment on. • In116055 – Five patients who were admitted to UHW under Cardiothoracics for surgery tested positive for Covid-19 post operatively and sadly died. All the information has been pulled together and presented in two SI meetings chaired by Ruth Walker. Awaiting RCA tools from WG via patient safety to complete for each patient then can progress to closure. SC to link in with Maria Roberts to determine time frame of tool. • In118938 - SI reported as declared outbreak on B5 nephrology however following further input from IPC, Corporate Nurse Director for Quality and Safety and information provided by the directorate it was confirmed it was not an SI reportable to WG. SC confirmed that this needs to be closed down. SC	**TN** **SC** **SC** **SC**

	to pull together and send to LH. Open Inquests SC updated the group. There are a few new inquests however they are all out of hospital events. Most of them are with Tracey Skyrme. SC noted that any injurious falls or avoidable pressure damage do not need to be reported to WG. CP noted that this has also been picked up in more detail separately in Nursing Board and that the Lead and Senior Nurses have cascaded this information to all their areas.	
2.2	Alerts/Patient Safety Notices For information/action where required: • Internal Safety Notice Ref 2020/July/004 – Acetone Liquid.	
2.3	Healthcare Associated Infections • Clinical Board HCAI Review to end of April 2020 • Specialist HCAI report CMah updated the group. There has been a general increase across the Clinical Board with regards to HCAI in the same period last year. Therefore, it has been agreed following a meeting held with CP, CMah and CMain to re-start the Specialist HCAI group. CMain has kindly agreed to continue to lead on this with further support from the SN/LN team. CP updated that, MH and OM agreed to join the group. CMah noted that a significant amount of the Staphaureus infections are linked to renal and dialysis. There was a conversation regarding MSSA screening at the last Q&S meeting. LH and LD updated that as a directorate they are looking at this and awaiting the outcome of the root cause analysis. It was agreed that LH would arrange a separate meeting to discuss. CMah and Gavin Forbes to take part in the discussions. CMain noted that what worked last year was to focus on the key areas causing the spikes in the rates. They looked at RCAs and put specific measures in place. CMain noted that she would distribute the action plan from last year and to feedback changes or new priorities to CP. It was re-iterated that having key people from each Directorate at the Clinical Board meeting is important. RS happy to attend as well.	**CMain** **Dirs**
2.4	Staff Antibody Testing MH informed the group that last week the Chief Exec announced that every staff member can access antibody test if they wanted to. MH updated that she had circulated the process and guidelines to all directorates. Each Directorate has a lead for this and all the paperwork has been circulated. Within each Directorate then, there will be department champion and they will need to think about how they are going to test in their departments/wards. MH encouraged Directorates to let their staff know it is available. The department champion will have a spreadsheet with all the staff details and the champion will populate the spreadsheet and when they have enough names will let their Directorate lead know, who will then send the spreadsheet to the hub. The hub will make contact 48 hrs later. The Directorate champion will pick up the packs and then distribute to the individuals. The HUB will communicate the results to the individual staff independently. It was noted that the directorates do not access individual results this will be undertaken by the HUB. Flu Update MH updated the group that Flu vaccines will be a key focus this year. Each Directorate has a flu lead and then champions within the departments. MH updated that all champions will be trained in August and that the vaccines it is hoped will be available from September. MH updated that last year SPs CB was	**Dirs**

	second highest % staff vaccinated. MH encouraged group that were aiming this year to be the top Clinical Board for vaccinating all of our staff. It is about engaging everyone. MH is happy to talk to anyone that has any concerns. CP thanked MH for supporting the flu vaccine work. The key message is the preparation and identifying champions.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee SC noted that she did send out the unconfirmed minutes late yesterday from the April meeting. GW to share. Carol Evans presented the mortality review at the meeting on learning from deaths. The level 1 compliance has seen an improvement in the last 12 months within Critical Care from 66% to 100% in January 2020 and overall as Health Board 80% compliance. Level 1s to continue through Covid. SC noted that a UHB mortality group is being set up and chaired by the Medical Director. The TOR are being developed for this. CP noted that the mortality group has been discussed in the last couple of meetings and that there have been nominations to attend from within the Clinical Board. SC updated there is also a new helpline for bereavement.	**GW**
3.2	All Wales Risk Assessment Tool CP gave a further overview of the All Wales Risk Assessment tool noting that each directorate need to ensure all staff need to be made aware of the All Wales tool and encouraged to complete it. All staff need to be risk assessed so all measures need to be in place to support them. It is the staff member's responsibility to complete the first element but as line managers we need to encourage/ support processes are in place. CP noted that if the staff member completes the first section and is low risk then no discussion needs to take place however if a risk is identified than a review/ discussion with the staffs line manager needs to take place and documented ensuring all appropriate measures are in place. It was noted if anyone has any concerns or advice needed then RS and CP are happy to support. RS noted that it is really important that staff are aware. RS reiterated as a group and employer it should be a standard item on all Directorate meetings and a record should be kept of what staff have completed their risk assessment. TN raised concern that the medical staff have not been very involved. RS will send further information to the directorate CDs following this meeting to ensure that this is a multidisciplinary approach. KN raised a query with the group – they have two medics within Cardiothoracics that are shielding. One of them had a letter and one scored very highly. The medic shielding now wants to return to work and has done a risk assessment and scored 3. HR is clear that this Doctor can return with safety measures in place. KN wanted to check that this was consistent advice within the other Directorates. CP noted that there is not a total blanket approach and that each case needs to be managed appropriately in line with guidance for each individual. It is important to utilise the people around i.e. HR and Occupational Health to help inform a decision which also means then that there is a record of evidence to support the manager and staff member. The key thing to do is to ensure a detailed risk assessment is completed evidencing risk, measures and advice received. There are now green zones and therefore more flexibility to manage staff. RS noted that those shielding will not be extended after 16th August.	**Dirs** **Dirs** **RS**
3.3	For review/ CB sign off: Standard operational procedures for Cardiothoracic surgery transfer to Green zones UHL. SW provided an update at the last meeting on the Cardiac move to UHL. Cardiothoracics have carried out a huge amount of work with regards to governance and clinical pathways. It is important that this is now fed into the room	

	in order to formally sign off. CP referred to the number of attachments embedded within the agenda and noted that she felt it was really important to share them all. SW requested feedback on the papers or anything they may have missed. All of the documents are available on teams. It is important that everyone understands what the pathways are. CP requested that in terms of the SOPs - can the group review them and direct any questions to SW and Richard Wheeler. If no responses within 10 days then the documents will be signed off.	**Dirs**
3.4	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Critical Care</u> CMain raised the ongoing issue of staff not having suitable break and rest rooms to maintain social distancing. If the polytrauma unit moves to C3 then that's another break room that they have lost. <u>Cardiac move to UHL</u> SW informed the group that surgery is being carried out at UHL but at a real minimum and the waiting list is starting to increase. Until the work is completed and there is more capacity it is still a concern. CP will enquire today and link in with Matt Temby in order to receive an update on the timeframe of when the required work will commence. SW noted that there is vital work being undertaken to determine/ agree the fractured rib pathway.in terms of clinical management of patients they are working through this and trying to resolve it. Agenda for the next Q&S. RS and RW to update. <u>N&T</u> LH noted that since the re-opening of the transplant service they have carried out 5 transplants and all patients are doing well. CP noted that a huge amount of work had taken place in order to make this service as safe as possible and thanked the team for their hard work.	**CP** **GW/RS/ Richard Wheeler**
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR IFNROMATION BY THE COMMITTEE		
4.1	• Updated documentation audits for all Directorates to complete in July • Public Health Link 24 June 20 – Personal protective equipment and heat: risk of heat stress (x 2 attachs) • Medication safety executive briefing: Issue 42 June 2020 • SBAR zoll defib pads Part 4 for information - nursing and medical documentation audit attached. And updates from public health.	
PART 5: ANY URGENT BUSINESS		
5.1	<u>Any Urgent Business</u> <u>HCS 2.9</u> CG referred to the email he circulated yesterday which noted the following: Further to our discussions on this at the last meeting, Fiona Jenkins will be presenting on the medical devices related implications of the <u>Cumberlege report</u> on the next *Zoom with the Exec Team* (Weds 22.07.20 1-2 pm). The report calls for even tighter regulation of medical devices thus emphasising our need to progress the <u>IMPACT Programme</u> (that is, the means by which the <u>UHB's Medical Equipment Strategy</u> is being implemented). Also, the ALAS Orbital Prosthetics Service has been in discussions with the UHB's Hospital Sterilisation and Disinfection Unit (HSDU) Manager, Mark Campbell, around mitigating potential Covid-19 cross infection risk. The risks have been	

	assessed and a number of measures have been recommended with action on the highest priority of these already underway. CP thanked CG for the summary. <u>Interim Director of Nursing</u> CP informed the group that Carys Fox would be returning on the 2nd August as Director of Nursing for Specialist. Carys will therefore be chairing the next meeting. CP thanked everyone for their support whilst covering the role.	
PART 6: DATE OF THE NEXT MEETING		
6.1	Fri 7th August 2020, 8-9am, Lecture Theatre 1, UHW.	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 25th September 2020
Skype Meeting

Minutes

Attendees:
Ceri Phillips (CP), Interim Director of Nursing (Chair)
Richard Skone (RS), Clinical Board Director
Hywel Roberts (HR), Critical Care Consultant and Medical QSE lead
Colin Gibson (CG), REU/ALAS
Steve Gage (SG), Pharmacy Lead
Tom Holmes (THol), SpR, Anaesthetics
Suzie Chessman (SC), Patient Safety Facilitator
Bev Oughton (BO), Interim Lead Nurse, Critical Care
Tessa Northmore (TN), Senior Nurse, Neurosciences
Sian Williams (SW), Interim Lead Nurse, Cardiothoracics
Mary Harness (MH), Senior Nurse, Haematology
Angela Jones (AJ), Resuscitation Service
Lisa Simm (LS), Service Manager, Neurosurgery
Mathew Price (MP), Service Manager, Neurology
Richard Parry (RP), QSE Facilitator
Rachel Barry (RB), Lead Nurse, Neurosciences
Beverly Oughton (BO), Lead Nurse, Critical Care
Khalid Hamandi (KH), Consultant Neurologist
Tom Hughes (TH), Clinical Director, Neurology
Keith Wilson (KW), Consultant, Haematology
Ravi Nannapaneni (RN), Consultant Neurosurgeon

Present:
Gemma Williams (GW), PA for the Specialist Clinical Board (Note taker)

PART 1: PRELIMINARIES		Lead
1.1	Welcome & Introductions	
1.2	Apologies for absence Apologies received from; Carol Evans, Claire Mahoney, Lisa Higginson, Gareth Jenkins, Lisa Davies, Gemma Ellis, Alison Short, Kevin Nicholls, Orla Morgan, Judith Burnett and Maria Roberts.	
1.3	To review the Minutes of the previous meeting 17th July 2020 The minutes were agreed as an accurate record, subject to; two minor spelling errors: typos page 3 and 4 – KN and not TN and page 4 Claire Main spelt wrong – GW to amend. Item 1.3 • Documentation audit will be discussed today at the meeting.	**GW**

	• HCAI - Directorates were previously asked to share the message that the hot and cold needs to be flushed on mixer taps. Claire Mahoney not at the meeting today but Critical Care and Haematology are providing a brief update on their areas. • Risk Registers – ongoing item. RP noted that there is still the need to continue to provide monthly submissions to the Executive Board. RP has spoken to a couple of areas who are reviewing their assessments, such as Critical Care and establishing the Major Trauma registers correctly. RP encouraged Directorates to contact him if they need any support. RP noted that he hasn't been getting responses from all areas and asked that Directorates still respond even if it is to say that no changes have been needed. Directorates to respond as an action. • Tom Holmes to discuss Datix and risk registers with Cardiff Uni – RP to contact Tom Holmes to discuss further outside of the meeting. • Treatment Escalation Plan – Tom Holmes very supportive of the form but raised in previous meeting that he would share with intensivists for input. CP shared all of the feedback with Angela so the action is now complete. • Page 3 – pick up as part of SIs with SC. • Hospital acquired infections – Claire Main agreed to continue to support the HCAI Clinical Board meeting. The action plan hasn't yet been circulated. Claire Main to pick this up. It was also confirmed that Mary Harness would work with Claire to support implementation. Item 1.4 MTC/ PTU Update • CW shared the governance structure with the group. • No Pharmacist in the Polytrauma Unit. SG to update. Item 2.1 Open Serious Incidents • In106895 – Neuro - a gentleman came in for neurosurgery, was treated and discharged, however his diabetes undiagnosed TN to discuss with RB re: update of improvement plan? • In108123 – Cardiothoracic - a cardiac waiting list death reported in January 2020. Following review it would appear that the 41 weeks of the cardiology pathway in Aneurin Bevan were excluded from the waiting time when transferred to Cardiff. Lisa Evans IO and RP supportingIn116055 – Five patients who were admitted to UHW under Cardiothoracics for surgery tested positive for Covid-19 post operatively and sadly died. WG framework sent from Maria Roberts. Directorate to work with pt safety to complete. • In118938 - SI reported as declared outbreak on B5 nephrology however following further input it was confirmed it was not an SI reportable to WG. LH to work with pt safety to close down. RP noted that there was a back log of IP&C RCAs. Need a decision regarding whether they are completed or not. It was suggested that a decision could be made about each one at the first HCAI meeting. CM need to look at this and identify prioritisation. RP will share a list with the Directorates of the outstanding RCAs to take forward. Item 2.3 Healthcare Associated Infections • Noted in previous minutes Clinical Board to re-establish the Clinical Board HCAI meetings. Claire Main to circulate the Clinical Board action plan. • Directorates reminded of the importance of sending a rep to the meeting.	**Dirs** **Claire Main** **SG** **RP/Dirs** **Claire Main**

	Item 2.4 Staff Antibody testing • Directorates let their teams know that antibody testing is available for all staff. Item 3.1 Feedback from UHB QSE Committee • April meeting minutes to be circulated when received. Item 3.2 All Wales Assessment Tool • Directorates have made staff aware of the tool. • Directorates were confident that the risk assessments are being carried out. SW noted that they have raised it in the Cardiac Directorate meeting to get medical feedback as well. • RS was going to email CDs to ensure that there is an MDT approach to ensuring the tool is completed for all disciplines Item 3.3 Standard operational procedures for Cardiothoracic surgery transfer to Green zones UHL. • The tool was signed off after the meeting. Item 3.4 Exception Reports Cardiac move to UHL • SW provided an update. The area is likely to be ready by the 9th Oct possibly a little earlier. • Work to be undertaken to determine/agree the fractured rib pathway in terms of clinical management of patients. BO raised concern regarding issues around storage at UHL – they moved the storage area into the void but with winter pressure this area will be in use. Struggling to find storage space. Matt Temby is looking at alternative storage.	**SC/GW**
1.4	MTC Update RS updated the group. MTC went live last week. The opening week of the MTC has been very busy and the unit has filled up quickly. In terms of the running, it has gone very well. One or two issues that need looking into but overall very successful.	
PART 2: SAFE CARE		
2.1	Open Serious Incidents SC updated the group. Currently 7 open SIs, with one new fall last month. 6 of these are over-due with WAG. 2 should be able to be closed this month. CP noted that there were 3 that we should potential be closing that need to be submitted by next Wednesday. They will need to go to Carol Evans before this date. The 3 referred to are; • SW in Neuro - the improvement plan has been completed and now trying to progress this one. • MB in Cardiac. Couple of amendments needed to the improvement plan. CP will try to speak to Kevin Nicholls to get this one firmed up. • Fall on B1 (fracture) – SW is in the process of tweaking it and it should be done this week. CP and RP will catch up regarding the other 4 outstanding: • LP - Maria Roberts is leading on this. The SI weekly meeting is today so SC will follow this up with her.	**SC**

	• Covid related deaths in Cardiothoracics – the Welsh Government brought in a new tool to investigate which is all completed and has been shared with the DMT. CP needs some designated time with Cardiac to go through all the information and then this will be a closure for next month. • Cardiac death initials PG – Lisa Evans is the IO. Challenges with information from the Gwent. No update as yet. There is a planned meeting to review everything coming up. CP and RP to catch up. <u>Open Inquests</u> SC informed the group that Suzanne Wicks in Claims and Eirlys Ferris are both managing inquests that are not SIs. SC noted that the open inquests all look to be the usual out of hospital events. SC needs an inquest catch up with Suzanne. HR raised a concern that he is not getting answers from the Bereavement Office. HR requested that they email him a list of who to send the referrals to. SC will pick this up.	**CP/RP** **SC**
2.2	Alerts/Patient Safety Notices • MDA/2020/019 It was agreed that Cardiac would discuss this alert at this meeting, however Nick Gidman is not present today so SW will ask him to present at the next meeting. GW will add to agenda for next meeting.	**SW/GW**
2.3	<u>Healthcare Associated Infections</u> <u>Specialist HCAI Report</u> CP noted that Claire Mahoney was not available to attend the meeting today but has sent a summary (embedded in the agenda). As of the 17th September, it has been 17 days since the last case of MRSA, 30 days since the last case of MSSA, 25 days for C.difficile, 3 days for E-coli, 5 days for Klebsiella and 28 days for Pseudomonous. SM noted that the meeting was requested as a suggestion to change routine screening so a meeting with microbiology was arranged to discuss plans. GW to agenda for a future meeting. <u>Critical Care - MSSA</u> BO informed the group that Critical Care had an increased incident meeting in August due to increased bacteraemia infections. Typing was done on all 7 patients and there was no link between them. It was raised that bacteraemia cases had increased in the last quarter. Awaiting some results for trends to be identified. No feedback as yet. The poorly maintained environment in Critical Care was picked up. Hand hygiene and double gloving was an issue which has now been changed. Dusty vents all picked up with housekeeping. In December, there was a walk around with Estates where 50 repairs were identified, which have not been actioned due to Covid. No further meeting required so just repairs sat with Estates. BO to send the list to CP to link in with Estates. RS noted that he was meeting with Craig Spencer, Matt Wise, Abi Harris and Stuart Walker this week regarding plans to improve the environment going forward. It was noted that Estates have been inundated over the last few months. <u>Haematology - Pseudomonas</u> MH informed the group that they had some water testing carried out over the last few weeks and pseudomonas was found in a few of their outlets. The	**GW** **CP**

	environment is not fit for purpose. It was noted that when the refurb for the bone marrow transplant unit was undertaken, the drainage and water pipes were not addressed. They've been treating the pipes to get rid of the pseudomonas but it has been found to be all different types so unlikely to be hospital acquired, however the facilities are just not good enough. KW noted that the issue has been on the Risk Register since Jan 2010 and voiced his significant concern around the risks associated with this. It was also noted that Haematology were almost deprived of their accreditation in 2013 solely because of the facilities. They met with the Chief Executive and the Medical Director as it would have meant sending patients elsewhere for their treatment. Still have no concrete plans in place to improve the situation. KW noted that patients have died. RS noted that the infrastructure is not right – the academic Avenue was a concrete plan however this got pulled due to the pandemic. RS noted that this has been escalated in the last 2 weeks to the Medical Director and that unfortunately the pandemic has meant that plans put place have not been possible. RS noted that work is most definitely ongoing to find a solution and that it does get discussed at all major meetings on a regular basis. SC recommended encouraging the incident reporting as a record. KW noted significant concern with regards to a recent issue where by open sewage was leaking into the showers on the bone marrow transplant side.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Documentation Audit results</u> Due to summer period the audit results were moved to this meeting instead of an earlier meeting. <u>Cardiothoracics</u> SW fed back for Cardiac – they undertook the audit on 2 ward areas in UHW. Overall main points from nursing were positive and there was good compliance. Main issue was staff actually printing their names clearly and designation of clear name of staff on documentation. The Medical audit main theme was the VT assessment not being undertaken at all. <u>Critical Care</u> BO fed back for Critical Care – they carried out the documentation audit in 3 areas and the results were in the main positive with similar issues to Cardiac. The main things were around people not printing their name on their entry – signing and dating but not printing their name alongside. Grade of nurse also not being entered which is being fed back. Similar with medical notes. Sometimes name not being printed or grade and time of entry not being entered by nurse or doctor. In the clinical system review none of them commented on the audit. <u>N&T</u> SM fed back for N&T - B5 was overall quite good, however they found they were not documenting when the information was given to the patient. Everything had a patient name and staff member name but same issue as others. The audit was carried out on T5 and B5 and the results were similar. Completing in 24 hours was an issue. There are a few things to pick up but most was well recorded. <u>Haematology</u> MH noted that Haematology had the same themes as the others with regards to name printing and designation of person. They were surprised to find that the documentation by more experienced nurses was much better than the juniors. TCT and B4 had good results.	

	Neurosciences RB noted that Neurosciences had very similar findings to the other areas. Overall good and pleased with compliance. There was however an issue around signing, timing and dating. Assessment was quite encouraging as compliance exceptionally high. There were some actions required around the nursing documentation in one area in Rookwood. Certain things not as high as other areas in the Directorate and targeted work around this. CP noted that the fundamental components were signing and dating. CP asked that the Directorates share their action plans with the Lead and Senior Nurses within the group and GW. This won't be picked up in Q&S but GW will circulate to the Q&S group as part of shared learning. ALAS CG noted that they developed their own audit tool within ALAS as their area has slightly different needs. A few issues were highlighted but across most of the topics there was very good compliance. 3 areas where there is room for improvement; hand written and scanned were not as compliant as they should be. 2 other areas (which is an ongoing process) was recording of mental capacity decisions as this needs to be more robust and also providing evidence as informed consent process. CP noted that the documentation audit needs to take place every 3 months. . HR noted that during the covid pandemic Critical Care have been using a hybrid electronic system for the clinical work station but that it has had some drawbacks. A significant problem is that when the patient is discharged it is difficult to access the patient's records. However it has given a glimpse of what an electronic system can offer as all areas could have 100% compliance if they went electronic. Critical Care is expecting to move over to electronic within the next year or two. CP noted that this is one of the Health Board priorities but due to covid this has been delayed slightly. The corporate team are trying to progress this.	**Dirs/GW** **Dirs**
3.2	Feedback from UHB QSE Committee SC has received the June UHB QSE minutes so will send them onto GW to share.	**SC/GW**
3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups Out of hours medical response at Rookwood TH informed the group that for about 10 years now the only out of hours cover has been neurology registrars without any support from an SHO. As Rookwood is moving to UHL a better system is required so that the patient gets a better service – the system needs to be more plugged into general medicine rather than neurological. RS informed the group that there has been a case put forward for the introduction of a patient at risk team (PART) which would have a 24 hour care emergency response and the Rookwood component would link in with this. Work is ongoing. Treat & Transfer Policy T Holmes noted that after the first wave of covid a Treat & transfer policy was put together which has worked well but with the second wave coming he raised concern with regards to where do we go if the system is over whelmed. An urgent plan is needed going into the weekend. He met with Matt Temby and the plan in the short term is to break into the day case recovery in UHL but there are still some loose ends to tie up around this. There are a lot of other stake holders that haven't been involved in the	

	decision making but Matt Temby will liaise with them. Need to firm up a plan. RS noted that he was in favour of getting this done fairly quickly but asked if medics were clear in terms of what they are doing. Need to then go back to Critical Care to see what their ideal plan is. CP asked if everyone was comfortable with the plan set for the weekend. THolmes noted that there is now 2 Treat & Transfer areas but if there is a succession of patients then they will back up quite quickly. No options currently of where to go when full. HR felt that there is a degree of urgency as there has been 3 referrals in the last 24 hrs and 1 has been taken. RS noted that he was happy to meet on Monday to discuss further. Concern was raised regarding the mental health of staff. The second wave will be a huge strain on staff especially on nursing staff. Julie Highfield is carrying out a standardised mental health review but the issue does need looking at further. RS agreed that the current stage is really difficult as there is so much uncertainty. RS thanked THolmes for bringing this to the meeting. <u>Haematology Waiting List Concerns</u> MH noted that Haematology need some drainage work carried out which will affect theatres. KW noted that during the height of the pandemic they had to triage patients during transplants when they were at intermediate risk and that they are now booked solid until December. The back log won't be cleared until the end of the financial year. KW raised concerns if the COVID rota is reintroduced and the impact on haematology pt/ waiting lists. KH updated. most immuno-compromised patients have been going to Spire but a plan is now needed for these patients to be seen safely at UHW. An issue was also raised around the BMT offices, as they have had waste water from the wards and sewage coming down into these offices. Lots of visits have taken place by Estates etc but this is still a huge issue. KW noted that the issue has been highlighted several times with no solution. RS noted that he would discuss this with the directorate outside of the forum to look at supporting current situation. RS noted that every speciality is trying to work out how to keep the covid rota going as best we can. With regards to Spire, RS noted that he spoke to Simon Rogers yesterday and he is looking for spaces available. There is a 40% gap occupancy at UHL. There are outpatient facilities and it is being looked at.	**RS/THolmes**
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	None.	
PART 5: ANY URGENT BUSINESS		
5.1	<u>Any Urgent Business</u> <u>Colin Gibson Email</u> CG circulated an email to the group ahead of the meeting around <u>Steve Gage - Pharmacy</u> SG will email CP some information for sharing with the group. <u>Flu Vaccines</u> MH informed the group that Flu vaccines were now available and vaccination sessions would be starting next week. MH noted that every Directorate has a flu champion who should be ordering their flu vaccine and also be linking in with everyone. Encourage areas to be mindful of social distancing.	**CP/GW** **Dirs**

	<u>World Patient Safety Day</u> SC noted that World Patient Safety Day took place last week and that information was on the intranet. SC will upload the recordings of the seminars as well. Directorates to encourage staff to look at the pages and to take part in the competition.	**Dirs**
PART 6: DATE OF THE NEXT MEETING		
6.1	Fri 9th October 2020, 8-9am, Venue to be confirmed.	

Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
20 August 2020 15:00 – 16:30
Skype/UHW Medicine Hub/UHL Medicine Ops Room

Attendees:
Rebecca Aylward, MCB Director of Nursing (Chair)
Aled Roberts, MCB Clinical Board Director
Jane Murphy, Deputy Director of Nursing
Matt Cornish, General Manager, Specialised Medicine
Barbara Davies, Lead Nurse Specialised Medicine
Diane Walker, Lead Nurse, Integrated Medicine
David Pitchforth, Senior Nurse, Integrated Medicine
Ceri Richards-Taylor, Senior Nurse, Integrated Medicine
Carly Simpson, Senior Nurse, Integrated Medicine
Jacqui Westmoreland, Senior Nurse, Acute/Emergency Medicine
Gill Spinola, Senior Nurse Specialised Medicine
Derek King, Clinical Nurse Specialist, Infection Prevention & Control
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team (SC)
Sarah Cornes-Payne, Senior Nurse, Diabetes
Rob Foley, Service Manager, Integrated Medicine
Kath Prosser, Quality & Governance Lead, Medicine
Sharon Jones, Clinical Director, Rheumatology, Specialised Medicine
Sian Brookes, Senior Nurse, Integrated Medicine
Iain Hardcastle, General Manager, Integrated Medicine
Sarah Follows, General Manager, Acute & Emergency Medicine
Ian Dovaston, Practice Development Nurse
Sarah Capstick, Health and Social Care Facilitator (SCa)
Gemma Murray, Practice Development Nurse
Ffion Lloyd, NHS Violence Prevention Team (part of meeting)
Vicky Lee, NHS Violence Prevention Team (part of meeting)
In attendance: Sheryl Gascoigne, MCB Secretary (Minutes)
Observer: Liz Vaughan

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Jeff Turner, Clinical Director, Gastroenterology, Specialised Medicine Maitrayee Choudhury, Consultant Endocrinologist Carol Evans, Assistant Director, Patient Safety & Quality Ruth Cann, Senior Nurse Integrated Medicine Hannah Mastafa, Deputy General Manager, Integrated Medicine Angela Jones, Senior Nurse, Resuscitation Service Wayne Parsons, Lead Nurse, Acute/Emergency Medicine	
Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	**Minutes of the previous meeting** – received and accepted.	
1.2	**Maters arising**	

	MSSA – ID advised Alex Vanner is moving forward on this work. Update required in September.	Update required September
1.3	**Patient Story – Acute and Emergency Medicine** **NHS Violence Prevention Team** – this project is part of the Violence Prevention Unit and funded by the Home Office with the aim of tackling violence at the prevention stage. A&E at UHW are piloting the project. **Patient A** – 16 year old male presented with minor head injury, was referred to the new service and assessed. He had been targeted by a gang for criminal exploitation, who encouraged him to steal items. His Mum contacted the Police, and as a result, he was assaulted by the gang. Following support from the Violence Prevention Team he later returned to school supported by the community who taught him new social skills. This has resulted in him making new friends of his own age and actively engaging in positive outcomes. **Patient B** – 17 year old male, presented with multiple knife wounds. He disclosed the use and selling of drugs, recognising this as a likely factor of his assault. Significant support was given to him and his Mum. He continued to engage with the service and has not returned to EU. The team saw over 30 people with varying injuries last month. The service was originally aimed at people 25 years and under, however, it now deals with any age and gender. SCa would like to offer third sector support. Ward Managers can refer patients direct to the team if the patients are inpatients.	
1.4	**Feedback from UHB QSE Committee –** read and review. Note: When referencing LFE's please add the reference number.	ALL
1.5	**Directorate QSE minutes – exception reporting**	ALL
1.6	**Papers for noting/feedback** **Shrewsbury & Telford Judicial Findings** – this cannot be circulated and currently not in the public domain. RA/KP will see if it is possible for staff to access the document via a link. **Blood Health National Oversight Group: Hospital Transfusion Committee: Allogeneic Red Cell use in Cardiac Surgery -** for info.	RA/ KP
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**Flu update** – 27/8/20 meeting to finalise when vaccine available. 62 champions across the CB. C4/Stoke needs a champion – KP will liaise with Tony Jones on how to take this forward. Decision will be made on vaccinating staff when Covid vaccine available.	KP
2.2	**Covid:** **Antibody testing update** **Covid Risk Register update** – top risks are shown in red. • Endoscopy restrictions and capacity issues and use of Spire – risk rating of 20. Still short of capacity and reliant on Spire. Risk rating remains 20. JM will send the UHL risk register to RA. • Fit testing – currently a 12. This can be reduced. • Social distancing – with mitigation 16. Remains same. • Inability to provide beds for Gastro – still have constraints around Gastro outliers. BD will look at scoring and review. • Poor patient flow – to be reviewed. Not a large issue at present. • Patient access and flow – to be reviewed. • Staffing – risks around staffing remain the same.	JM BD

	• Covid-19 transmission/ IPC – remains a risk if we were to have another peak. At present measures are in place. • EU – cannot comment on this as no EU rep present. • Dermatology/risk of patients being delayed – currently a 12. To be reviewed, however, there are issues around capacity, patients being seen. • GIB rota – re-established. Current risk rating now a 2. Remove from register. JM will cross reference both registers and update RA. All to review their risks. Register to be signed off at next meeting. **Update on UHL Covid Action Plan** – discussed at previous meeting. Just a few actions remain outstanding. This can be removed as an agenda items for future meetings of this group. **PPE Safety Briefing Newsletter** – June 2020 edition 4 v 2 shared for information	JM ALL KP
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	**Serious Incidents Update** Serious Incidents for closure: **In113572** – Injurious injury resulting in a fractured neck of femur. This was an unwitnessed fall for a patient with a significant background history of falls in the past. All risk assessments and falls preventions undertaken in line with best practice. Post falls procedures undertaken. Falls simulation training continues. **In118504/118837** – Covid transmission outbreaks on East 7 and East 2 wards at UHL. Extensive live action plan ongoing and following investigations for both the initial index patient/staff could not be identified. Areas of concern were highlighted in relation to the nightingale layout of the wards, the ability to safely socially distance staff and patients and the amount of footfall through the clinical areas. Beds were removed to ensure appropriate distancing for patients, and patients reminded about the importance of social distancing. Staff rooms and 'doning' and 'doffing stations' revisited to support social distancing and safe/effective infection prevention and control measures. Support from IP&C colleagues and daily visits and audits. Oversight of the action plan with the Directorate, Clinical Board, Infection Prevention and Control, Public Health Wales and the Deputy Executive Nurse Director. Most of the actions are now completed but the clinical areas remain under review to ensure standards are maintained.	
3.2	**Infection Prevention and Control update** DK provided an overview of the Clinical Boards IP&C information from 16th July: 135 days since last MRSA bacteraemia 14 days since last MSSA 49 days since last C Difficile 5 days since last E Coli 146 days since last Pseudomonas 3 days since last Klebsiella To date there are four outstanding HCAI RCA's. There are currently no outbreaks across the Clinical Board. Positive feedback regarding the reduction of C. Difficile compared to last year and a 50% reduction in the number of E Coli. 4 outstanding RCA's. On target as of the end of July 2020.	

	No current outbreaks in Medicine. Flu update – seasonal flu is low in Australia, seasonal flu low, hopefully that will translate to the UK. Detailed mass Flu Vaccination programme being implemented by PHW. On going discussions regarding the IP&C RCA's that are sitting with Surgical Wards who are currently caring for medical patients. DK to feedback at the next meeting. Trialing clear curtains on C6. Quite a thick curtain, which aids visibility. Need to evaluate how they will clean. BD and RA to discuss the A6 environment further.	DK BD/ RA
3.3	**Point of Care Testing**; any actions required following circulation of information from POCT team.	
3.4	**Medical devices/equipment issues** PSN051 IO injector battery checks – for information.	
3.5	**Patient Safety Notices/MDA's/ISN's – shared for information and cascading as required** • Acetone Internal Safety Notice July 2020 • CEM_CMO_2020_029 Department of Health and Social Care: Cannabis Oil disguised as confectionary • ISN2020 005 – IV Paracetamol packaging	
DIGNIFIED CARE		
4.1	**Patient Hydration 'Jelly Drops' Hydrating Treats** – SB shared information on sweets that hold 12.5 mls of water classed as a hydration tool. These have been successful with dementia patients who do not drink very much, recognising that patients with cognitive impairment tend to enjoy eating sweets. SB will look at securing funding to trial these at £4.95 for a tray. Invented by a doctor who had a family member with dementia who was constantly getting dehydrated. SB will liaise with Judith Hill. Would need to risk assess patients to ensure they had no difficulty swallowing. SB will send info on the promotional info so can be sent out with mins.	SB
4.2	**HIW action plan AU UHW (March follow up visit) – to be discussed in September**	
TIMELY CARE		
5.1	**Pathway for CPAP and NIV patients UHL** AR described how we are transferring all Covid patients, who may require CPAP, as well as transferring non-Covid patients for escalation who are on/or require NIV. This is a temporary arrangement, being reviewed weekly and evolving. There are approximately 1–2 transfers per week, however it should be noted that the Respiratory intake doubles in the winter months. This is on the UHL risk register.	
5.3	**LFE CN/WHIT/2318** A 20 year old woman, presented with headaches to GP. Returned to her GP, and then admitted to Whitchurch Hospital with a Psychiatry disorder. The patients condition continued to deteriorate with abnormal movements and fits which was believed to be an organic cause. Transferred for a CT scan but this was not undertaken as it needed to be completed under sedation. Patient represented with worsening symptoms and required admission to Critical Care, CT and LP performed. There was a delay in diagnosing Encephalitis which has	

	resulted in the patient requiring ongoing care in the community. Ongoing mediation regarding redress as it was agreed that there was a delay in completing the CT and LP to inform the diagnosis and ensure safe, timely and clinically effective care.	
INDIVIDUAL CARE		
6.1	**National User Experience Framework** **Feedback from 2 minutes of your time survey** – relevant improvement plans are in place.	
6.2	**DTOCs** – no update.	
6.3	**Compliments** Following admission to UHW, a patient gave their heartfelt thanks to Dr Dunn and EU doctors for their assistance.	
6.4	**Safeguarding** Following yesterday's review meeting JM advised there are currently 15 open cases. Compliance for Level 2 on-line training could be improved. JM will circulate the compliance figures.	JM
6.5	**Concerns update** 30 day compliance is 78% (this has slightly dipped). Need to work around responses. Reviewing all concerns and responses. Weekly meetings with EU required. Main Themes: 3 or 4 received regarding visiting. Values and behaviours – regarding how patients perceive they are spoken to. JM looking into this. Treatment delays – due to Covid. Legal and Risk are preparing for potential claims for delays due to Covid.	JM
Staff and Resources		
7.1	**Staff well-being update** – work done on A7/A6 – to be deferred to next meeting. The learning to be shared by BD at next meeting.	BD
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	**Pressure damage reporting** - remains the same. **Referring to patients as numbers posters** - SB and GM prepared a poster regarding referring to patients by their bed numbers. Trialing it this month. SB will share the posters so others could trial them. **World patient safety day 17/9/20** – the Execs are running a workshop with the focus being on staff wellbeing. Any work to be shared, send to SC. Contact JM if wanting to attend the workshop. **Visiting** – is still causing concerns. It will be discussed with Execs next week. SB has a 'crib sheet' with advice for non-essential visiting and also for essential visiting and arranging best interest meetings etc. SB has sent the crib sheet out for comment today. **Staff recognition awards event on 21/8/20**. 11 categories with winner and runner up for each award.	SB ALL

	Future meetings – from mid Sept 2020 – we will no longer have use of this meeting room. Meeting via Teams will be trialed for September's meeting and possibly for a few months. **Date and time of next meeting** – 24th September 2020 14:15 – 15:45.	

Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
24 September 2020 14:30 – 16:00
Venue: Teams Meeting

Attendees:
Rebecca Aylward, MCB Director of Nursing (Chair)
Aled Roberts, MCB Clinical Board Director
Jane Murphy, Deputy Director of Nursing
Kath Prosser, Quality & Governance Lead, Medicine
Barbara Davies, Lead Nurse Specialised Medicine
Diane Walker, Lead Nurse, Integrated Medicine
Ceri Richards-Taylor, Senior Nurse, Integrated Medicine
Jacqui Westmoreland, Senior Nurse, Acute/Emergency Medicine
Derek King, Clinical Nurse Specialist, Infection Prevention & Control
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team (SC)
Rob Foley, Service Manager, Integrated Medicine
Ruth Cann, Senior Nurse Integrated Medicine
Glenys Morgans, CNS, Rheumatology
Philippa Hicks, Head of Operations, Patient Access
Jennifer Evans, Consultant Paediatrician, Child Health (part)
In attendance: Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Carol Evans, Assistant Director, Patient Safety & Quality Carly Simpson, Senior Nurse, Integrated Medicine Claire Matthews, Directorate Support Manager Geraldine Johnston, Director of Operations Iain Hardcastle, General Manager, Integrated Medicine Jeff Turner, Clinical Director, Gastroenterology, Specialised Medicine Matt Cornish, General Manager, Specialised Medicine Sarah Capstick, Health and Social Care Facilitator (SCa) Sharon Jones, Clinical Director, Rheumatology, Specialised Medicine Sarah Follows General Manager Acute and Emergency Medicine Gill Spinola, Senior Nurse David Pitchforth, Senior Nurse	
Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	**Minutes of the previous meeting** – received and accepted. If anyone has not seen these and needs to comment, please advise KP.	
1.2	**Maters arising** **MSSA** – add to agenda for October 2020 meeting.	KP
1.3	**Patient Story – Rheumatology, Specialised Medicine**	

	GM CNS for Rheumatology presented information on changes to patients being reviewed in Rheumatology as a result of Covid. As a result of the Covid-19 pandemic, Rheumatology implemented the use of virtual clinics to support the safe and timely review of Rheumatology patients who are required to shield. Rheumatology use a patient electronic system called Cellma which supports the Rheumatology advice line. During the initial stages, patients due to attend hospital for face to face appointments were advised their appointments would be virtual and they would be contacted by telephone at the time of their original appointment. Face to face appointments were arranged for those identified as needing them. Overall improvements included: reduced footfall; less travel/ transport time for patients; no travel costs for patients; reduced DNA. This has shown a 95% satisfaction rate and deemed a very successful venture. Dedicated areas to hold the virtual clinics, without disturbance, would be useful in the future. The Rheumatology Nursing Team has embraced the change and are keen to continue in the transformation of services.	
1.4	**Feedback from UHB QSE Committee –** read and review.	
1.5	**Directorate QSE minutes – exception reporting** Acute and Emergency Medicine - QSE Minutes have been received. Integrated Medicine – QSE not taken place. Specialised Medicine – QSE held last week, minutes in progress.	
1.6	**Papers for noting/feedback/sharing with wards** • Peri-operative Care Guidance on use of Personal Protective Equipment Amber Zone Theatres. • Peri-operative Care Guidance on use of Personal Protective Equipment Green Zone Theatres.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**Flu update** – Once all of the identified Champions have completed their training there will be 63 flu champions across the Clinical Board. The Clinical Board has already seen a significant uptake for the vaccination this year. KP highlighted the importance of staff who receive the flu vaccination to make a note of when they have the vaccination as there needs to be a 28 day gap between this vaccine and a potential Covid vaccination.	
2.2	**Covid Risk Register update** – RA needs both Covid and Operational risk registers updated by the next QSE Meeting in October.	ALL
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	**Serious Incidents Update/ Serious Incidents for closure:** **Emergency & Acute Medicine: In107418** A 17 year old presented to the Emergency Department in the presence of South Wales Police following concerns raised by the parents of acute paranoia. The patient was known to CAMHS and Mental Health with episodes of acute psychosis of unknown origin. Whilst in the Emergency Unit following a review by Mental Health the patient was placed on a Section 2 of the Mental Health Act and transfer arranged to Hafan Y Coed UHL for further assessment. Whilst waiting for WAST transfer to UHL the patient absconded from the Emergency Unit despite efforts by staff to prevent them from leaving. South Wales Police were informed, the patient was found near to the hospital grounds and transferred by the Police to Hafan Y Coed.	

	The investigation highlighted that on presentation to the Emergency Unit on triage staff documented as per guidance a clear description of the patient and clothing recognising the potential risk of absconding. The patient was seen by EU clinicians and the appropriate mental health assessment undertaken and referred to the Mental Health Team for assessment. During this assessment it was deemed that the patient required further mental health assessment and was subsequently placed on a Section 2 of the Mental Health Act. The mental health team advised nursing staff that the patient was a high risk of potentially absconding from the EU but no formal risk assessment was undertaken. The patient was also not informed of their pending transfer to Hafan Y Coed as the Mental Health team believed the patient would attempt to leave. Whilst in the Emergency Unit the patient was waiting in the Ambulatory Care area. It is widely recognised that it is not conducive to keep mental health patients within this area for protracted periods of time, balanced against the other pressures within the department. The investigation also highlighted that there was no further documentation from nursing staff in relation to what the patient was informed and why they were waiting; this may have increased their anxiety and frustration leading to them attempting to abscond. It was also identified that there was a significant delay in the WAST transfer from the time of request. These delays are balanced against calls polling in the community and pressures within the Emergency Department, however, it should be noted that mental health patients under a section who require transfer to UHL can only be transported with WAST or South Wales Police. It is not unusual for mental health patients to experience significant delays in transfer. Actions undertaken: The Emergency Unit have introduced additional documentation to their Part B booklet which supports the care provision of mental health patients. The Emergency Unit have been asked to undertake an audit to accurately capture the length of time mental health patients are waiting in the department for transfer to UHL with WAST to support further discussions with the Clinical Board and the UHB for the provision of appropriate transport. The EU controller should be informed of all mental health patients who are waiting for transfer to Hafan Y Coed and escalated at Safety Briefings to inform safe and clinically effective care. Patients should also be moved out of the Ambulatory Care area if not deemed clinically appropriate balancing the risk of patient acuity across the whole department. **Dermatology: In109492** A patient was referred by their GP in April 2019 with a skin lesion on the left foot. The referral was received as an 'urgent suspected cancer' (USC). This was reviewed by Dermatology and added to the USC list for review in 4 weeks in order to rule out Melanoma. The patient was seen in Dermatology clinic at the end of April 2019 and at that time the lesion was believed to be that of a verruca, but needed melanoma excluded. The lesion was shaved and sent to histopathology noting the USC category. The investigation highlighted that there was no documentation to support what was discussed with the patient regarding the potential diagnosis, although the diagnosis of melanoma was confirmed to be low on the list of potential diagnosis when discussed with the treating clinician. A follow up appointment was made to review the patient in Dermatology clinic with the histopathology results. The investigation highlighted that there was a delay in the histopathology report being available, and confirmed with Laboratory Medicine that this result took longer than would be expected. Once the	

	results were available the plan was for referral to plastics for consideration of a wide local excision of the lesion with sentinel node biopsy. Unfortunately the patient contacted Dermatology prior to their follow up appointment and cancelled their appointment believing the lesion to have been a verruca which had healed. This was not followed up by staff in the Dermatology department, or the medical records checked to inform clerical staff that this was a cancer diagnosis and further follow up should have been made. This incident was only highlighted following a review of key worker data by a CNS. The patient was seen in Dermatology clinic in January 2020 where full staging CT scans were performed which did not identify any metastases but further melanoma identified at the original melanoma site. The patient remains under the care of Dermatology. **Dermatology: In110713** A patient was referred by their GP March 2019 as an USC for a lesion on the left forearm, referencing concerns that this may be a melanoma. Following a review by Dermatology the patient was placed on an USC pathway. The patient was seen in clinic in May 2020 with the potential diagnosis of a BCC with a plan made for an excision and biopsy. Reference was made to further follow up pending the biopsy result. The potential diagnosis of BCC would result in the patient being placed on an urgent waiting list (31 days RTT). This is secondary to BCC not being treated in the same category as a SCC or melanoma which are on USC pathways. A GP expedite referral was received by Dermatology noting the lesion had increased in size and started to bleed. The patient was seen in clinic November 2019 where a biopsy was undertaken referencing USC. The histopathology findings were that of invasive melanoma with no intransit metastases. The investigation highlighted that there was a delay in the turnaround time of the histopathology results. The patient was seen in Dermatology clinic in January 2020 and full CT staging requested with no diagnosis of further metastases. The Clinical Director of Dermatology confirmed that the diagnosis of BCC was reasonable. No reference was made on the histopathology request form regarding a potential diagnosis of melanoma. In addition there was no documented evidence of any potential diagnosis discussed with the patient when seen in clinic. A timelier turnaround of the histopathology could have potentially resulted in the patient being seen in Dermatology clinic earlier. **Dermatology: In111660** A patient was referred by their GP in July 2019 as a routine referral for a 'lesion' potential melanoma. On review by Dermatology this was amended to an USC and fed back to the GP to ensure timely review of any suspected cancer referral. The patient was seen in clinic September 2019 where the lesion was excised and sent to histopathology. The results reported in October 2019 confirmed an in-situ melanoma. This confirmed that the lesion was fully excised with clear margins evident. As part of the investigation the Dermatology Surgical Checklist and Operation note documentation was reviewed. This is a surgical checklist that is completed noting safety checks pre surgical intervention. At the bottom of the checklist there is a section for clinicians to complete which notes 'follow up'. This was documented as 'nil'. The treating Consultant could not account why this was documented and recalled that further follow up would be required pending the histopathology report. There was no evidence of a follow up appointment being made. The patient was not seen in Dermatology	

clinic again until February 2020. The patient was advised of the biopsy report undertaken in September 2019 and remains under the care of Dermatology for surveillance. In-situ melanoma is considered pre-cancerous with no risk of spread. Once treatment had been completed, ie, wide excision, patients are often discharged, but followed up with the CNS for a final visit to discuss the results prior to discharge.

As a consequence of the three Dermatology Serious Incidents a 'live action' plan was implemented with Clinical Board oversight and discussed at QSE meetings.

Derm SI Action Log (Feb 2020) updated Ju

3.2 **Infection Prevention and Control update**

KP asked for an update on the HCAI's associated with wards that sit outside of MCB but are providing Medical Consultant cover. DK to update following a review of the RCA's at a panel.

DK

Overview of the Clinical Boards IP&C information for August 2020:
46 days since last MRSA bacteraemia (UHW C6)
16 days since last MSSA bacteraemia (UHL E6)
3 days since last *C difficile (UHW A6)*
22 days since last E. *Coli* bacteraemia ((UHL E7)
22 days since last Pseudomonas bacteraemia (UHW C6)
56 days since last Klebsiella bacteraemia (UHW B6)

Outbreaks for August

Date	Ward	Cause	No. Patients Affected	No. Staff Affected	Bed days Lost
28/07/2020	UHL E7	D&V	4	0	6
11/08/2020	A1	D&V	3	0	1
14/08/2020	A6	Respiratory	2	0	1

Number of outstanding RCA's = 6 (all fairly recent)

UHB goals have been agreed by Exec Board. On target to achieve HCAI reduction goals with C. *difficile*, E. *coli* and Klebsiella for 2020-2021. There has been a reduction in C.*difficile* (30%) and E. *coli* (55%) when compared to July 2019 results. Pseudomonas reduction goals are static and an increase in SAUR (72%) and Klebsiella (25%) is noted.

Flu – Australia had a lower than average season and we are anticipating this in the UK.
Covid-10 – there were 45 confirmed cases as of yesterday and there is an increase in Covid-19 across Wales.
Audit – good results. Improving on environment audit.

MSSA remains a concern across the Clinical Board. BD advised of an investigation following a concern which identified a breach of duty of care, which is being taken through re-dress, as a result of a patient's cannula being left in for 8 days.

3.3 **Point of Care Testing** - any actions required following circulation of information from POCT team. Request sent to Aaron to see if more temporary staff/bank staff to be trained in Point of Care training.

3.4	**Medical devices/equipment issues -** BD is the nominated rep for Medicine and attends quarterly medical equipment group meetings. Any issues with devices/equipment, let BD know.	ALL
3.5	**Patient Safety** – shared for information and cascading as required - Notices/MDA's/ISN's - Internal Safety Notice Ref 2020/Sept/008 Tissue Damage from Plaster Cast Saws - Internal Safety Notice Ref 2020/Sept/007 T34 Syringe Driver: Unexpected powering down of devices - Internal Safety Notice Ref 2020/Sept/06 Paediatric Tracheostomy Ties	
DIGNIFIED CARE		
4.1	**HIW action plan AU UHW (March follow up visit)** Deferred to next meeting. KP to add to next meeting agenda.	KP
TIMELY CARE		
5.1	**Feedback from LC Serious Incident and Regulation 28** - Dr Jennifer Evans (JE) joined the meeting and delivered a presentation. JE was asked to carry out an investigation following the death of baby LC. This was a joint investigation pertaining to the Emergency Unit and Paediatrics, which was also subject to a Coroners inquest. LC was born in December 2018 and died in March 2019. 13 week old LC presented to ED at 20.12pm on 21/3/19 where a sepsis was missed. The investigation highlighted that LC had been triaged correctly by nursing staff but there was a failure to obtain a blood sample and start antibiotic therapy until it was recognised that LC had significantly deteriorated and was acutely unwell. **Lessons to learn**: rolling programme of recognition of seriously ill children. KE/ JE have a meeting planned to discuss sepsis in children as part of the rolling programme. Communication with family and those involved could have been better. Need a strategy to keep in touch with people whilst investigations are progressed to completion. **Recommendations:** - Urgent review of provision of senior paediatric decision makers in EU. - Strengthening of training modules and simulation scenario's for the recognition of seriously ill infants. - Situational awareness training for paediatric trainees focusing on viewing patients as evolving situations. - Introduction of observation charts documenting every set of observations taken on a patient from the time of presentation and throughout their patient journey as they move department. The Coroners inquest concluded the cause of death was natural causes contributed to by neglect – gross failure up to and including 11.30pm on 21/3/2019. **Regulation 28 put in place** - Coroner highlighted the use of the word Sepsis and if Sepsis is suspected, that clear and continuing reference be maintained, if and until it is superseded by an alternative diagnosis. Use the word 'Sepsis' when you mean a life threatening condition. A sepsis recognition tool is being piloted for six weeks which will pick up the correct children. Radical thinking of how the split Paediatric site works is required. An admissions area is required. Having a point of	

	contact for the family is important. Empower nurses to challenge the consultant and who to escalate to.	
5.3	**Major Trauma and ward reconfigurations** BD has asked for a refresh of data to understand the numbers. PH awaiting pathways from each CB and one overall SOP is required.	
INDIVIDUAL CARE		
6.1	**National User Experience Framework** **Feedback from 2 minutes of your time survey** – relevant improvement plans are in place.	
6.2	**DTOCs** – no issues	
6.3	**Compliments** **Specialised Medicine: Endoscopy UHL** Thank you for treating their relative with such compassion and care whilst having his OGD and explaining the findings. **Gastro: A6** Outstanding gratitude expressed to staff on A6 during the evening of 26/08/2020. The H@N team received a 2222 call only to be confronted with a situation where there was a simultaneous arrest situation. Staff where outstanding and showed the highest level of professionalism and advocacy for the patients involved in the arrests. **Integrated Medicine: B7** Regarding care of a family's Aunt during her last illness. All the staff were very understanding and supportive, especially at the end of her life. Nothing was too much trouble. The family were very touched by Father Pritchard's attendance and prayers for last rites. Thanks were given from the family who said the staff were amazing.	
6.4	**Safeguarding** cancelled this month as had QSE forum.	
6.5	Concerns update reports that performance is improving up to 81%. There are currently 58 concerns ongoing.	
Staff and Resources		
7.1	**Staff well-being Covid work** – no issues raised.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	**Date and time of next meeting** – 22nd October 2020 14:30–16:00 via MS Teams. Feedback on having QSE via MS Teams is required.	ALL
	World Patient Safety Day last week – sessions were recorded and will be uploaded and SC will email the link to the group. http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,177884421,253_177884682&_dad=portal&_schema=PORTAL **Competition for staff to win money for wards** – opportunity for staff to be recognised for what they have done. Poster in the meeting file.	ALL
	SC attended SI meeting with child with medical error – incorrect GP noted on child's record. SC to email Suzanne Collins, and copy in Wayne Parsons, to ask if people, when they arrive at EU, are asked if their GP information on file is correct.	SC

	Two patients transferred from EU to amber areas - ensure if Covid test taken, results are received before placing patient. DK will speak to Ceri Richards-Taylor to see why pathways have not been adhered to.	DK

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

AGENDA
Surgery Clinical Board
Quality, Safety & Experience Committee
22nd Sept 2020
VENUE TBC

Clare Wade	Director of Nursing, Surgery Clinical Board (Chair)	CW
Dr. Richard Hughes	Anaesthetics	RD
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Urology	AJ
Ceri Chinn	Lead Nurse, Perioperative Care	CC
Angela Jones (via Teams)	Senior Nurse, Resus	AngJ
Adrian Turk (via Teams)	Clinical Board Pharmacist (Surgery)	AT
Rafal Baraz	Consultant Anaesthetist	RB

Preliminaries		**Lead**
	Welcome & Introductions CW, RH, RB, AJ, CC, Angela Jones (via Teams)	RH
	Apologies for absence Mark Bennion, Michelle Abel (Vince Saunders deputising), Barbara Jones, Catherine Bradshaw and Carol Evans.	RH
	To receive the Minutes of the previous meeting Accepted as an accurate record. **Matters Arising** **18/105** HL noted no further update as not doing enough hip or knee surgery to warrant discussion. AT updated that Orthopaedics are not interested in using aspirin for thromboprophylaxis but the documents have been updated and awaiting sign off from Corporate Medicine Management Group in October.	RH

19/106 AJ forwarded to Chris Williams for comment and asked to feedback to PA. PA has no record of further communications. **Action:** CW to formally write to Chris Williams.

19/134 Closed by AJ and CW.

10/34.11 In response to RB, Nicola Bevan updated that HCSW have been divided into 3 groups; 1 includes staff working with women in the last 4 weeks and neonatal and intensive care doctors, group 2 consisting of general paediatric staff, paed. Cardiology and surgery including anaes. and health visitor staff and group one and two consists of all other staff. The pertussis vaccination will be given to all three groups, starting with group 1 in August.
Action: RB to forward email trail to PA CLOSED

20/1/01 MBe raised awareness that there is a high incidence of allergic reactions related to Tycoplanin, which has become the default antibiotic in Orthopaedics, therefore we need to consider if a change is needed. RB and MBe relayed that their colleagues in other health boards have reported the same reactions. AT relayed that some national Trusts have recommended administering via infusion over 20 minutes to minimise the risk and recognised it is a national issue. MBe agreed and noted that he has been giving via mini infusion that the message needs to be reiterated and made practice to coincide with the restart of elective orthopaedic activity.
Action: AT to forward email trail to MBe.

20/1/02 **Action:** CW to write formally to Guy Blackshaw to request update

14/194 CW clarified the action; whether marking the injection site for anaes. will be reconsidered RCA Stop Before you Block. RB updated that 6 out of 10 obstetric anaes. did not agree with marking their own block (4 did not respond) but trainees mark their block with the letter "B", RB also noted non-compliance in England where it is policy. CW highlighted that it is a recommendation for discussion, not call to implement. RB suggested miscommunication regarding blocking indications, which could result in a procedure being done on the wrong side. CC updated that AT has recommended to wait for the new Starter Block Guidance from the Royal College of Anaesthetists. Attendees agreed.

14/195 CW highlighted the action was regarding a new registrant who should have been inducted and therefore aware of the policy to wait before having checks done in the anaes. room, but the individual claimed not to be. **Action:** CC to check.

14/196 AJ SOP's were tested and well received and were circulated and uploaded to the Intranet's PESU page. Attendees agreed that action 14/196, 14/197 and 14/198 can be closed on this basis.

MBe recommended to CC that clinicians be included in distribution list for PESU SOP's

14/199 CW updated that all staff either risk assessed or are risk assessing themselves. **CLOSED**

	14/200 ACTION: AT will chase up. **14/201** CW updated that Pressure and Tissue Damage Infection and Prevention has been reinstated, the latest one was held a month ago **14/202** HK to attend a future meeting when sufficient audit data has been collated. **14/203** AJ updated one learning disability liaison nurse is shielding, with the other on leave today. **Action:** AJ to invite to future meeting **14/204**: included on agenda.	
1.1	Patient Story – ENT/Ophthalmology In98276 Joanna Lord AJ summarised case; patient referred on 8th May 2019 to ophthalmology with a sight threatening diabetic condition. The referral was marked as urgent with the patient to be seen by consultant VR surgeon within 6 weeks, the patient was informed she was on the waiting list but told the waiting time was one year by the Patient Appointment helpline. The patient's vision deteriorated to hand movements only on the 6th Aug 19 and she was seen in the Emergency Eye Casualty clinic the following day. The patient was seen by a VR consultant on the 8th of Aug who confirmed a subtotal macular op traction retinal detachment. Patient underwent emergency surgery that afternoon. The patient was then seen as an outpatient on the 30th of Aug, her vision remains poor and is only able to count fingers. An RCA was opened by Rowena Griffiths *[AJ gave thanks to RG]* that determined that the patient was referred as urgent, which was received by the Health Records Department and date stamped and subject to various demographic checks. The referral was then vetted in a timely manner by VR consultant who prioritised it with an appointment to arrange for the next 6 weeks. It was confirmed that the patient did call and was told the wait was one year, the patient was then referred by her GP back to the hospital suffering with the detachment. Root cause: Constraints within capacity, which is a historical problem with Ophthalmology. A lack of appropriate new patient slots meant that the Health Records Team were unable to book the patient within the 6 week timeframe given by the consultant. At the time of the incident there was a lack of robust systems in place to escalate the lack of capacity and also did not escalate any backlog of patients. Following the incident: The Ophthamology department have put in place digital sessions to clear the new patient referrals waiting over 5 weeks, which is an ongoing managed issue being managed by the service manager. Consultant ophthalmologists have drafted exception criteria to manage the new patient referrals, which included the issue regarding out of area patients being referred in.	AJ

	Ophthalmology directorate are also reviewing commissioning arrangements for out of area patients as there is a constraint on treating our own C&V patients. Ophthalmology Service manager and Deputy Health Records manager now meet weekly to agree new referrals and escalate any that can't be accommodated into capacity. Changes have also been made within PMS to allow staff in Health Records to input a target date for new patients. AJ confirmed that as there have been changes in the Ophthalmology directorate management structure, this is continually being reviewed to ensure that demand for capacity is continuing to be aligned. CW highlighted that this incident was pre-COVID, AJ agreed but noted that the concern of demand in Ophthalmology is frequently greater than the capacity, but hopefully these processes will prevent similar situations in the future. CW agreed and noted that as this was the last lost in treatment RCA that was conducted the changes that have been put in place following the last few RCA's will prevent the situation from happening again. AJ raised the concern that diabetic patients have not had their follow up as clinics have not been held regularly during the COVID period, which has resulted in a concern that bears resemblance to the one discussed, with significant sight loss a concern as a result of delay, so the actions above have become more stringent, but AJ expressed concern that COVID may expose issues with the service. CW raised that there is a balance to consider as the patient wasn't being seen as it wasn't the right thing to do. AJ agreed although some conditions can be considered stable, a delay of 4 months could see significant deterioration in sight. MBe stated that unfortunately we will see more co-morbidities deteriorate during COVID, with the vast majority going unnoticed. AJ and MBe agreed and predicted that a cohort of patients will be seen in Ophthalmology and other specialities in different ways. CW noted that an incident form has been submitted this week detailing a patients concern over the suspension of regular bowel screening. RH encouraged all attendees to fill in incident and near miss forms if a patient comes to harm due to delays related to COVID in order for them to be logged. AJ noted a reluctance expressed at the HB's Quality and Safety meeting last week to submit forms as there is a perception it is placing blame on individuals, whereas AJ and MBe agreed that the intention is to raise awareness of issues. AJ expressed that near miss forms in particular are vital for organisational learning, as situations where harm to patients was averted is rarely reported compared to when harm was done. AJ informed that Nicola Carter has been employed as the Service Manager for Ophthalmology as historically assumptions that process are in place have been incorrect. **Action:** AJ to ensure that Nicola Carter is aware of process detailed above and has been trained on DATIX.	

1.2	QSE bring forward action log	
1.3	Feedback from UHB QSE Committee AJ feedback that the NHS Governance in Care Bill was discussed, with an agreement that Quality and Safety will be at the forefront. HB wants to strengthen the voice of the citizen and combining what the patient wants with what we think is right. The duty of Pandora being open and honest was considered. 7 key areas were discussed: operational safety. Leadership, patient experience (specifically involving the patient), learning and communications, staff engagement, data and insight and the last being professionalism. Paul Bowing gave talks on the safety culture and the climate and attendees discussed the 7 aspects on groups. Outcome: Relaunching quality and safety in line with the quality act, to be big and bold. Learning events will be promoted Training and education across the whole MDT was found to be nursing led Leadership; giving staff a voice with common positive language and a good communication plan How do we recognise positive contributions staff make to Quality and Safety? AJ noted that the Executive Nurse and Medical Directors actions were to write these 5 points into an action plan that will be disseminated to us shortly.	AJ
1.4	Health and Care Standards – sign of self-assessment/ ongoing review of implementation/ improvement plan CW noted stood down this year due to COVID, therefore no formal reports were officially given but next year's will be announced in January.	CW
1.5	Regulatory compliance and external accreditation (where relevant) • dental external accreditation manual surveillance audit - 2 external audit in 2 days, very robust whereby documentation and Infection, Packing and Sterilisation area was reviewed. Department scored very well with one minor non-conformance around reviewing the current complaints process and form in use. • QUAD audit plan - CC updated in MBe absence. No QUAD audits were done due to COVID but Education Team have been reassembled and QUAD audits will be reinstated every month for the next year. CC stated that the QUAD audits can be reported on in the meeting after next, as they have to be done across SSSU, Children's and UHL. - RH asked attendees to consider reinstating all audits for their specialities as healthcare and activity must continue throughout COVID and highlighted a need for AUDIT compliance to remain consistent.	RG MBe

1.6	Risk Register - review and revision as required CW noted that the current risk register has been trimmed recently and mainly focuses on COVID. Main risk COVID has raised has been the risk to not only having a deployable nursing workforce (which has historically always been a risk), but also the new risk of a medical workforce; junior doctors, availability of staff and changes to working Risk of morbidity and mortality as patients aren't presenting in a timely manner or patients not having regular screening. Delays in USC pathways – Green Zone and Spire are being used. Spire will reduce the amount of accessibility to hospital activity to us in the run up to Christmas, with activity reducing by 50%, therefore the work will have to be taken back by the HB, which presents an additional huge risk, particularly to complex cases such as colorectal. Recently added risk is the staff experience, long term retention and absence due ward changes (flipping from Green to Red) and the rapid service changing put in place in order to restart services such as Orthopaedics. CW highlighted the importance of staff's ability to retain this activity in the long term.	CW
1.7	Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities • Directorates Gen Surgery: AJ nothing significant to raise. Resus: AngJ noted nothing T+O: HL work for the Green Zone is ongoing with no definite date as to when activity will restart, but timeframe may be given by next week, in the meantime work is being done on how to maximise capacity. RH noted that Anaes. have seen the schedule of new UHW lists, to start on the 14th Oct. CC noted as the work in UHL has been delayed, Cardiac ITU will have to move out of theatres before Breast can come back. RH noted the importance to all attendees of having T+O resume as thousands of patients are suffering. - CC: MTC theatre opened on the 14th Sept, plastics list has been included in the schedule. SSSU have enhanced social distancing, PPE and hand hygiene compliance after +ve cases were identified, which were discussed in Health and Safety meeting. IP+C and Unison also contributed to arranging the layout of coffee rooms and ensure that social distancing registers have been improved. Incident reported as an SI in Children's Hospital whereby a baby arrested following suffering a pneumothorax post intubation, an investigation is underway. CAT continues to run 7 days a week and assist emergency throughput. CC noted that work to PACU in UHW has been delayed as well as UHL, therefore measures for PACU have been put in place in the meantime. Incident reported in UHL whereby a patient undergoing cardiac surgery experienced significant complications while using the Radiology equipment, which prompted an investigation and has been reported as an SI. Two in house RCA's being done, one focuses around an implant	Lead Nurses and Q&S leads Adrian Turk Therapy lead

	for a hip fracture surgery not being available when requested, therefore the surgery had to take place the next day. 2nd RCA – incorrect procedure was booked onto Bluespier and wasn't booked onto TheatreMan. No harm was reported as a result but raised as an RCA due to process non-compliance. - Dental: RG feedback from Q&S meeting 17th Sept (she was unable to attend due to attending Workshop day), but enhanced IP+C SOP produced by Nigel Wilson was discussed at the group. Flushing SOP for Dental unit waterlines has been updated and reviewed and authorised by the Water Safety group. RG raised that YH has agreed to set up a group with Estates and John Prendegast to establish agreement on the HB's position on requirement of water testing those lines. Air purifiers will be installed in clinics for AGP procedures, with an SOP being drafted currently. Students have all been FIT tested for respirators. RH noted that air scrubbers may prove to be a useful tool in improving efficient activity by enabling use of anaes.rooms, as pioneered by Cardiff. • Pharmacy AT gave an overview of the outcomes of two Meds Management meetings held on 5th of Aug and 3rd Sept: - Noted a number of over and under doses in the HB - Hepatitis B reactivation guidelines have been updated to use high dose steroids in Ophthalmology. AT to forward information to Ophthalmology to raise awareness	
2.1	Initiatives to promote health and wellbeing of: Patients Staff RH reiterated the importance of compliance with social distancing as emphasised in Len Richard's Exec Connects updates. • Peri-operative Guidance on use of Personal Protective Equipment (PPE) (green and Amber Zoning) Version 14 that have been agreed at Surgery Clinical Board, Microbiology and IP+C meetings and widely circulated. Main changes are AGP air change time now 5 minutes for Green, 15 for Amber. CW predicted updated versions. - PPE availability – CW no issues as raised by Hub meetings held 3 times a day. YH stated no problem of availability of PPE, rather the issue was standard of gloves, which is being worked on by Procurement at an All Wales level. YH noted good supply of power hoods that have been well received by Theatres. YH gave thanks to Subram Balachandran for his efforts in developing the PPE guidance. All attendees agreed. - YH praised the compliance of staff with social distancing guidelines in work, but raised the need to comply outside of work, as Cardiff's case number is increasing significantly to ~40 cases a day over the weekend [19th 46, 20th 43 Sept]. RH agreed and stated rumours of a South Wales lockdown.	CC or MB

	• **SCB H&S meeting update** - CW have update on meeting held on 3rd Sept. Topics consisted of keeping staff and patients safe during COVID and raised in particular the need for staff to adhered to social distancing in communal areas whilst on breaks, as well as clinical areas, as it was reported that furniture layout was being reconfigured by staff to not comply with measures after they were put in place, with support from Unions and IP+C doing walk-arounds. RH agreed and noted each individual's personal responsibility to maintain their health. • **Decontamination group update** - CC noted a meeting has not been held since the last update given. • **Water safety Group Update** - CC speculated that she may have been taken off the mailing list whilst on maternity leave as she did not receive the invite but has attended previous meetings regularly. RG stated a meeting was held last week but had no clinical board representation from any clinical boards apart from Dental nurses for Surgery **Action:** RG to ensure CC is included on mailing list for Water Safety Group invites.	CW CC CC
2.2	**Bring forward –progress on relevant improvement plans** • **SHS paper and update from February 2020** - Attachment is paper that went to UHB Quality and Safety Committee in Feb as a response to issues of insourcing was released to public domain. CW gave summary that it was found that harm was caused to 15 patients, with all 15 patients had RCA's and formal letter communication and are currently going through claims process CW noted that little correspondence from SHS reported, as previously haven't engaged with RCA's or C&V process. SHS did ask towards the end of last year why C&V haven't been in touch, but evidence was provided of attempt to engage, but no further comms from SHS have been reported.	CW
3.1	**Implementation of relevant care bundles and changes to patient pathways** • **Hip Fracture Measure Planning and Monitoring Template** - HL noted good progress made, which may not have been reflected in the data collection as there are gaps due to nurse's not in work and redeployed, therefore 85% may be an underestimation as orthogeriatrician presence 7 days a week. Work to be done on prompt mobilisation and delirium testing but frailty nurses will adopt new ways of working which will assist. RH noted that Alex Kennedy is working on compiling data to show improvements made. HL praised Alex's work, which is included on the agenda	BJ

	of Trauma meetings. Gold and Silver patients will be reintroduced to improve time spent in theatre. • **UHL T&T** - CC meeting being set up this week to do Treat and Transfer team. A diary is being kept as a record of activity of Teams as we have an ODP on 24/7. CC wasn't aware of any calls being made prior to the last two weeks when she was on annual leave. Processes are being put in place to ensure an OPD isn't needed 24/7, Jon Barada is discussing with Dave Smalley to ensure the room is secure with appropriate drugs and PPE stock, but CC noted that the intent is not to carry the team on for the long term as it is not needed and would enable the ODP's to do theatre lists. CC noted a conversation needs to be had with all clinical board to ensure the process and SOP is clear should a patient deteriorate in the area. CW noted that the first Treat and Transfer meeting was held in first week of CC's leave, with the next scheduled for either this week or next week to finalise the provisional plan that the day ODP would be stood down from the 4th of Oct and pulled from the list of required of put on call at night. CC noted that Jon Barada has updated the local SOPS CC queried whether the Team mentioned in the policy consists of Critical Care team, not Theatres. RH noted that as the situation is evolving the specific draw on workforce is not clear and could be anaes on call, critical care transfer or emergency hospital response team would be decided at the time on an individual basis as Critical Care are stretched as they cover UHW acute admissions. CW highlighted that a Patient at Risk Team would be created with the agreement of UHL and Execs which would be a huge step forward as UHL have never had an outreach team.	
3.2	**Patient Safety Incidents** **Overall Trends** **New SIs (include reference numbers for specific SIs)** **RCA/Improvement plans** **WG closure form status** **WG closure forms – sign off** - CE stated that two were submitted last month and that a few forms can be closed this month. **Regulation 28 reports (of relevance)** - CE stated no reports to note. CE noted only 8 open SI's. Welsh Gov have asked for reporting framework to resume as normal after withdrawing the need for collapse reports, injurious falls and health acquired grade 3 and 4 pressure damage over the last 3-4 months. CW hoped that a few more SI's can be closed over the next few weeks. **Inquests:** - CE noted a few scheduled for the next few months. Tracy Johnson and CE attended a pre-inquest review in person last week for patient who missed two doses of apixaban, with the inquest date	PSF CE

	being next June with only two witnesses are required to give evidence as the HB has admitted liability. CW stated that an RCA investigation was done at the time, prior to the patient's death 6 months later. CE stated that the family approve of the conclusion. CE noted that guidance to giving evidence virtually is being given to inquest participants as the physical capacity of the room is constrained to comply with social distancing.	
3.3	**Patient Safety Alerts (internal/external)** **New alerts** **Addressing compliance issues with historical alerts** • **PSN 051** - CE noted that issue with the older devices that have battery indicators whereby staff are depleting the battery life by mistaking the device for a drill and pressing continuously. This advice is included in training for new staff and new devices don't have a battery indicator. • **ISN 2020 05** - RB asked how clinical areas who have the older device know *[battery life]?* CE explained not many clinical areas have access to the older devices, with only a handful across the HB including in Children's Hospital and Emergency Unit. • **ISN 2020 / Sept / 008** - RH discussed new formulation of intravenous paracetamol as bottle look similar to other drug stock and advised staff read the label. CW thanked C7 for raising issue quickly. RH noted that a bottle of bupivacaine bears a similar resemblance in terms of bottle shape and label font. RB suggested bottles shouldn't have similar resemblance. AT raised that the packaging options are limited and advised staff to read the label. • **ISN August 2020** CW noted reported as an SI, to be brought to next meeting. **Action:** PA to add to agenda. CW explained due to harm caused to a child when using plaster saws as the staff member continued to use plaster saw despite the child being in distress. Medicine also reported a similar incident around the same time. CW noted that a lot of learning will come from incident. HL noted that training is available for nursing staff and attempts are being made to link in with consultant leads to confirm what training is available for Medical colleagues. - **3.3.5 T34 syringe drive battery – unexpected powering down.** - CW stated widely shared. RH raised drivers mainly used in palliative care, but patients coming in from the community may use T34 syringe drivers, therefore awareness is needed. • **Schrader probes - MHRA email to MDSO and MSO networks**	

	- RH stated that probes may also be found on trolleys as well as walls as portable oxylog ventilators connect to Schrader probes. CW reiterated ask to report if issue is found as although safety alert hasn't been sent, awareness is needed. • **ISN 2020/ Sept/ 006** - CW explained incident in the community whereby a paeds ENT patient tracheostomy became dislodged. CW noted paeds ENT team have done significant training on a small number of patients on a case by case basis have been done over the last few months on children and community services to changed the way tracheostomy ties are carried out in the community. RH queried whether this would also apply to adults. **Action:** CC to check with Lorraine Coultis/	
3.4	**Health Care Associated Infections** **HCAI rates** - CW stated C. Diff and MRSA rates okay but MSSA's are above average, with particular issues reported on Duthie ward. - CW praised the low number of C. diff 1 infections since April as figures we should be proud of as a HB. - **CDiff/MRSA RCA reports** • **Duthie HCAI action plan** AJ stated that a few cases of MMSA's on Duthie were marginally attributed to a patient who had been on Duthie for 24 hours. Work has been done with IP+C colleagues, the daily commode checks have been enhanced and is reported on the daily safety briefing. Weekly hand hygiene audits are ranging from 90-100%, equipment cleaning schedule has been introduced, communication between Housekeeping departments has been enhanced in reference to a particular Housekeeper's practice. - Stock levels have changed in accordance to the increased number of beds from 18 to 24 beds, which has presented issues with storage and additional Housekeeping hours. - A lot of work has been done on VIP scoring to improve since the last audit and is being monitored to ensure maintenance. - IP+C are happy to monitor actions and not hold an outbreak meeting as issues are being addressed. CW highlighted that some ward bases are not historically consistent and have housed various patients. For example, Duthie housed medical patients from April to June whilst it was a Gastro ward. VC recommended that VIP scores should be done at least twice weekly while the scores are low. **Action:** AJ agreed to ensure this is being actioned. CW asked if Duthie have adopted VIP trolleys as they were successful on A2 and B2. **Action:** AJ to double check.	CW AJ CW

	CE stated that there was a VIP scoring page in the new Risk Assessment book but it has been taken out and raised concerns that this may affect future compliance. YH explained that it was taken out of the booklet because most areas were using their own individual charts rather than the VIP scoring page. **Action:** YH to circulate appropriate chart to share with wards, on request of AJ. CW expressed disappointment that the Environmental Audit raised that junior staff on C7 were not following basic hand hygiene guidance despite being a COVID ward at one point, which resulted in a poor score. Bare Below the Elbow was 100%. CW asked attendees to pass onto teams that extensive audits are being done on C7 and reminders given to certain staff groups. VC stated that despite the low score of hand hygiene reported in the first week on Michelle's baseline audit, it subsequently increased to 100%. VC raised that VIP scoring is an issue, **UHB Covid situation** **Progress with relevant improvement plans** • COVID social distancing action plan and Risk Assessments - CW noted that the Risk Assessment used for the Clinical Board can be adapted to any ward, the one shared concentrated on staff rooms. CW stated that each directorate should have completed risk assessments for each of their areas including wards, offices and staff rooms, which MBe can assist with when back from annual leave. CC confirmed that coffee rooms, theatre and recovery but was unsure whether Nikki Rabone had completed one for the anaes. office. - **Action:** CC to double check. RH noted that offices should have been risk assessed as some staff members are vulnerable. - CW raised the importance of not overlooking ensuring non-clinical areas such as SCB owned meeting rooms are COVID safe and signage indicates capacity as IP+C have been very supportive. RH recommended that MBe link in with Emma Johnson. HL noted that markers have and maximum capacity signs have been placed in CAVOC seminar room. HL thanked VC for conducting a walkaround last week. CE raised that this also needs to be applied to the resus service training seats in UHL. RB asked how the anaes. offices can be made complaint. CC to email Nikki Rabone for clarification.	
3.5	**Any key patient safety risks:** • **Q& S performance data** - CW summarised August data; 8 open SI's and two closure forms submitted last month, CW praised Patient Safety on their work as two years ago 18-21 SI's were open compared to this year. - CW asked attendees to ensure that managers are reviewing their DATIX queues and ensure reports are delegated if staff member is off sick. - CW noted a small dip in safeguarding training but is no surprise given the pressures on our Clinical Board over the last few months.	CW

	- Mortality reviews are 78% which may have been influenced by the doctor's handover in August. RH and AJ are the medical and nursing lead, respectively for the UHB Mortality Group that has been set up. AJ summarised the meeting that took place on 9th of Sept and outlined the organisation's process, with more extensive discussions to be had in subsequent meetings. RH asked to be linked into future communications. • **Falls reduction** • **Pressure and tissue damage reduction and prevention** • **Medicines management issues/incidents/audit findings** • **Safeguarding – any key issues; action being taken** - AJ noted that the Safe Guarding Steering Group has been stood down. COVID meant that changes had to be made the ways in which safeguarding for pressure damage was managed, but it has since reverted back to the usual process of submitting RCA's promptly and submitting VA1's if damage was preventable. - AT agreed that having gone through the Medicine Management Group minutes there are no more issues to raise. • **Medical devices/equipment issues** - RH stated that new forms requiring more information for medical equipment bids will be distributed throughout the clinical board. RH stated that the money in the New Year, albeit speculated to be less than last year but there will be money for medical equipment and urged bids to be submitted. RH will request that the forms be released from Clinical Engineering ASAP. - CW asked attendees to ensure that their group's Risk Registers are up to date so that the risks from our equipment are highlighted. • **Blood management –** - CW noted a large number of rejected samples but praised B2 and C7's low rejection rate of <6%. The data shows which wards are Green, Amber and Red but highlighted that if one sample gets rejected but the overall number of samples sent is low to begin with this can affect the data. CW encouraged attendees to review data for their own areas to see if anything can be done differently. CW noted rejected samples is an ongoing problem with hospital Transfusion teams.	
3.6	**Mortality data analysis** • M&M committee update – 1st meeting has been held to set agenda etc AJ and RH are CB reps	AJ or RH
4.1	**Monitoring of CB Clinical Audit plan**	CW

	CW stated that the audit plan continues, with groups monitoring their localised audit. HK's audit will be brought to the meeting at a later date to present. Earlier this year each clinical board highlighted two main audits to focus on rather than having multiple audits, they then report back to audit board as per normal process.	
4.2	**Implementation of key NICE Guidance** CW noted no new additional guidance released.	
4.2	**Research and development update** CW noted nothing to update.	Julie Cornish
5.1	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** Ward inspection reports and improvement plans CW noted no physical improvement plans or inspections being carried out but HIW may arrange virtual inspections but no learning has been noted from anything that has come out in the last 6 months. RH raised that Spire have been given notice of a virtual HIW review that will be conducted over an hour instead of 3 days in person.	
5.2	**Initiatives to improve services for people with:** **Dementia** **Sensory loss** **Learning Disabilities** AJ will invite acute liaison nurses to the next meeting but nothing to report otherwise. HL stated no updates regarding dementia.	
5.3	**Any initiatives specifically related to the promotion of dignity** CW states ties into agenda 5.2 Dementia.	
6.1	**Initiatives to improve access to services/ management of risk** CW noted that the Quarter 3 plans MB presented on at the last meeting still stand, with work being done to improve future efficiency and will be determined by what Peri-op can do differently, how more cases can be increased, what activity Spire return to us, the COVID in the community over the next couple of weeks and the completion of the Estate work for then Green Zone in UHL.	General Managers

	CW noted that the main prioritisation of the clinical board currently is reviewing how much activity can done for urgent and cancer patients.	
6.2	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** CW: RTT in normal format is not being managed, with the main focus being on urgent and cancer patients.	
7.1	**Feedback from surveys – relevant improvement plans** CW noted no further updates. 2 Minutes of Your Time surveys haven't been shared for the last couple of months.	CW
7.2	**Compliments** CW noted compliments are logged with Patient Experience Concerns team. CW suggested they are shared widely and brought to this meeting. **Complaints (include reference number for specific complaints)** CW noted that the complaints during COVID reduced dramatically. CW praised the Patient Experience Team for managing, however complaints are now steadily coming in with themes being patients on routine list wanting to know when treatment will be, in particular for Orthopaedics and the understandable need for families of patients wanting to visit their loved ones and not having a complete understanding of their next of kin's treatment because they cannot visit. CW noted that these complaints are aimed to be resolved as quickly as possibly by calling the family to give information, however this is particularly difficult if the patient's family is large. **Trends** Ombudsman reports/improvement plans CW noted a large number of ombudsman reports being submitted which she is forwarding to directorates for them to answer. **Claims** CW noted that there is a new learning from events form. A large number of claims are coming in but some are from 10-15 years ago, therefore it is proving hard to provide evidence of what has been done to change practice to prevent situation from reoccurring. CW gave the example of a 25 year old claim where a patient had their appendix removed and the stump was removed again 25 years later but it is hard to evidence what was done at that point in time or even who his surgeon was. CW noted that Welsh Risk Pool are challenging evidence before being able to sign it off and release	CW

	money. WRP also require evidence that the cases have been discussed at Quality and Safety meetings. CW recommended that any cases that have local learning be discussed at local Quality and Safety meetings and the wider cases to be brought to these meetings in the future. CW noted that the main theme of claims are communications, consent. Montgomery claims are coming back in regards to keeping patients informed and raised that patients need to be cc'd into their own letters for their treatment when being discussed with other clinicians and numerous teams.	
8.1	**Staff awards and recognition** • Update on Surgery Stars CW noted that nominations are closed with 100 applicants, who are currently being judged by a panel consisting of unions etc. A socially distanced face to face event was intended, but will now be virtual with prizes to show appreciation for staff. CW noted gratitude to be sponsored by Health Charity, RCN and Unison	CW
8.2	**Staffing levels** • Update on Safer Staffing Levels - Staff nursing levels are reported every 6 months to Welsh Gov in line with their Staffing Act. A report wasn't sent in April due to COVID but our ward staffing levels are being formally reported to the Exec team every month. CW raised that collecting the data is challenging due to wards changing uses but the staffing establishment data is being captured monthly	CW
8.3	**Staff surveys** • CC to attend to give overview of Peri-Op Staff Survey -Feedback in regards to hours and how theatres should be utilized is quite split; ~60% of staff prefer to work longer days, ~40% wanted to return to 8am – 6pm shifts. CC noted that the asks of the surgeons and anesthetists as well as the utilization of theatres had to be taken into consideration as having longer lists would be impractical if theatre time isn't being utilized effectively. CC noted that the schedules have been completed, with days going back to 8am – 6pm in UHL (with the exception of Cardiac), where unfortunately the staff would have preferred to work the longer days. CC noted the shifts in UHW are split with some specialties such as Liver, keeping the longer days they normally had and some continuing to work 8am – 6pm. The Unions have been informed of the theatre timetable, CC has informed them she would be happy to meet to discuss further. The timetable is temporary and will be reviewed regularly.	CC

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8.4	**Monitoring of attendance at relevant training e.g IP+C, Safeguarding, MCA, DoLs pressure damage, falls prevention.** CW confirmed clinical board representation on all of the above meetings with the exception of DoLs, which has been suspended. **AOB** RG raised issue identified when discussing with manager of DSDU and asked if the potential for the air change system in the class 18 room to spread COVID between asymptomatic staff members has been discussed at Peri-Op care meetings with HSDU. CC unsure of issue, RH and CC recommended RG discuss with Mark Campbell the manager of HSDU.	CW
	Next meeting 17th November 2020 via teams	

PART 2: Items to be recorded as Received and Noted for Information by the Committee			
	Elective Surgery During COVID		RCS England Elective surgery during COVID19

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 23rd June, 9am, Seminar Rooms A&B, 3rd Floor CHFW / Skype

Preliminaries	
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing Clare Rowntree, Clinical Board Director (Interim) Alyn Coles, Cancer Services Matt McCarthy, Patient Safety Advisor Paula Davies, Lead Nurse Children, Young People & Family Health Services Anthony Lewis, Clinical Board Pharmacist (Skype) Suzanne Hardacre, Head of Midwifery, Obstetrics & Gynaecology Mary Glover, Lead Nurse Children's Hospital for Wales Services Martin Edwards, ACD Quality & Safety Lead, Children's Hospital for Wales Angela Jones, Resuscitation Nurse Practitioner (Skype) Louise Young, Quality & Safety Manager, Children, Young People & Family Health Services (Skype) Sarah Spencer, Deputy Head of Midwifery, Obstetrics & Gynaecology (Skype) Angharad Oyler, Risk Manager, Obstetrics & Gynaecology **In Attendance** Kirsty Hook, Board Secretary Jennifer Evans, Consultant Paediatrician (item 2.1 only)
1.2	**Apologies for absence** No apologies to note.
1.3	**To receive the Minutes of the previous meeting 28th May 2020** The minutes of the meeting held on 28th May 2020 were agreed to be an accurate record.
1.4	To note and update the action log of the meeting of 28th May 2020
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY	
2.1	**Ratification of Terms of Reference for C&W Clinical Board QS&PE Committee** The terms of reference were discussed where it was noted that minor changes had been made to the membership of the meetings specifically. All present agreed to review and advise of any comments , subject to no specific changes other than those discussed, it was agreed that the TOR were ratified. **(ACTION: ALL)**
2.1	**Patient Story – Patient LC (In88983)** JE provided a presentation on the case of LC. Background to the case was provided and a number of key lessons and teaching points were identified as part of the investigation. The root cause identified as failure to recognise illness severity and delay in treatment for bacterial sepsis. Contributory findings were identified as: • Care delivery issues • Absence of senior paediatric decision maker in ED • Split site for paediatric patients • Poor documentation

	Notable practice was highlighted that the nurses had identified how seriously ill the patient was and it was acknowledged that there is a need to empower nurses more. Discussion ensued with regards to a protocol for "jump call" and it was agreed that the pathway within used within Maternity would be shared for information and potential implementation. It was agreed that this should be an MDT training approach going forward. It should also be acknowledged that although it was extremely busy, the staff we working well together however were compromised due to the wide area required to cover. Recommendations as part of this investigation were noted as: • An urgent review of the provision of senior paediatric decision makers in the emergency unit at all peak times. • The development of a single point of entry for paediatrics, including an observation/ admission area fully staffed by paediatric trained nursing and medical staff. • Strengthening of training modules and simulation scenarios for the recognition of seriously ill infants, for doctors of all grades in both primary and secondary care • Situational awareness training for paediatric trainees focusing on viewing patients as evolving situations. • The introduction of observation charts documenting every set of observations taken on a patient from the time of presentation and throughout their patient journey as they move department. • Trends of deteriorating or improving condition would be visible. This should include consideration of the use of charts where parameters outside of the normal range are colour coded amber or red to facilitate the recognition of a seriously ill child. It was agreed that the presentation would be shared for information. (ACTION KH) It was noted that this has been shared via staff forum and work is being undertaken with regards to the teaching points that have been identified. Lessons learnt for those carrying out RCA investigations were identified in relation to: • Communication with family • Communication with those involved • Parallel planning for external investigations Regulation 28 was issued by the coroner and work is progressing to ensure that all actions are completed and appropriate training is in place and robust going forward. It was agreed that this should be presented with Medicine Clinical Board and CH agreed to discuss with the senior team to ensure that the lessons are learnt and shared widely. (ACTION: CH) It was also agreed that this should be presented at the Resuscitation Committee for sharing lessons and awareness. (ACTION: CH) Discussion ensued and it was agreed that everywhere where a child is admitted the NICE Sepsis Tool should be readily available to use. It was agreed that this would be taken forward following the meeting. There was further discussion with regards to the use of the NEWS/ Observation chart that should be used within ED for paediatric admissions. It is noted that work was being undertaken as part of the PUMA study and MG agreed to follow up on progress with regards to the observation tool. (ACTION: MG) It was agreed that a separate meeting/ task & finish group would be arranged outside of this meeting to discuss further. (ACTION: CH)
2.2	Patient Story – In113169 Noted for information. Training has significantly improved and MDT processes in place through PROMPT. Work is also being taken forward with regards to informed consent. CHAPS Case SH provided an update on the case, the patient disclosed FGM and had fled Sudan and left her children as she feared for her safety. 4 weeks post-partum the caesarean wound had broken down and the patient was readmitted to a local hospital. The patient stated that the male doctors in this hospital felt that she needed to be punished for her political views and for being an educated woman. She was taken to theatre and placed under

	General Anaesthetic for re-suturing of her wound, on return from the operating theatre, Mrs A felt increased pain and discomfort, on inspection of her wound she then noticed that her wound had been sutured with IV tubing. This case highlights the complex needs of women attending women's wellbeing clinic and need further psychological support. Discussion ensued and it was suggested that this be linked with Safeguarding. SH agreed to forward. **(ACTION: SH)**
2.3	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** CHFW • COVID 19 continues, waiting on new masks and fit testing continues. Social distancing is being maintained where possible. • Directorate Q&S meetings have been reinstated • Improvement plans are being reviewed at Q&S meetings and will continue to be reviewed every 3 months • No pressure damage reported this period • Drop in reported Medication Errors through April. X3 tenfold errors reported in May, no harm caused to patients • CYARU is supporting a number of COVID 19 studies including RECOVERY, ImmunoCOVID and RAPID 19. RTT has been liaising with PCCU regarding delivery to tocilizumab if needed for the PIMS-TS patients. The team had already received over 600 responses to the RAPID 19 antibody study which is testing for antibodies in children. • Patients are being treated on clinical priority whilst routine RTT pathways are suspended. • Shielding numbers remain high, although some staff are starting to come back to work. • New consultant appointments have been made O&G • Continuing issue with no Neonatal Consultant in attendance at the Obstetrics Risks Meetings and this is currently under review in order to achieve a more streamlined process to prevent duplication and ensure cases as discussed appropriately. • RCA's are progressing and meetings have taken place with Patient Safety in order to review processes to achieve a more timely and robust process going forward • X3 new RCA cases are being investigated but are potential claims • x1 pressure area reported within Gynaecology • X1 fall reported, patient fainted following venepuncture. No harm was caused to the patient. • Cystoscopes process is being progressed and further update will be provided following the meeting scheduled with the IP&C team. • Service evaluation through COVID19 is being developed for services for women to gather patient views and to support planning of getting maternity services back to normal. • IT for virtual meetings is proving challenging due to lack of IT support, work continues to address • IT structure for guidelines on Clinical Portal is problematic and there are significant governance concerns that have been highlighted. System crashes persistently and reinstates old and out of date guidance. Escalated to the executive team for action and added to the risk register. Work has been undertaken in order to manage this risk, and interim measures have been put into place. CH agreed to raise this issue at Directors of Nursing meeting as this is a significant UHB wide issue. **(ACTION: CH)** CYPFHS • Catch up sessions have been undertaken in the Vale of Glamorgan. Difficulties with schools in Cardiff as the LEA have not agreed for schools to be used. Catch up programme for Cardiff will need to be reviewed when children are back at school • Request from PHW for Year 7 to be included in the Fluenz programme and concern has been raised that this will not be manageable, specifically taking into account social distancing etc. • Patient facing activity within St Davids & UHL Children's Centres are being reviewed and Attend Anywhere is also being rolled out in a number of areas. Staff anxieties have been highlighted specifically in relation to provision of face masks, and it was noted that agreement has been provided that face masks will be provided

	where social distancing cannot be adhered to. Consistent approach is required in order to ensure that there are not too many patients attending at any one time. • Ty Gwyn and YYD Special Schools particularly do not want NHS staff on site if they have been on NHS sites same day. • PPE across the Directorate is being managed robustly through the DMT and training is being undertaken where appropriate. Support also being provided to Ty Hafan. • Plans for some staff who are shielding to come back to work • Cardiff YOS Inspection Report is awaited. Recommendations have been noted for all agencies. Model of the post has been changed in order to ensure that the needs of the service are met more appropriately. • IP&C issues for St David's have been noted and clinical areas require further review • School based immunisations is still paper based, and benchmarking is being undertaken to look at e-consent and how this could be implemented. • Nurse transcribing - transcribing pathway being developed • Hafan y Coed - CAMHS. Work is taking place on the 16-18yr old pathway however at present, the pathway is admission to Hafan y Coed. Whilst this is well supported by staff, it is felt that the environment is inappropriate. It was agreed that the patient story would be shared for learning and awareness. **(ACTION: PD/CL)** • Recovery programme within Health Visiting is progressing. Pilot of Attend Anywhere is also being progressed. The HV Helpline implemented through COVID 19 was very well received. • Formal evaluation of the multi-agency hub for children with complex needs to be undertaken and work to review how this can be supported through the summer. • Closer to Home model for Paediatric EU referrals is being explored and further discussions have taken place with regards to new referrals. • CAMHS referrals are increasing and cases are more complex. • S&LT has moved to 6 week working • Recruitment of additional support from CAMHS has been undertaken to support young people who meet continuing care with primary health needs. • Issue with Flying Start and fixed term funding, impacting on recruitment due to the length of contract.
2.4	**Exception Reporting / New Risks to be considered for the Clinical Board/Directorate Risk Register** • Fragile high risk services have been added to the risk register (ACH) • IT guidelines for Clinical Portal has been added to the risk register (O&G)
2.5	**Long Waiting Patients Update** ACH Outpatients will be opened early July. Partly via face to face appointments and Attend Anywhere. ND waiting list has increased to 62 weeks and an action plan is being developed as to how this can be managed and improved going forward.
2.6	**Business Continuity Update** There were no issues to note for this meeting.
SAFE CARE	
3.1	**Update on Serious Incidents** No SI's or surprises reported since the last meeting. Include detail from the report. Improvement in the number of incidents awaiting review. COVID 19 related incidents reported were noted, and there were no specific themes identified. Work is progressing on the open SI's within Obstetrics & Gynaecology. The quality of the reports were highlighted, as well as some delay with information being received from other areas, however it was noted that a number of these are now almost at completion.
3.2	**SI's & RCA's for noting/sign off** **RCA AI (Datix Ref 289277)** This case relates to an undiagnosed abnormally adherent placenta, resulting in massive obstetric haemorrhage and life-saving hysterectomy. Near miss maternal death. The background to the case was shared. There were a

	number of recommendations identified as part of the RCA and an action plan has been developed in order to manage and close the actions appropriately. The report was approved and it was agreed that this would now be shared with the family for closure. The report will also be shared at Directorate Q&S Meeting for sharing and learning. **SBAR RJ (Datix Ref)** This case relates to a 4th degree tear following forceps delivery. The background to the case was shared for information. Discussion ensued and assurance has been received that there has been reflection and lessons learnt from the case. It was agreed that further discussions are needed with regards to induction processes for locum consultants. The report was approved and it was agreed that this case could now be closed. MM agreed to complete the closure form for submission to Welsh Government. **Birth Injury Tool Baby East** Background to the case was provided relating to Erb's Palsy being identified following a shoulder dystocia. Issues with regards to informed consent have been highlighted as part of this case. Discussion ensued and it was noted that this has been graded as a 3 and it was agreed that further discussions should be undertaken with Redress, whilst the deferred review is awaited as to whether this issue is now resolved. **In82212 Improvement Plan** Updated improvement plan was noted for information.
3.3	**Learning from Clinical Negligence Claim (Shoulder Dystocia)** Discussed as part of item 2.2.
3.4	**Annual 3rd & 4th Degree Tear Audit** Noted for information and work is being taken forward with the RCOG. This is also linked to the SBAR RJ noted as part of item 3.2.
3.5	**Infection Prevention Control Update** No update received for this meeting.
3.6	**Safeguarding** **Wales Modern Slavery Safeguarding Pathway** Noted for information and onward dissemination as appropriate.
3.7	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • ISN2020 003 – Pre Transfusion Sampling • PSN053 – Risk of death and harm to infants from batteries in hearing aids • Coronavirus Newsletter All alerts were noted for information and have been shared widely across all services. There were no specific exceptions to note for the Clinical Board.
3.8	**Mortality Review Group Terms of Reference & Representatives** Terms of reference will be shared for information and a request has been made for a clinician, nurse and or midwife to represent the Clinical Board at the UHB group. All were asked to consider and feedback. **(ACTION: KH/ALL)**
3.9	**Acute Child Health/Health Foundation Project Midpoint Report** The mid-point report was shared for information.
3.10	**Treatment Escalation Plan**

	The escalation plan was noted for information, and it was acknowledged that this is not for use for under 18yr old. It was noted that paediatrics have a separate escalation plan is in situ and is embedded into practice. It was agreed that this could be implemented within Gynaecology and it was agreed that this will be reviewed. AJ agreed to feedback once confirmation has been received as to the required implementation. **(ACTION: AJ)**
TIMELY CARE	
4.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** No issues/exceptions to note for this meeting.
INDIVIDUAL CARE	
5.1	**Update on latest 2 minutes of your Time feedback** No updates to note for this meeting.
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE	
6.1	**SANDS Feedback** The SANDS feedback was shared and noted for information.
6.2	**O&G R&D Newsletter** Noted for information.
6.3	**O&G Mandatory Training Figures** Noted for information, this is linked to item 2.2 In113169. Midwifery training is currently at 93%.
6.4	**Caring for You Action Plan** Noted for information.
ANY OTHER BUSINESS	
	Risk Registers It was noted that risk registers should be reviewed and risks adjusted as necessary in light of COVID 19 processes. **(ACTION: ALL)** **Post Delivery Sepsis** It was noted that there has been a reduction in post-delivery sepsis and it was agreed that when available, this information would be shared for information. Discussion ensued with regards to an audit that has been undertaken with regards to 30day admissions in COVID 19 and it was agreed that further information would be shared when received. **(ACTION: SH)** **HCIW Placements** Discussions have taken place with regards to placement programme and it was noted that 29 placements have been received. Work is progressing. **Trauma Call** Thanks were expressed to all who were involved in the trauma call outside of maternity yesterday.
DATE AND TIME OF NEXT MEETING	
The next meeting is scheduled for **Tuesday 25th August 2020, 8.30am, Lecture Theatre 4, UHW & Skype** PLEASE NOTE – A SEPARATE H&S MEETING WILL BE ARRANGED FOR JULY – TUESDAY 7TH JULY 2020, 8.30AM VIA SKYPE **2020 Meeting Dates** Tuesday 22nd September, Venue to be confirmed (H&S FOCUS) Tuesday 27th October, Venue to be confirmed Tuesday 24th November, Venue to be confirmed Tuesday 22nd December, Venue to be confirmed (H&S FOCUS)	

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

Minutes

CHILDREN & WOMEN'S CLINICAL BOARD
EXTRA ORDINARY QUALITY, SAFETY & EXPERIENCE COMMITTEE – SI'S/RCA'S/CLOSURE FORMS
Thursday 27th August, 12.30pm, COVID Operations Hub, Education Suite UHW

1. Preliminaries		
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing Mary Glover, Lead Nurse, Children's Hospital for Wales Services Matt McCarthy, Patient Safety Team Suzanne Hardacre, Head of Midwifery Chelsea Thomas Hamblin, Senior Midwifery Manager for Outpatients & Gynaecology Henry Coles, Risk Lead for Obstetrics **In Attendance** Kirsty Hook, Board Secretary	
1.2	**Apologies for absence** No apologies to note	
2. SAFE CARE		
2.1	**Update on Serious Incidents** Noted for information. There were no specific exceptions to report.	
2.2	**Closure Form for sign off (In112812)** The closure form was noted for information. This has been submitted to Welsh Government for closure and the RCA will be discussed in detail as part of this meeting in order to sign off and agree for sharing with the family and for lessons learnt.	
2.3	**SI's/RCA's/Closure Forms for noting/sign off**	
	RCA & Improvement Plan - Patient GM (In82059) The detail and background to the case was noted for information. Highlighted there were a number of missed opportunities as part of the care due to inconsistency and lack of continuity of care of the case and poor documentation of outcomes and tests. The root cause was identified as delay in diagnosis of congenital CMV infection, leading to delay in consideration of treatment. Incidental learning relating to: • Delay in performing partial septic screen (2hr 15 min following review) and antibiotics not started within 1 hour following identification of need to start (took 2 hours and 30 min for antibiotics to be given) • The decision to treat for suspected meningitis was made on 06/10/2019 after multiple failed lumbar punctures, which is when Cefotaxime should have been started (Cefotaxime started on 09/10/2018). The improvement plan has been developed and discussions are ongoing with newborn hearing screening with regards to results being included as part of the patient's notes. Any further issues will be escalated where necessary. Discussion ensued with regards to the lack of continuity of care and it was noted that this has now been resolved so that there is a named consultant for each new patient. It was agreed that some table top learning would be progressed in order to highlight the issue of failure of newborn hearing	

	screening tests. It was agreed that redress may also need to be considered, as well as retrospective reporting as an SI. MG agreed to review and update further to discussions taking place.	MG
	RCA & Improvement Plan – Patient BB (Datix Ref – 298237) Joint investigation with neonates and obstetrics. The detail and background to the case was noted for information. Some issues were highlighted with regards to documentation, however it was noted that there are no specific issues that would indicate the reason for the neonatal death as the delivery and care was within normal parameters. It was agreed that this case would be shared at the CHFW Directorate Q&S Meeting for learning to be shared. It was agreed that the RCA could now be signed off and improvement plan timescales will finalised for sharing with the family and closure form submitted to Welsh Government.	SH
	RCA & Improvement Plan – Patient SK (Datix Ref – 304587) The detail and background to the case was noted for information. The root cause was identified as, misdiagnosis of the position of the fetal head prior to forceps delivery. Forceps delivery in the Labour Ward room with inadequate maternal analgesia and failure to involve multidisciplinary team. Resultant extended perineal tear and major primary postpartum haemorrhage Lessons learned were noted with regards to attending staff have a responsibility to ensure patient analgesia is adequate throughout labour and delivery. This should always be maintained unless there are urgent concerns about fetal or maternal wellbeing. Lack of a standardised safety process for instrumental delivery taking place in a Labour Ward room. There is a standardised operative checklist performed for every procedure performed in Labour Ward Theatre including instrumental delivery, promoting good communication and supporting a robust safety culture. No such process exists for deliveries performed in the room where communication and safety are just as important concerns. The improvement plan was noted and the safety briefing checklist has been drafted. It was agreed that this would be shared with Patient Safety to ensure that this meets guidelines. The RCA was approved and it was agreed that this would be shared with the patient, and a meeting to discuss offered.	SH
	RCA & Improvement Plan – Patient AS (Datix Ref – 309033) The detail of the maternal death and background to the case was noted for information. The root cause was identified as inappropriate management of secondary PPH in an anti-coagulated patient. Evidence of good MDT discussions antenatally and appropriate care provided, however there were issues raised with regards to documentation and lack of access on re-admission. Failure of communication was also highlighted as part of the investigation. There was notable practice highlighted in relation to; • Good MDT discussions antenatally • Tranexamic acid was administered by the ambulance team before arrival. • The anaesthetic team escalated to the on call Consultant Anaesthetist early. • The band 7 midwife and Anaesthetic Registrar communicated effectively with the ambulance team. • The Major Haemorrhage protocol was activated. • Involvement of the ITU intensivist is appropriate. • Blood loss was objectively measured	

	SH agreed to discuss the case further with WAST as there was a significant delay between attendance and patient admission. It was agreed that further discussions would take place with the IO and MM to understand the complete pathway for the patient and any further actions that are required. CH also agreed to discuss with Executive Nurse Director.	SH/MM CH
	RCA & Improvement Plan – Patient CT (Datix Ref – 308291) Deferred to next meeting	
	RCA & Improvement Plan – Patient MB (Datix Ref – 305880) The detail and background to the case was noted for information. From the investigation it was noted that a root cause could not be identified for Baby R's unexpectedly poor condition at birth, which resulted in severe hypoxic-ischaemic brain damage. Extensive resuscitation was provided by a full team of neonatal professionals. The steps taken during resuscitation were reasonable, proportionate and appropriate. Although some neonatal and multi-professional learning points were identified, these did not impact on the final outcome nor were they implicated in the condition at birth. Lessons learnt and incidental learning were noted as increased awareness among neonatal / anaesthetic teams on use of CO2 detector in delivery suite / during resuscitation / intubation scenarios. Discussion ensued and it was agreed that this would be shared with CHFW Directorate Team and Neonatal Team for sharing lessons learnt as part of Q&S process. The RCA was approved and it was agreed that the timescales on the improvement plan would be finalised and this could then be shared with the patient and the SI closure form completed. Roles and responsibilities for obstetric anaesthetists were discussed and it was agreed that this should be clarified in order to ensure that there is appropriate training provided where necessary. Recommendations were also discussed for a Neonatal Consultant to be resident on the unit and it was agreed that this should be considered.	SH
	RCA & Improvement Plan – Patient LP (Datix Ref – 310393) The detail and background to the case was noted for information. The scope of the investigation covers the time of the call to 999 and the period of care involving Cardiff and Vale UHB. Poor communication was identified and no methodical approach taken. Cwm Taf UHB were contacted for a joint investigation however no response was received so the RCA has been completed solely by C&V UHB. Lessons learnt were identified; • WAST to consider more appropriate methods for paramedics to contact hospital units rather than personal mobile phones so that calls can be recoded appropriately. • Ensure understanding of roles and responsibilities of different health care professionals during referrals from WAST to the maternity unit and ensure who has the ultimate responsibility for actions taken. • The telephone triage forms should be completed fully to ensure full and assessment is made and correct advice given. Recommendations were noted as; • In an emergency all women regardless of which hospital they are booked should be seen in nearest hospital. The Cardiff and Vale UHB Obstetric Assessment Unit guidance should be updated to reflect this. This should also be reflected in WAST guidance. • The Health Board should work with Welsh Government and the Maternity / Neonatal Network to support implementation of a national electronic maternity information system.	

	• An audit should be taken of the completeness of the OAU telephone triage forms to establish any training requirements • A review of the antenatal care should be undertaken by Cwm Taf University Health Board. LP contacted the maternity unit the previous day as she was experiencing tightening which she reported were getting worse. The review of care should include whether a full Obstetric assessment in view of LP's gestation and history of a bicorn ate uterus and the associated risks. This is not within the scope of this investigation. It was agreed that this report would be shared with WAST to share lessons learnt. MM agreed to enquire the best route for sharing. The RCA was approved and it was agreed that this can be shared with the patient, with the offer to meet provided following confirmation that this has been shared with WAST.	MM SH
	RCA & Improvement Plan – Patient LE (Datix Ref – 292181) Deferred to next meeting.	
2.4	**Healthcare Safety Investigation Branch (HSIB) Report & Action Plan – Patient DT (Datix Ref – 305808)** Deferred to next meeting.	
2.5	**Neonatal Improvement Plan & Feedback** The Peer Review was noted for information. Formal report received and an improvement plan has been submitted. Positive feedback has been received, specifically with regards to family centered care. Recognition of level of support and care provided, and transparency of information sharing. No immediate risks were identified. Concern raised with regards to AHP provision, 24hr cover for neonatal transport and funding for QIS. There were also reinforced concerns of refusals and the impact on neonatal network. Meetings have taken place to discuss the improvement plan and actions that have been undertaken accordingly. A number of ICP's are being developed for submission to WHSSC for consideration as current provision is not adequate to meet the tertiary service and demand.	
2.6	**Learning from Events – Patient EG** Deferred to next Q&S Meeting	
2.7	**Learning from Events – Patient CB** Deferred to next Q&S Meeting	
3. ANY OTHER BUSINESS		
DATE AND TIME OF NEXT MEETING		
The next Clinical Board QS&PE meeting is scheduled for **Tuesday 22nd September, Venue to be confirmed (H&S FOCUS)** **2020 Meeting Dates** Tuesday 27th October, Venue to be confirmed Tuesday 24th November, Venue to be confirmed Tuesday 22nd December, Venue to be confirmed (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
Tuesday 27th October 2020, 8.30am, Via Microsoft Teams

Preliminaries		Action
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing (Chair) Alyn Coles, Cancer Services Mary Glover, Lead Nurse, Children's Hospital for Wales Services Laura Hutchinson, Senior Nurse, Children Young People and Family Health Services Jane Jones, Consultant in CAMHS Suzanne Hardacre, Head of Midwifery, Obstetrics & Gynaecology Directorate Nia John, Consultant in Community Child Health, Children, Young People & Family Health Services Louise Young, Quality & Safety Manager, Children, Young People & Family Health Services Sarah Davies, Risk Midwife, Obstetrics & Gynaecology Clare Rowntree, Clinical Board Director **In Attendance** Helen Whalley, Interim Bereavement Midwife Anne Owen, Project Implementation Officer (Item 2.1 only)	
1.2	**Apologies for absence** Anthony Lewis, Martin Edwards, Laura Owens, Kirsty Hook	
1.3	**To note the minutes from the extra ordinary Q&S (RCA/SI) Meeting held on 22nd October 2020** An extra ordinary meeting was held on 22nd October 2020 to discuss active RCA/SI investigations. It was agreed that the minutes would be shared with the meeting once finalised for information and noting of current position, progress and lessons learnt.	KH
1.4	**To note the Minutes of the previous Q&S meeting held on 23rd June 2020** The minutes of the meeting held on 23rd June 2020 were agreed to be an accurate record.	
1.5	**To note and update the action log of the meeting of 23rd June 2020** The action log was noted for information. The following actions were agreed to be followed up outside of the meeting and would be closed by exception, unless there were any exceptions to note. **Lessons Learnt – RCA LC** CH to check if this presentation has been shared at the Resuscitation meeting for lessons learnt. The PEWS is progressing and it is hoped this can be noted/shared at the next meeting **Treatment Escalation Plan** CH agreed to request an update from Angela Jones.	 CH MG CH
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Attend Anywhere Presentation** Overview of the Attend Anywhere rollout was provided to the group. Attend Anywhere is a video consultation platform for clinical practice, includes virtual waiting rooms etc. Significant progress has been made across the Health Board to imbed into practice and increase usage. Breakdown of the services that have a waiting room set up within the system, total of 23 at present 20 of which are being utilised for Children & Women's Clinical Board. Graham Smith is the	

	implementation lead for Children & Women's Clinical Board. It was agreed that the presentation would be circulated for information, which includes links to intranet site for guidance on the Attend Anywhere platform. Very positive feedback received that this provides continuity of service for patients, as well as allowing more effective and efficient services to be provided. This also provides patient empowerment which has been a very positive outcome to the rollout. Request made to promote Attend Anywhere across all services and if further help and support is required this can be provided by the implementation leads. CH requested that the breakdown be provided on a monthly basis so that this can be shared via the Clinical Board Q&S agenda as part of business continuity.	AO/KH
2.1	**Patient Story – Patient GM** HW provided an overview of the case, which unfortunately resulted in a very sad baby loss. Whilst this was a very sad case, the patient noted that the care provided both during and after the birth was exceptional. The team were very passionate and caring throughout, and thanks were expressed to all staff involved for making a very sad time as positive as possible. Thanks were expressed to all. It was noted that it is important to share patient stories as and it was agreed that there should be a patient stories shared as part of every meetings. All were asked to consider the next patient story to be shared.	ALL
2.2	**LFE Report – Patient CB (CN/UHW/2867)** The comprehensive report was shared for information. Case was from 2010 and the background of the case was provided which detailed that (include from the report) The allegations was that there was a breach of duty of care within the birth experience which has resulted in brain damage to the baby and further developmental problems for the child, which if delivered earlier it was felt that earlier delivery would have resulted in a better condition at birth. The breach of duty has been accepted and lessons learnt from the case. It was noted that regular ongoing training takes place however it was acknowledged that since this case, CTG monitoring and training has significantly improved in the last 10 years. A review of the case notes is being undertaken to look at what would have been done differently now as part of ongoing learning. It was acknowledged that the service currently has a low below average HIE rate and CS rate is low compared to other units which provides assurance that the monitoring and training is robust. Important to demonstrate the actions that have been put in to place since such learning events to provide assurance and robust governance and evidence to support the learning from these events.	
2.3	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** CHFW • Staff have been requested to disable the Track & Trace App whilst in work due to the recording of inappropriate/false contact • A reminder has been circulated to staff to advise that if lift sharing, there is a need to ensure that surgical masks are worn in the car • Flu Vaccine uptake is excellent • X1 RCA ongoing and this will come to the meeting next month • Improvement plans have been updated and rolling programme is in place to update every 3 months • PCCU cubicle work to be undertaken, liaison with Estates is ongoing • Roll out of single nurse checking from January 2021 across medical, surgical and CAU areas. • Reinvigoration of the Paediatric Medicines Management Group. Discussion ensued with regards to closing the loop from the learning and CH agreed to discuss separately with AL outside of the meeting as to how this can be resolved. • Fresenious Pump and leakage of chemotherapy drugs from the side port. The risk is acknowledged and appropriate mitigation has been put into place. This has also been highlighted to the MHRA.	

- RTT continues to be on hold due to COVID 19 pandemic and patients are continuing to be treated by clinical priority.
- Revised elective theatre schedule is due to continue until March 2021. Ongoing discussions regarding the weekend CEPOD lists. The reduction in the number of paediatric theatre sessions has added increased pressure on the inpatient waiting times however pressure is continuing to be received to deliver the 36 week position, which is ongoing.
- All newly qualified nursing staff are in post, however there is no maternity leave cover so work is continuing to look to mitigate this.
- Urology Post out to advert
- Children's Rights and Children's Charter to be reviewed and improve momentum going forward. CH agreed to provide a further update when available

CH

CYPFHS

- AGP information has been disseminated across all health services. Visor wearing has also been disseminated to special schools and third sector.
- Fluenz up to 70% uptake. HPV catch up has been completed and feedback was very positive
- Flu vaccine delivery has been excellent across the Clinical Board, over 1400 vaccines. It was noted however that vaccines ordered have been difficult as not deemed as frontline, which has impacted across the patch with a number of clinics having to be cancelled due to availability but it hoped that this can be improved.
- Transcribing is Special Schools is ongoing. SOP being developed and training needs have been identified.
- Plan in place for waiting times
- Risk Assessments for concerns associated with LAC placements and mental health assessments
- Decommission of Park View Health Centre which involved archiving issues, there are a few Estates issues that needs to be reviewed. It was agreed that the RCA investigation should be shared with the Estates team for lessons learnt when complete.
- Birth notifications becoming paper-lite is progressing
- Alison Davies is H&S lead for the Directorate
- Lone Worker Devices are being shared across CCNS service and guidance is being developed to ensure safety of all staff.
- Increase in pressure ulcers in CYP, a multi-disciplinary task and finish group has been set up to devise guidance and pathways for management of pressure ulcers in CYP within the Community.
- Blended diet training plan is being progressed to roll out the Blended Diet Policy
- Directorate Medicines Management Meeting is being implemented
- Increase in safeguarding cases over the Summer following COVID 19 pandemic, drop in sessions has been prioritised now that children are back in school and emotional mental health training being sought for school health nurses in order to provide support.
- Safeguarding supervision for CCNS is ongoing

O&G

- Health promotion work continues including a care pathway consultation for perinatal mental health
- IPad has been purchased to support the Healthy pregnancy clinic, and funding also made available to set up PARIS diaries for community midwives.
- BFI has been postponed for the year
- Maternity Performance Report has been received and there is discrepancy on the numbers. There will be no Performance Board with Welsh Government this year, however a table top review exercise is being undertaken and more information will be requested to gather more qualitative performance data.
- HIW Maternity Services Report is being published in November and a learning event is being planned. It was noted that going forward this will also be joint with Neonatal Services which was agreed that this will be a positive approach.
- Flu uptake has been excellent, 540 members of staff vaccinated
- Patient Safety Investigation meeting implemented in September. CB Extra ordinary meeting was undertaken last week to get some of the investigations moving towards closure also.

	• No falls in month. • Walkabout with IP&C being undertaken with regards to contact tracing for COVID positive patients and the routine screening of all elective and emergency admissions and the challenges this is having an impact. • Medicines management issues have been highlighted and work is ongoing with supervision and risk midwife to investigate • Instagram page for Midwives has been reinvigorated and weekly communication is being provided to staff following the Directorate COVID Meetings. Work is also being undertaken with the Maternity Services Liaison Committee (MSLC) Chair to develop a "Talking Heads" presentation for Board of women's experience following the COVID 19 Pandemic • Staff recognition award winners this year • Number of posts that are being matched at present and all newly qualified midwives are in post.	
2.4	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** No items to note. Work continues on the risk registers across the Directorates.	
2.5	**Long Waiting Patients Update** It was acknowledged that there has been an increase across all services with regards to the number of patients waiting as a result of the COVID 19 Pandemic and assurance was requested from all that these patients are regularly being reviewed and prioritisation is being undertaken robustly to ensure no patients are coming to harm.	**ALL**
2.6	**Business Continuity Update** No items to note.	
SAFE CARE		
3.1	**Update on Serious Incidents** The report was noted for information. Extra ordinary meeting undertaken last week and these will continue going forward to allow detailed discussion.	
3.2	**SI's/RCA's/Closure Forms for noting** **RCA & Improvement Plan - Patient RB (Datix Ref – 317172)** Further work is being undertaken and this will come to the next meeting for discussion and closure The RCA's below were noted for information. It was acknowledged that all cases were discussed in detail as part of the extra ordinary meeting held on 22nd October and it was agreed that once the minutes are finalised, these would be shared for information and noting of any lessons learnt. A number of actions are being progressed to finalise the RCA reports so that they can be shared with the families and x2 RCA's were agreed for closure (noted below for information). • RCA & Improvement Plan – Patient JC (Datix Ref – 298210) • RCA & Improvement Plan – Patient CT (Datix Ref – 308291)- Closed • RCA & Improvement Plan – Patient LE (Datix Ref – 292181) • RCA & Improvement Plan – Patient MB (Datix Ref – 305880) – Closed	**MG** **KH**
3.3	**Claim for Reimbursement – TK (POT/UHW/3380)** Learning from events report received following the insertion of a portacath recommended by the oncologists and following the routine procedure, the patient suffered a burn to the skin near the port site. Breach of duty was established following the investigation where it was noted that no incident form was completed and considered that the burn was felt to not be a natural complication of the surgery therefore the claim was settled. **Recommendations** • Incident reporting in theatre • Advice should have been sought by plastic surgery colleagues in order to have minimised the damage. This report is also being shared with Surgery Clinical Board for sharing of lessons learnt.	

3.4	**Complex Multi-agency Case update – MJ** MJ had a diagnosis of global development and violent outbursts. Behavioural difficulties had intensified and in March 2019 Ty Gwyn Special School were unable to manage his needs and Ty Coryton accepted him in September 2019. Destructive behaviour and poor behaviour to staff was noted within TY Coryton, however it was acknowledged that this was not experienced within the community. MJ was referred for continuing care in January 2020 however no provision identified by the local authority for Health to support but there were ongoing issues with his behaviour and wasn't accessing respite, so mum had little support overnight. Following incident in school he refused to return to school in March 2020. In June 2020 partnerships of care re-commenced support. This stopped due to self-isolation which had a significant impact on MJ. Physical aggression escalated resulting in attendance to CAU. Mental Health assessments were undertaken and was felt to not be suffering with mental health issues and did not need to be detained. Tier 4 assessment bed was sought and in July 2020 a further incident took place resulting in admission to CAU and following assessment it was confirmed MJ was not safe to return home. Admitted to Hafan y Coed under the Mental Health Act in July 2020. MJ remains an inpatient at Hafan y Coed. Care plans have been devised and is being supported by staff as part of care package. Joint application by Health and Local Authority was submitted for decision on ongoing care management. It has been agreed that MJ will remain in Hafan y Coed until a suitable and safe placement is found. Thanks were expressed to Adult Mental Health colleagues for their support to both C&W Clinical Board staff and also to MJ. This case has been reported to Welsh Government as a serious incident.	
3.5	**Infection Prevention Control Update** ANTT compliance and Antimicrobial stewardship updates for nursing and midwifery staff across the Directorates was requested in order for an update to be provided to Corporate IP&C Group. SBAR for Paediatric Oncology Routine COVID Swabs has been produced as there are difficulties due to daily attendance of patients. This has been assessed and it has been agreed, in conjunction with IP&C colleagues that these patients would not be routinely swabbed as this could delay treatment for patients. CH agreed to share the SBAR for information.	ALL
3.6	**Safeguarding** • Help your Mate Campaign • Flow Chart Enclosed Immediate Action for any Disclosure of Physical or Sexual Assault Documents were noted for information and onward dissemination as appropriate.	
3.7	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • ISN Tracheostomy Ties • ISN Blood Transfusion Laboratory – Expired Blood Tubes • ISN Tissue Damage from Plaster Cast Saw • ISN T34 Syringe Driver The alerts were noted for information and have previously been circulated for onward dissemination where appropriate. There was no specific exceptions to report. An update was provided with regards to the tracheostomy ties, significant work has been undertaken in order to change to the new ties following an incident within the community and compliance with the ISN. This will be revisited in cases where there has been found to be a preference to use the Velcro ties which are still available via the emergency boxes. Work is being undertaken in conjunction with Patient Safety in order to resolve this.	
3.9	**Children's Hospital for Wales Hospital Footprint (Winter)**	

	Noted for information. This has been approved by the Directorate and Clinical Board as the plan going forward for the Winter.	
4.0	**Falls Delivery Group Terms of Reference** The terms of reference was shared for information. Any comments to be fedback. Jane Maddison is the Clinical Board representative for the Falls Delivery Group.	
4.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes – for information** Performance matrix will be shared for information. Performance is positive across all areas.	
INDIVIDUAL CARE		
5.1	**Update on latest 2 minutes of your Time feedback** **O&G 2 Minutes of your Time Report – September 2020** Noted for information. There were no specific exceptions to report.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
6.1	**Minutes of extra ordinary Q&S (RCA/SI) Meeting held on 27th August 2020** Noted for information.	
6.2	**Healthcare Safety Investigation Branch (HSIB) Maternity Investigation Report** Shared for information. MDT Meeting is due to take place shortly in response to the action plan and when this is finalised it will be shared for lessons learnt.	
6.3	**Maternity Performance Board Report** Noted for information.	
6.4	**Newborn Bloodspot Health Board Report** Noted for information.	
6.5	**RCOG Assurance Framework** Noted for information.	
6.6	**Joint Position Statement of NPPG & RCPCH - Using standardised concentrations of unlicensed liquid medicines in children** Noted for information. **Fenobarbital Liquid Strength** One of the concentrations has been removed and only one strength can now be prescribed.	
6.7	**Medicines Safety Newsletter** Noted for information	
6.8	**Paediatric Medicine Safety Update** Noted for information.	
ANY OTHER BUSINESS		
7.1	**AWMSG Acknowledged Resource** Noted for information.	
DATE AND TIME OF NEXT MEETING		
The next meeting is scheduled for **Tuesday 24th November, via Microsoft Teams** **2020 Meeting Dates** Tuesday 22nd December, Venue to be confirmed (H&S FOCUS)		

Report Title:	**Self-assessment of Committee Effectiveness & Forward Action Plan**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	15 Dec 2020	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Corporate Governance**								

SITUATION

It is good practice and good governance for Committees of the Board to undertake a self-assessment of their effectiveness on an annual basis, in line with the requirement of Standing Orders. This is done for all Committees of the Board.

This is the second review undertaken by the Committee. The survey questions were selected based on their inclusion as key considerations in the Good Governance Handbook and remained the same as last year's survey allowing comparison year on year to be made. Survey Monkey was again used as a tool to gather the feedback.

ASSESSMENT

Attached at appendix 1 are the results for the Committee Effectiveness review undertaken by Committee Members in addition to the Executive Director Lead for the Committee. Where comments have been provided these are also included together with an indication of improvement or deterioration in results.

Attached at appendix 2 is a proposed action plan to improve the areas in which the results had either an 'adequate', 'needs improvement' or 'no' response to the questions asked.

More areas for improvement were identified this year however the action plan will strengthen certain processes and review of the Committee's Terms of Reference and work plan following the outputs of the Quality Governance Self-Assessment, WAO work on Quality Governance and Executive review of the processes and structures associated with Quality Governance will bolster the Committee's effectiveness.

RECOMMENDATION

The Committee is asked to:

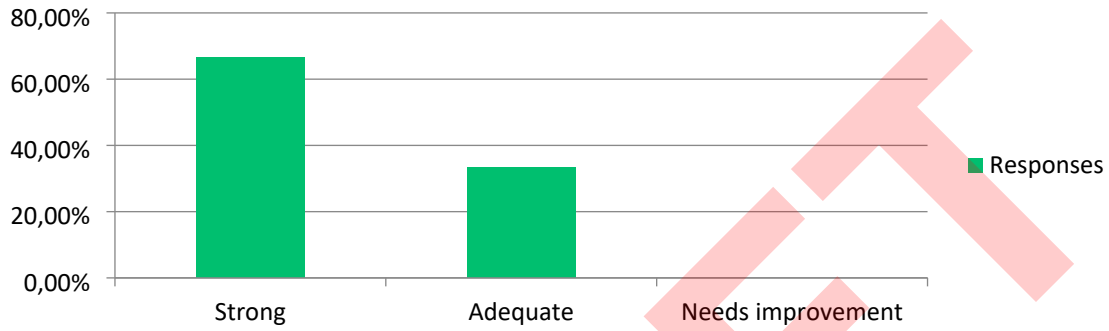
- Note the results of the Committee's self-assessment Effectiveness Review for 2019-20.
- Approve the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which will feed into the 2020-21 Annual Governance Statement.

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

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term	x	Integration		Collaboration		Involvement	

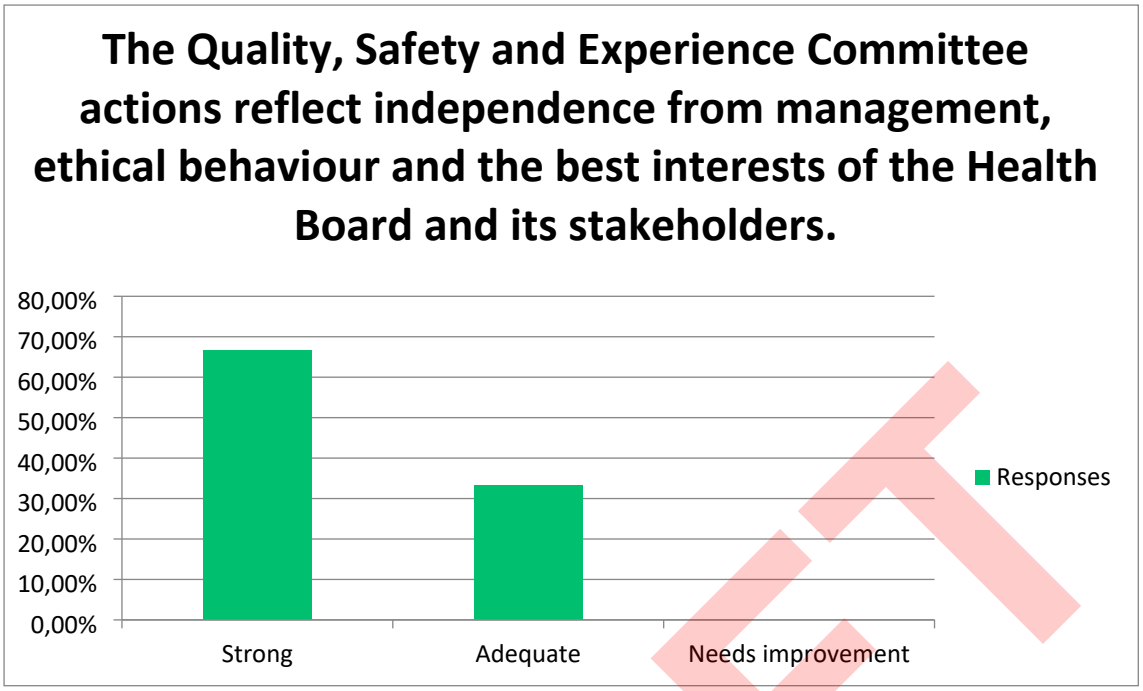
Equality and Health Impact Assessment Completed:	Not Applicable

The Quality, Safety and Experience Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the committee and the full



The board was active in its consideration of Quality, Safety and Experience Committee composition.NHS Handbook status: 2 - should do

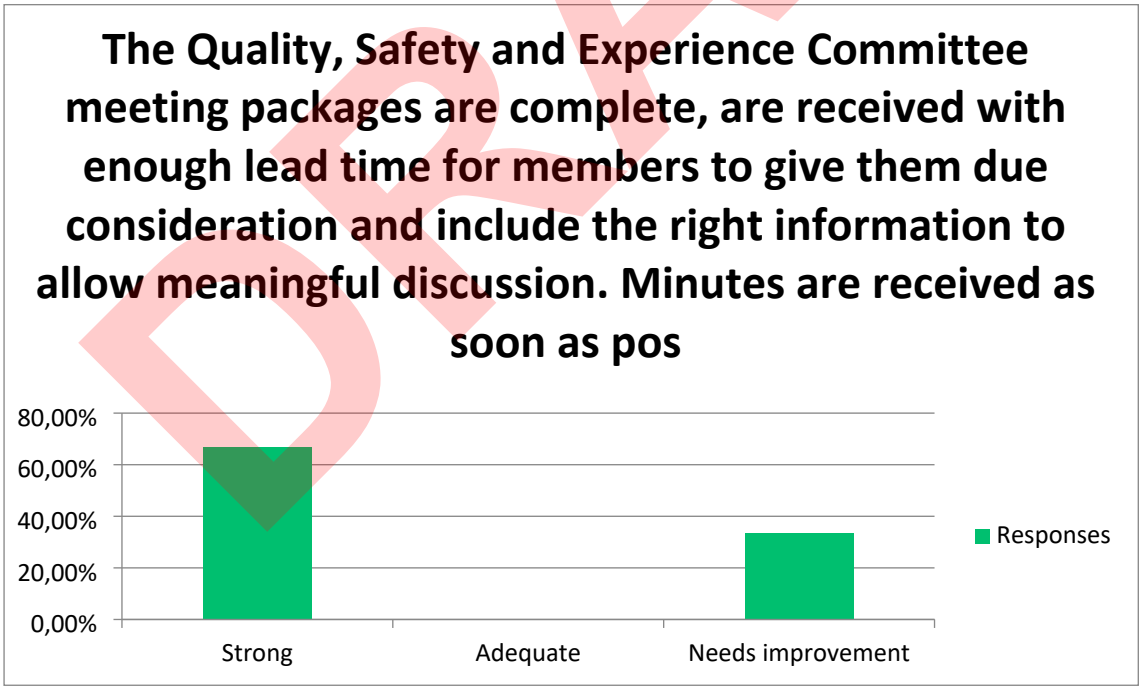
* Improvement on last year



* Scored 100% "Strong" last year

Comments

"The 3 clinical executives ensure specifically that issues are raised as needed".
"We may wish to consider some service users to be present".

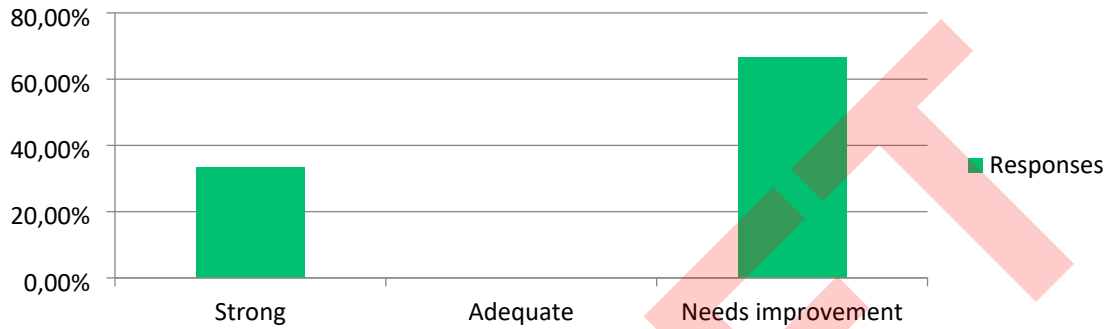


*Improvement on last year

Comments

"Far too much information/data - requires filtering, and summarising with appropriate assurance and escalation processes in place. It is impossible to see the wood for the trees...".
"Available electronically well in advance".

Quality, Safety and Experience Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.NHS Handbook



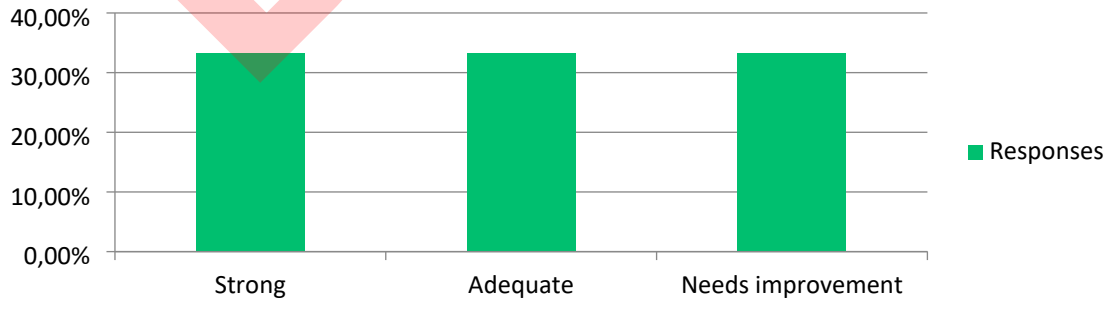
* Deterioration since last year.

Comments

"*Agendas are far too large which prevents adequate discussion, in sufficient depth, for key safety/quality issues".*

"Too long, too much on the agenda and tends at times to going into operational detail rather than stay strategic, trying to improve but not quite there yet".

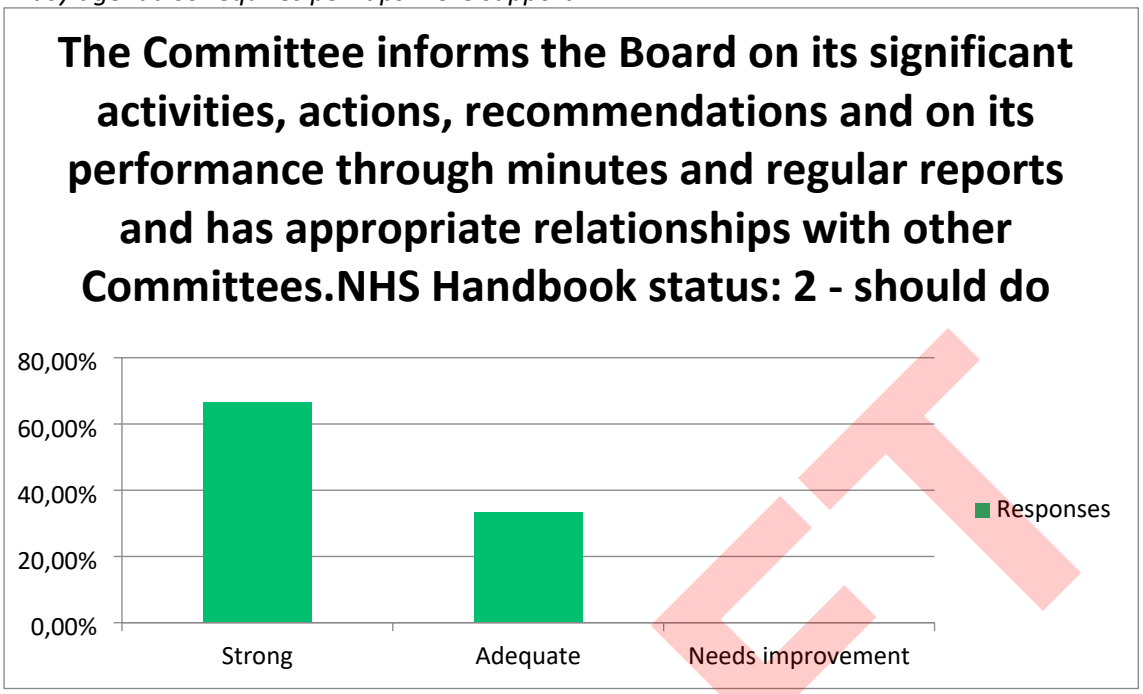
Appropriate internal or external support and resources are available to the Quality, Safety and Experience Committee and it has sufficient membership and authority to perform its role effectively.NHS Handbook status: 1 - must do



Comments

"The UHB has insufficient resource allocated to the quality and safety processes, preventing appropriate filtering, assurance and escalation getting to the QSE Committee".

"Busy agenda so requires perhaps more support".

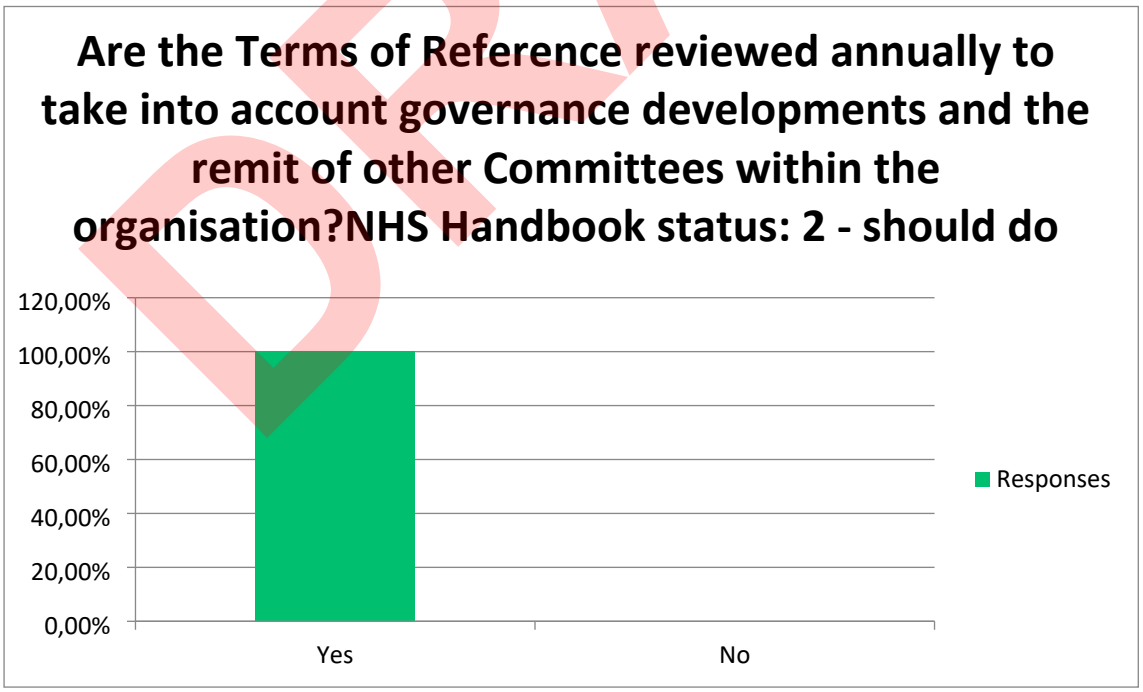


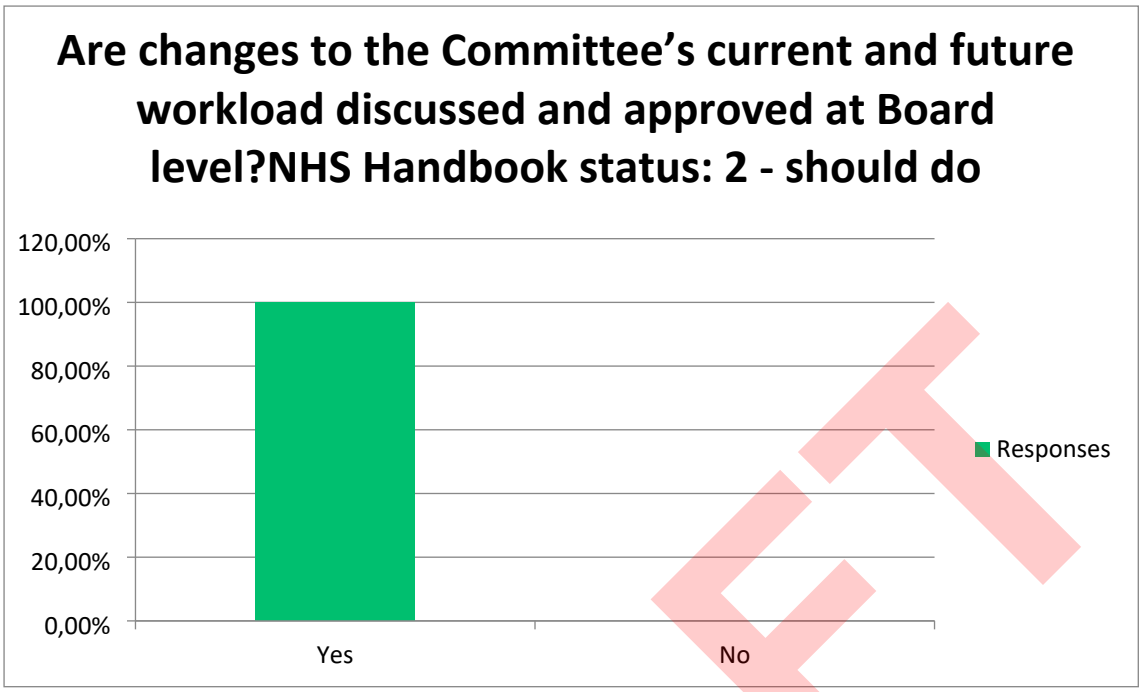
* Scored 100% "Strong" last year

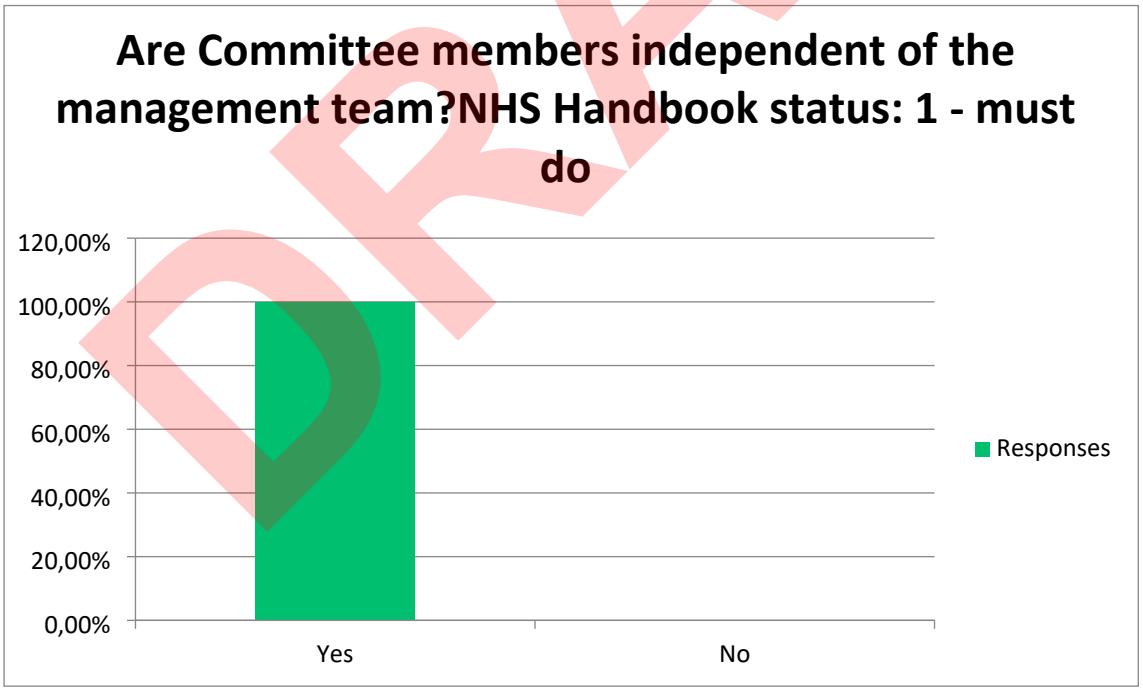
Comments

"The assurance and escalation processes need refinement and alignment with those from other Board Committees"

"Always draws to attention issues for escalation to Board".

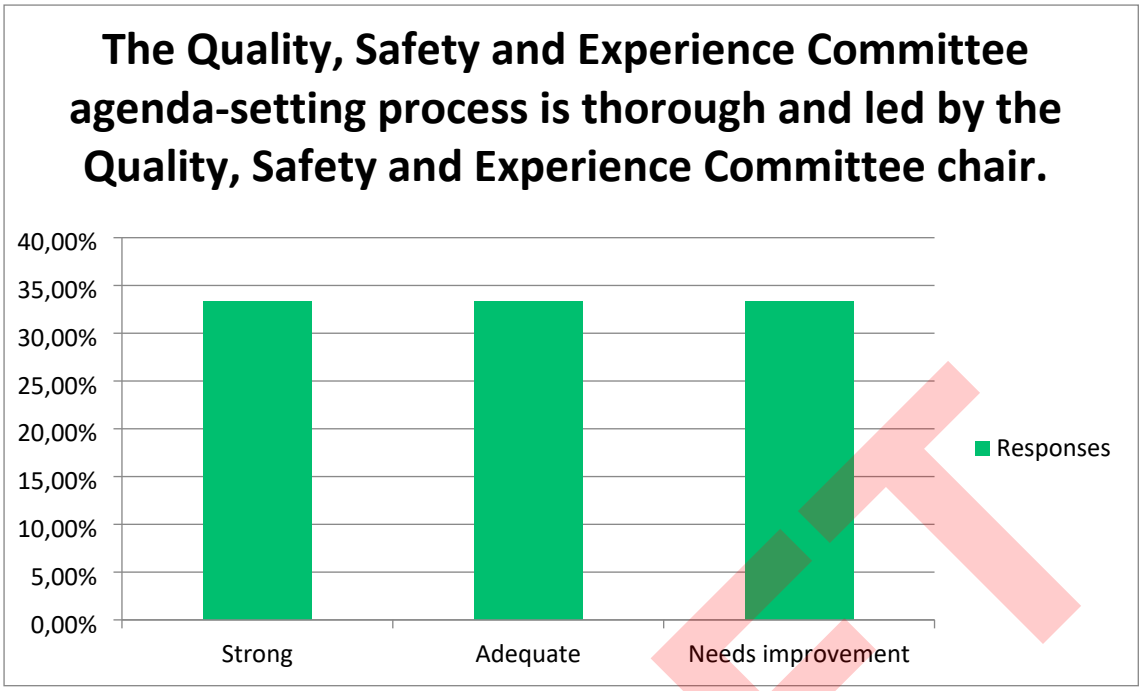






Comments

"Yes though by definition some of the roles are Executives".

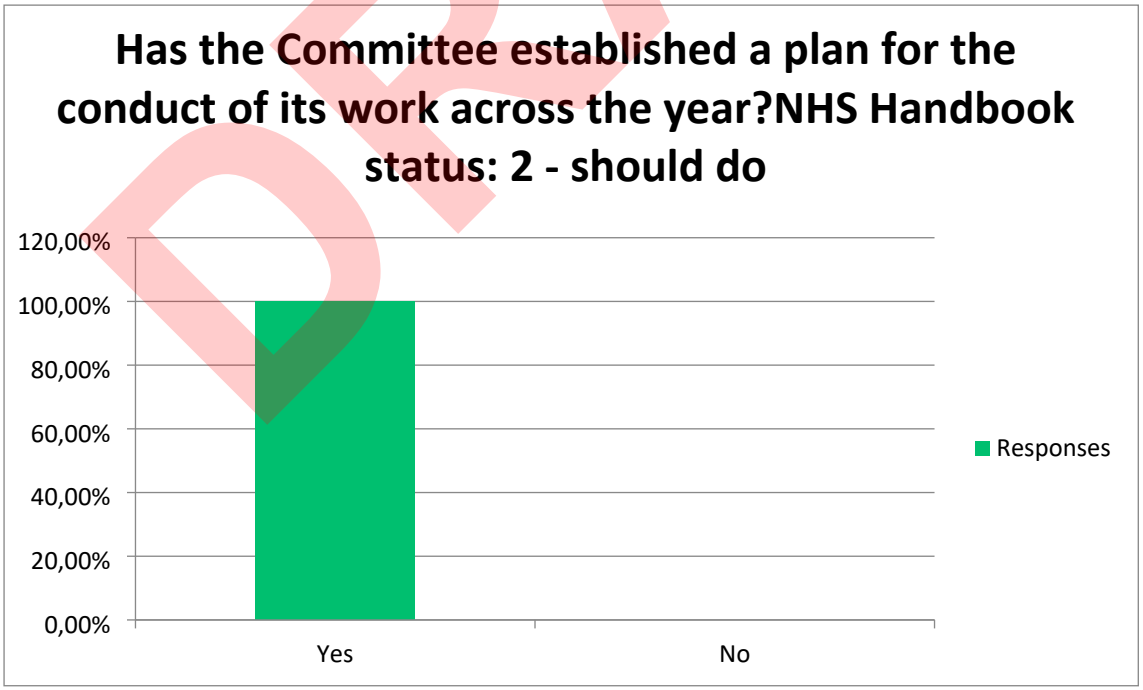


* Improvement since last year

Comments

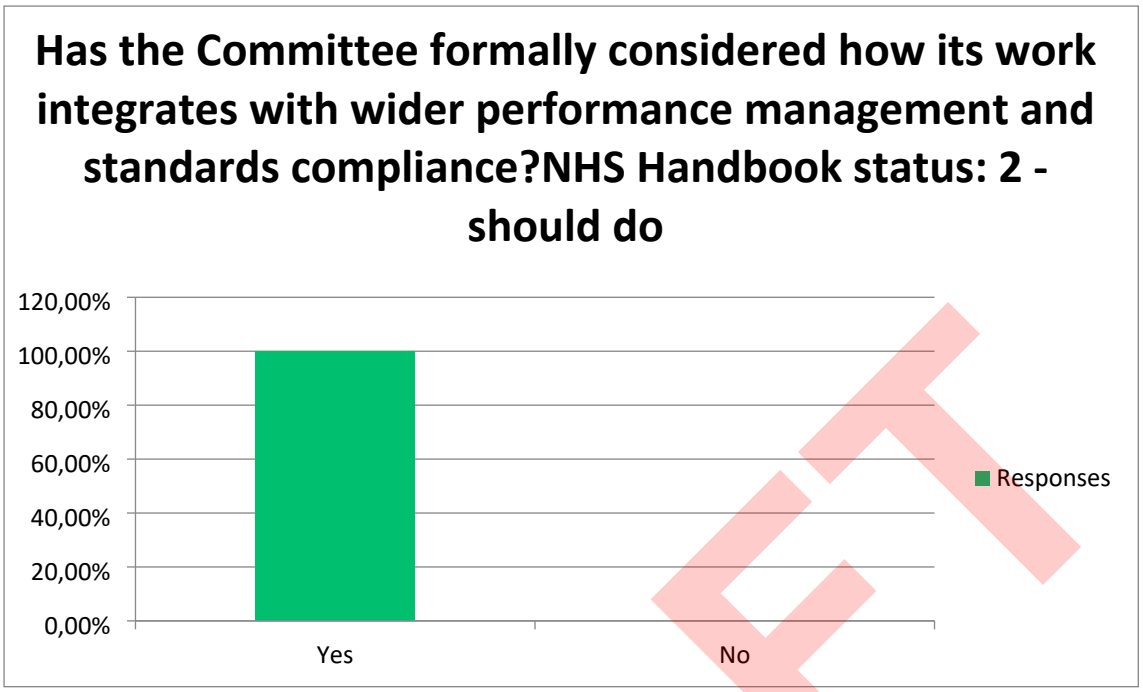
"It is thorough but the agenda is not right, as the sub-board processes are not sufficiently mature".

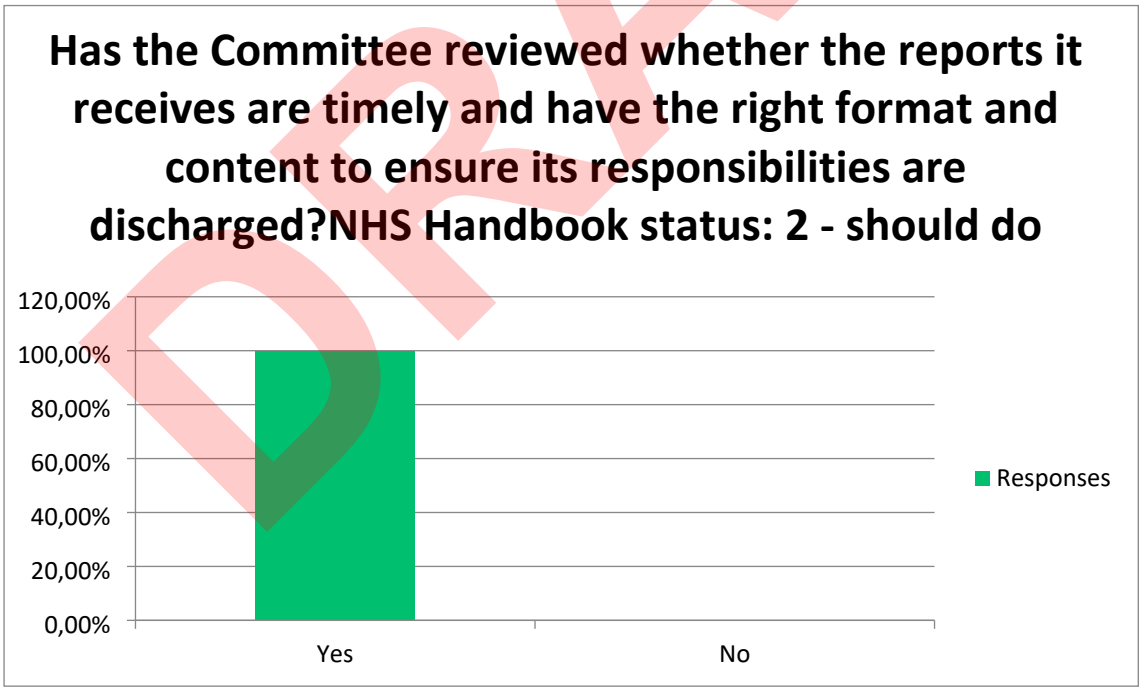
"I believe it is, though the content put on the agenda is sometimes more than time of the Committee allows for- and hence over runs".



Comments

"Annual report".


Has the Committee formally considered how its work integrates with wider performance management and standards compliance?NHS Handbook status: 2 - should do
120,00%
100,00%
80,00%
60,00%
40,00%
20,00%
0,00%
Yes
No
Responses


Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?NHS Handbook status: 2 - should do
120,00%
100,00%
80,00%
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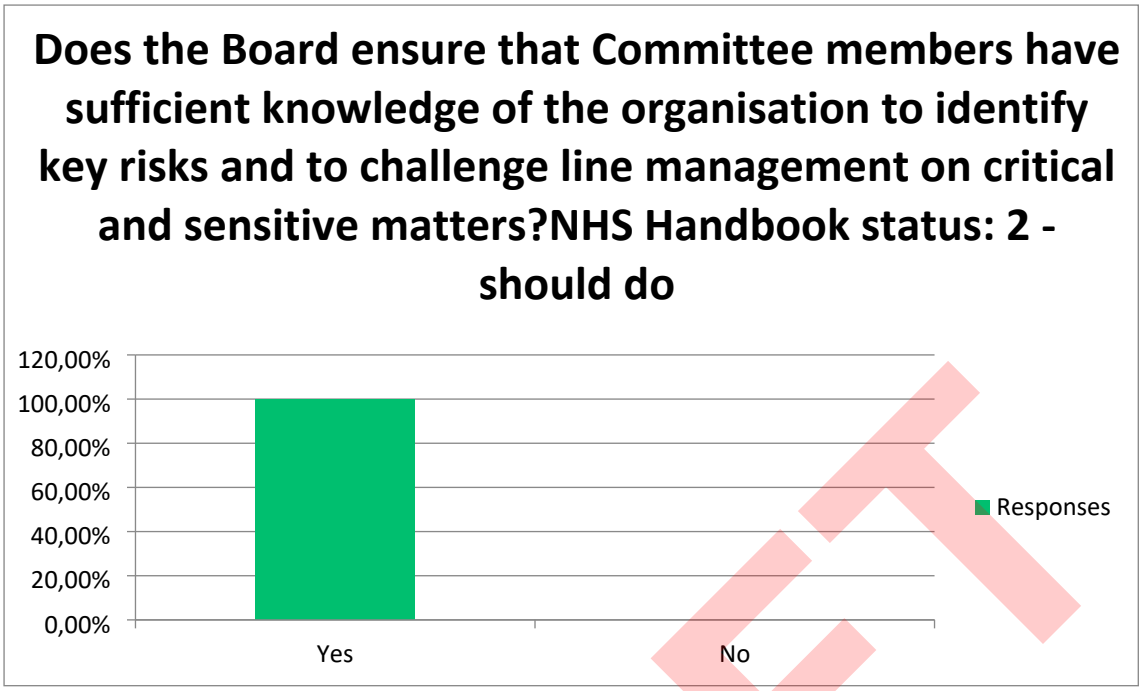
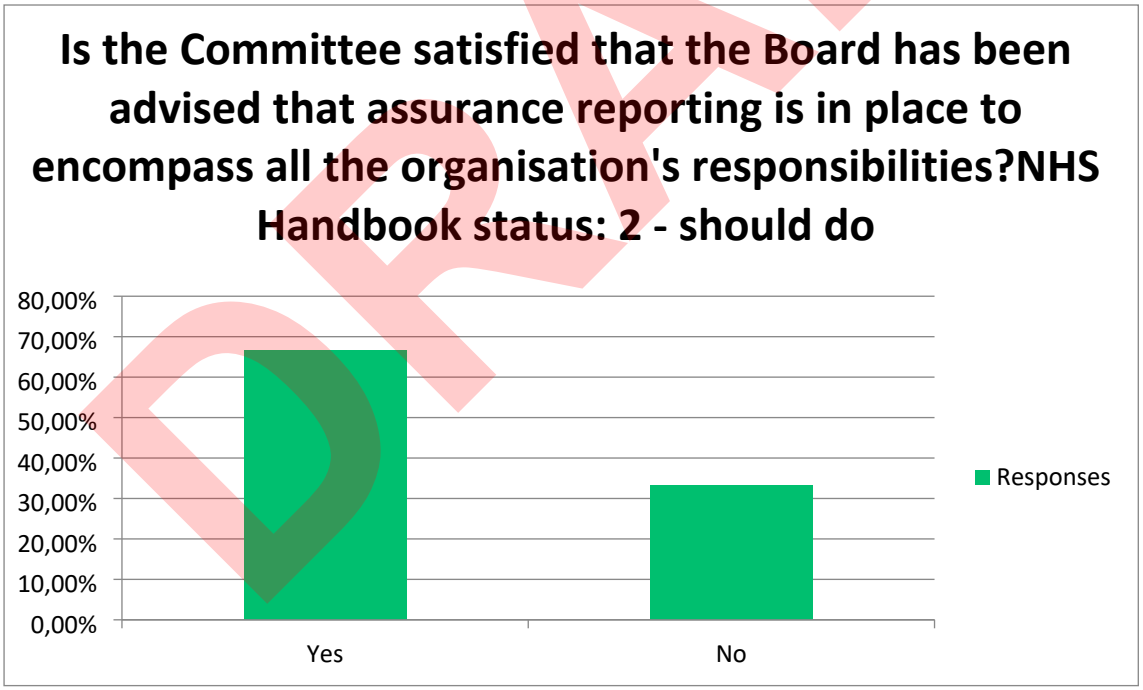
20,00%
0,00%
Yes
No
Responses

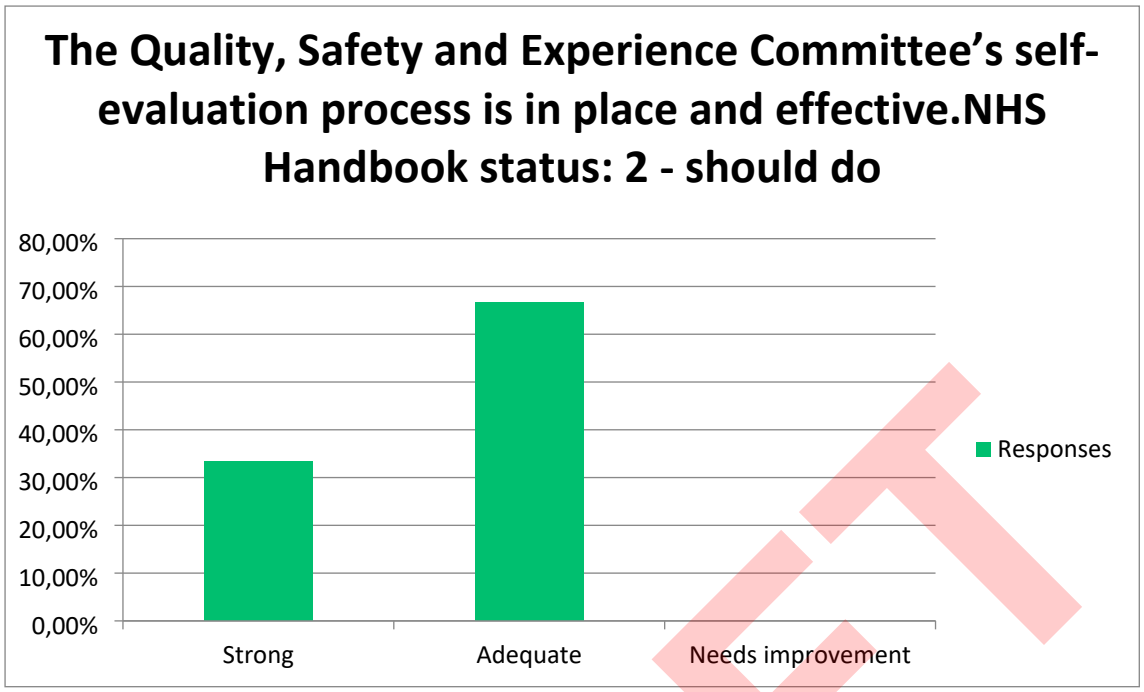


Comments
"Cover the breadth and depth of the organisation, well experienced".

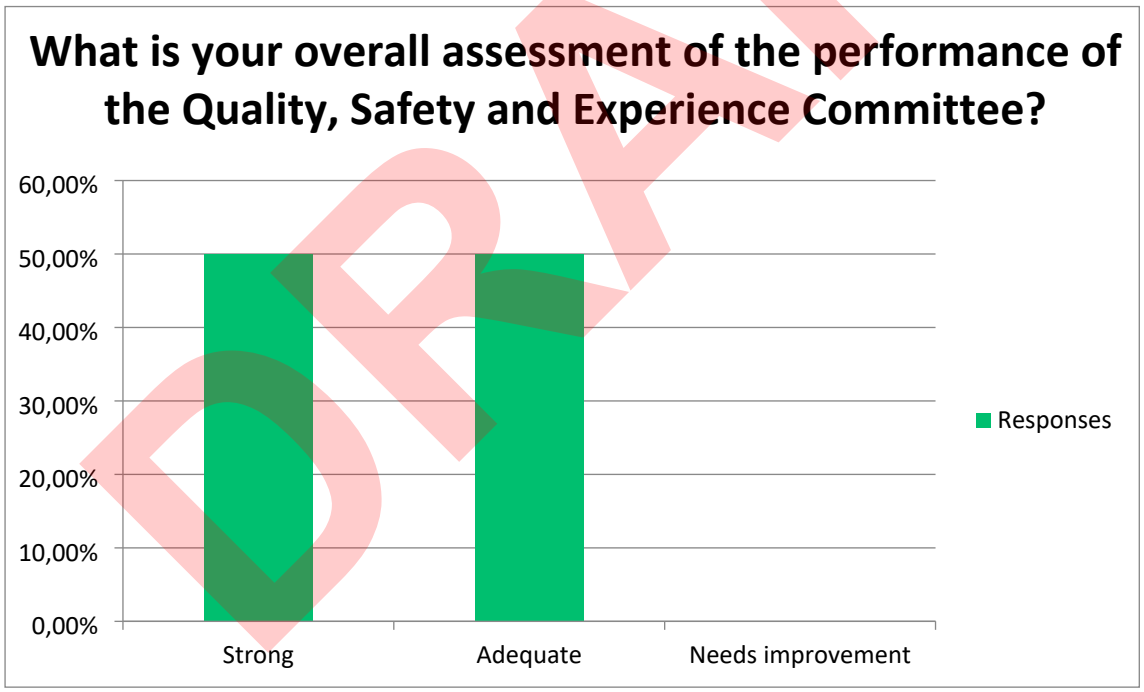


*Scored 100% "Strong" last year

Comments
"The assurance processes are not sufficiently robust to give the board this assurance".



* Slight deterioration



*Scored 100% "Strong" last year

Comments

"A key Committee, works well but agenda is heavy and time consuming".

Question asked	Action Required	Lead	Timescale to complete
The Quality, Safety and Experience Committee Terms of Reference clearly, adequately and realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.	Terms of Reference to be reviewed and new work plan developed to reflect outputs of quality governance reviews. This will include the work undertaken by the Executive Medical Director and the Executive Nurse Director and also the outputs, where relevant, from the Quality Governance Review being undertaken by Audit Wales. Current Terms of Reference and work plan to remain in place until the reviews are concluded.	Director of Corporate Governance	March 2021
The Quality, Safety and Experience Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.	Discussion as to how this can be strengthened such as service user involvement. However, the COO does provide a good counter function and enhances independence.	Director of Corporate Governance / Committee Chair	Dec 2020
The Quality, Safety and Experience Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible.	Meeting packages to be reviewed and uploaded within the timescales set out within Standing Orders. The Corporate Governance Department have clear timescales for delivery and Executive Directors are also required to ensure their reports are submitted on time. The Corporate Governance Department and Executive Director Teams are working closely to achieve this. The issuing of rules for submitting of papers, will further strengthen	Director of Corporate Governance / Committee Chair	Dec 2020

	this in 2020. However, going forward this will require constant review to ensure standards are maintained.		
Quality, Safety and Experience Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.	Robust agenda setting with Chair and Executive Directors which is overseen by the Director of Corporate Governance will improve on this going forward. Quality governance reviews and new work plan will also strengthen.	Director of Corporate Governance/ Executive Leads and Committee Chair	March 2021
Appropriate internal or external support and resources are available to the Quality, Safety and Experience Committee and it has sufficient membership and authority to perform its role effectively.	To consider at next agenda setting support and resources to be provided to improve the Committee's scrutiny and effectiveness. This will include training for IMs on the responsibilities of the QS&E Committee.	Director of Corporate Governance/ Executive Leads and Committee Chair	Jan 2021
The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other Committees.	Chair's reports, Committee annual reports and confirmed Committee minutes will continue to be fed into Board. The Director of Corporate Governance will continue to support the Chair to ensure items are fed into other Committees as appropriate.	Director of Corporate Governance/ Committee Chair	March 2021 for next review
The Quality, Safety and Experience Committee agenda setting process is thorough and led by the Quality, Safety and Experience Committee Chair.	The new Committee work plan will support this and the Director of Corporate Governance will support the Chair in leading the agenda setting and ensuring items are	Director of Corporate Governance/ Executive Leads and	March 2021 for next review

	appropriate. The Work Plan alongside the ToR will also be changed significantly to reflect the Sub Committee Structure and reporting arrangements into the QSE.	Committee Chair	
Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisation's responsibilities?	This will be strengthened with the work being undertaken and led by the Executive Medical Director and Executive Nurse Director. The recommendations of the quality governance review and Audit Wales review will be incorporated in Terms of Reference and work plan renewal to improve assurance reporting.	Director of Corporate Governance/ Executive Leads and Committee Chair	March 2021
The Quality, Safety and Experience Committee's self-evaluation process is in place and effective.	The Committee will continue its annual self-assessment in keeping with all other Committees of the Board.	Director of Corporate Governance	March 2021 for next review
What is your overall assessment of the performance of the Quality, Safety and Experience Committee?	Completion of the action plan will improve the position in addition to the robust and rigorous processes being put into place.	Director of Corporate Governance	March 2021 for next review

Report Title:	**HEALTHCARE INSPECTORATE WALES ACTIVITY**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	**15.12.2020**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Executive Nurse Director								
Report Author (Title):	Head Patient Safety and Quality Assurance								

Background and current 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 September 2020. 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.

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.

Inspections are a means of providing assurance that services are meeting the Health and Care Standards (2015) and are meeting any other relevant professional standards and guidance. Inspections are a structured process and are underpinned by the view of Francis (2013), who emphasised the importance of undertaking direct observations of a service and care provided. Unannounced inspections undertaken by HIW allow them to see services in the way they usually operate and 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

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

HIW stepped down their usual inspection programme at the start of the outbreak of Covid-19 maintaining a scaled down service of assurance and inspection. They will be piloting a different approach to their work going forward between August and October 2020. Three unannounced inspections have been undertaken since the last report to committee, and the second phase of the National Maternity review has been resumed.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

Update on HIW activity during the COVID-19 outbreak

HIW ceased their routine inspection and review programme from March 17th 2020 due to the Covid-19 pandemic. HIW have however continued to monitor and follow up on any significant concerns regarding safety and quality of care. They have continued to:

- Monitor intelligence relating to healthcare in Wales and use this to identify patterns and concerns
- Meet and exercise their essential statutory duties regarding the regulation of Ionising Radiation (Medical Equipment) Regulations
- Deliver the second opinion appointed doctor service, however, this service is delivered remotely
- Work with key stakeholders and partners to ensure they can monitor the quality and safety of healthcare services in Wales
- Together with counterpart regulators of the Ionising Radiation (Medical Exposure) Regulations in England, Northern Ireland and Scotland, HIW published a response to the developing COVID-19 epidemic which you can read here
- HIW have also made changes to the way they operate the Review Service for Mental Health in Wales during this period. You can read the updated guidance and amended methodology for the service here

On 6th July 2020, HIW announced its intention to revise their approach to assurance and inspection for the foreseeable future. They will be piloting a new way of working from August to October which will allow them to deploy their workforce in a more agile way, responding to risks and issues while taking account of revised operating models during the pandemic.

A key feature of the new approach will be the use of a three tiered model of assurance and inspection that reduces the reliance on onsite inspection activity as the primary method of gaining assurance. This will include:

- Tier 1 activity which will be conducted entirely offsite and will be used for a number of purposes but, at this stage, primarily where issues cannot be resolved via the standard concerns process and where the risk of conducting an onsite inspection remains high.
- Tier 2 will introduce a combination of offsite and limited onsite activity,
- Tier 3 will represent a more traditional onsite inspection.

HIW expect the majority of their work to be Tier 1 throughout August and September. For this activity, where work is announced, there will be a shorter lead in time (at least 7 working days), a smaller inspection team with most of the assurance work being completed through a request for information, and a follow-up phone or video call with key personnel. Following a short period of factual accuracy checking, there will be a written summary and, where required, an improvement plan. The summary report will be published as soon as possible after the activity has taken place and the accuracy checking has been completed.

HIW have announced a continuation of the quality checks inspections that have taken place during COVID, further inspections have been planned (November – January) which will take the same 3 Tier approach for MEAU at Llandough hospital, The Teenage Cancer Unit and Nao's Arc (surgical Ward).

Tier 1 Quality Check Inspections

Morgannwg Ward , Barry Hospital – 22nd September 2020

The Tier 1 inspection took place on Morgannwg ward in Barry hospital on the 22nd of

September 2020. A virtual interview was undertaken between the ward manager and HIW, and the documented evidence that was submitted in advance of the meeting were discussed.

The report published by HIW was very positive, HIW found that the ward had made the necessary risk assessment audits and developed relevant procedures to meet the additional demands stemming from the COVID-19 pandemic. Regular environment audits were undertaken as well as clinical audits such as handwashing, pressure areas, patient falls etc.

HIW in their report shared that there were clear admission procedures were in place including for admission of COVID-19 patients, there were risk assessments and procedures developed to comply with the standards set in national guidance. The Infection Prevention and Control Team conducted regular walk arounds to the ward, good communication and access to the team for advice and support was evident.

It was recognised that efforts had been made to ensure patients emotional and mental needs were considered in view of the visiting restrictions in place. Mobile devices and tablets were acquired to facilitate patients to have contact with their families. Measures were also put in place to maintain patient dignity to ensure patients had adequate clean clothing despite the impact of restricted family visiting. There was evidence of proactive thinking and implementation of Intentional rounding to ensure that patients had everything they needed.

In addition to ensuring a socially distanced ward patients could also use the day room which had been adapted to ensure that patients could socialise safely. Staff decorated the dayroom with flags and bunting on VE day and provided patients with a buffet tea to celebrate.

Staff were reported to have responded well to the demands and needs of the service and in supporting their colleagues, which was reflected through their discussion with the senior nurse and ward sister. Adequate skill mix and staffing was evident and there was good compliance with staff mandatory training. No improvements were identified during the inspection process.

See full report here:
https://hiw.org.uk/sites/default/files/2020-10/20201022BarryCommunityHospitalen.pdf

E3 and 4 Llandough 7th - October 2020

HIW undertook a Tier 1 inspection on E3 and E4 at Llandough hospital on the 7th of October 2020. The report was published by HIW was of a positive nature.

In response to COVID-19 the environments on the E3 (identified as a COVID positive ward) and E4 had taken the appropriate measures to ensure that the COVID-19 standards set in national guidance was adhered to.

Reconfiguration of the wards to ensure adequate social distancing had resulted in a reduced number of beds available, there was evidence of a continuous risk-based review in place to monitor overall demands for beds across the health board to ensure patient safety where capacity was increased.

There was clear signage for use of PPE and level of PPE required. Cleaning schedules were in place with an increased frequency of cleaning, hygiene equipment (hand sanitisers, wipes, disinfectant) were accessible and replenished regularly. Consideration was also given to

patients requiring additional tests outside of the ward area, which were carried out at the end of the day to reduce the risk of transmission.

Safety briefings were in place at very handover of shift and daily safety huddles which included identification of patients at high risk of falls, which were reported to be lower during this time as well as other clinically relevant information.

Regular walk rounds were undertaken to E3 and E4 by the Infection Prevention and Control nurse to provide support and training to staff. Staff did not alternate between E3and E4 to reduce the risk of spread of COVID. Office space was freed up to ensure that staff could have socially distanced breaks. Rates of staff personal appraisals and mandatory training were good, and learning programs had been put in place to support staff when support was required with positive outcomes.

Efforts were made to consider the emotional and social wellbeing of patients in view of the restrictions to visiting. Patients were encouraged to use mobile phones, tablets and portable landline which are accessible on the ward to keep in touch with friends and family. Arrangements are made so that family and friends can drop off and collect items for patients to ensure they have everything they need.

No impartments were identified as being necessary during this inspection.

See full report here:
https://hiw.org.uk/sites/default/files/2020-11/20201104llandoughhospitalen.pdf

T4 Neurological HDU – 30th of September 2020

On the 30th of September 2020 a Tier 1 inspection was carried out on T4 neurology HDW, the same approach was taken as with the other Tier one inspections, the Ward Sister was interviewed by Virtual platform with the pre-submitted evidence. Over all this inspection report is very positive.

It was highlighted that there had been significant multidisciplinary team approach in preparing the area to provide lever three care for patients, there had been cross directorate working and extensive collaboration between clinical staff, managers and clinical leads from critical care and cardiac services to ensure that any bespoke environmental and clinical requirements could be safety accommodated which was subject to continuous dynamic risk assessments and oversight from the health and safety department.

Regular risk assessments were undertaken and the ward to ensure that they were compliant with national COVID-19 guidance and had sufficient supplies of PPE. Changes to IP&C guidance were disseminated to staff in a timely way by the ward manager through a variety of different channels.

Usual Visiting arrangements had been suspended to reduce the transmission of COVID, a process of visiting had been put in place for example for end of life care which in line with national guidance. A quiet room was also available for family, patients and staff to have private conversations to maintain their dignity.

The inspection reflected positively on the results and the range of ongoing audits undertaken

including rates of infection, patient falls, equipment and pressure damage. A robust investigation process and sharing of learning to the wider team was also demonstrated.

Appropriate upskilling of staff had taken place to ensure that patients received the appropriate level of care, which included 1:1 nurse led training with oversight from the ward manager to ensure that staff met their competencies. Staff that were risk assessed as high risk were supported to work in different or a non-clinical environment. The ward manger shared her pride in her staff in their approach to the pandemic. It was expressed how some staff were suffering from fatigue due to additional pressures as a result of COVID. HIW advised that the Health board continue to maintain the existing support and explore other means of support for staff.

Adequate monitoring and escalation arrangements were in place for monitoring of staff sickness and absence and increased demands on the service. High compliance rate was noted with mandatory training, it was also noted that additional training was provided to staff such as restraint techniques to support staff and maintain patient safety which was reflected upon positively

There were two areas for improvement identified, an action plan was developed and accepted by HIW – Immediate actions completed.

• Longstanding estates issue relating to a leak on the ward which impacted on bed capacity and IP&C when leaks occurred. Immediate actions- completed. Estates to develop a solution to address the reoccurring leak on ward.

• It was identified that the annual IP&C inspection was overdue, last carried out in September 2020. Immediate actions –IP&C inspection completed.

See full report here
https://hiw.org.uk/sites/default/files/2020-10/20201028univeristyhospitalofwalesen.pdf

Update on thematic reviews:
There have been no thematic reviews since the last report

National Maternity Review
We continue to work with HIW on the National Maternity Review. The report has just been issued and can be found here.

The review found that the quality of care being provided across Wales is generally good, and the majority of women and families who use maternity services report positive experiences, delivered by a hugely committed and dedicated group of professionals. They state that maternity services are, in general, delivered in a safe and effective way, and this is supported by almost 3,500 responses to their public survey. The overwhelming majority of respondents were satisfied and positive with the standard of care and support they received along each stage of the maternity pathway, however, we identified some areas requiring improvement. The Babies don't Bounce initiative, FGM clinic and the live CTG system in Cardiff receive specific mention.

There are a number of recommendations and these will be considered within the UHB and presented to the February 2021 QSE Committee.

HIW are now working on phase 2 of their review and this will run in to Spring 2021.

HIW Annual Report

HIW have also published their annual report which can be viewed here

Overall findings in relation to the UHB are summarised in the table below.

Cardiff and Vale UHB

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

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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration	x	Collaboration	X	Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	**HIW Primary Care Contractor Report**						
Meeting:	Quality, Safety and Experience Committee				**Meeting Date:**	15.12.20	
Status:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information** ✓
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Primary Care Support Manager						

Background and current situation:

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.

HIW visits were suspended at the start of the Covid-19 pandemic. The Primary Care Team received a new Covid-19 "Quality Check" report for a GMS practice on 12th October. The following information was also provided:

"*HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.*

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focused on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance".

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.

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:
General Medical Services

Since the last SBAR report to the Committee in December 2019 there have been three HIW reports received by the Primary Care Team. Two further HIW visits were scheduled but were cancelled by HIW and have not been rescheduled.

The following reports were received:

- Llanishen Court
- The Practice of Health
- Llandaff North Surgery

Two of these reports included concerns that required immediate action. Llanishen Court had no process in place to ensure that all staff had the recommended level of DBS checks. The Practice of Health had stored emergency drugs that were easily accessible by patients. Both concerns were addressed within an appropriate timescale.

All actions recommended in these reports have been completed by the practices. They are therefore displayed as green and will not feature in the next update report.

General Dental Services

Since the last SBAR report to the Committee December 2019 there have been four HIW reports and one Immediate Assurance Letter received by the Primary Care Team.

The following reports were received:

- N Dental (Grangetown)
- Newport Road Dental
- Mount Pleasant Dental Practice
- Advance Dental Clinic

These HIW reports have been reviewed by a Dental Practice Adviser (DPA), 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.

An Immediate Assurance Letter was issued to Birchgrove Dental Practice in relation to concerns of non-compliance with Covid-19 guidance. The practice was visited by a DPA and HIW are satisfied with the actions taken to resolve the concern.

Since the last report, three practices have been removed from Appendix 2, as their actions have been completed. These are as follows:

- Restore Dental Whitchurch Road
- Tynewudd Dental Practice
- Park Place Dental Practice

Due to the actions of the practice, Llanedeyrn Dental Practice has been re-categorised from an Amber to a Green.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

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 Primary Care Team continue to report inconsistencies in the receipt of reports. Two of the reports included in the appendices where not received at all, and where instead discovered on the HIW website.

The review and summary of reports are attached **(GMS Appendix 1, GDS Appendix 2).**

Recommendation:

The 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

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								

APPENDIX 1

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions/Update*
Llandaff North Surgery	15th September 2020	Covid-19 Arrangements: • The practice, where possible, limits the number of patients attending the site for appointments • Patients are reviewed by a clinician prior to being offered a face to face consultation. • We saw evidence that all staff had received up to date infection prevention and control (IPC) training that included sufficient training to ensure appropriate use of Personal Protective Equipment (PPE). Environment • A risk assessment had been undertaken to identify specific needs in light of the COVID-19 pandemic • The practice is undertaking home visits and visits to care homes when necessary. Infection prevention and control • Evidence of the cleaning contract, and audits by the company to ensure compliance with the contract. • Patients who attended the practice are given instructions prior to attending their appointment, to stop patients waiting in the practice at the same time. • Home visits are conducted in PPE which is disposed of in clinical waste Governance • The cluster business continuity plan includes the sharing of staff, buildings and general resources if necessary.	G	No actions or improvements identified
The	16th March	Cancelled		

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Waterfront Medical Centre	2020 -			
The Practice of Health	10th February 2020	1. Emergency drugs were kept in an unlocked room, which patients could gain access to. 2. The practice must ensure changes to appointments are communicated with patients. 3. The practice must ensure that patient records are maintained in line with professional standards for record keeping.	G	1. Completed at practice during visit. 2. All appointment changes are now reported to patients via SMS or phone as per new process. - Complete 3. Clinicians to reflect and refresh on the GMC guidance Good Medical Practice (2013) on record keeping - Complete
Clifton Surgery	27th January 2020	*Cancelled by HIW and not rebooked*		
Llanishen Court	10th December 2019	1. The practice must ensure all staff (where applicable), have DBS checks completed to a level appropriate to their roles, and records are up to date 2. The practice must maintain a clear record of staff training, and ensure that staff attend training within appropriate timescales 3. The practice must implement a clear and robust recruitment policy to ensure that all pre and post appointment checks are completed, prior to a new member of staff commencing 4. The practice should ensure it holds an up to date practice information leaflet	G	Originally categorised as Amber. All actions complete

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

		5. The practice must ensure that records are kept in line with professional standards 6. The practice must ensure that meeting minutes are available to all staff within the practice 7. The practice must ensure policies and procedures are readily available to staff and reviewed regularly	
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*
Practice of Health	10th February 2020	Emergency drugs were kept in an unlocked room, which patients could gain access to.	The drugs were locked away in the fridge, and staff were reminded of the importance of ensuring drugs were kept secure.
Llanishen Court	10th December 2019	The practice must: • Ensure all staff (where applicable), have DBS checks completed to a level appropriate to their roles, and records are up to date.	The practice was provided with NHS guidance on what DBS checks should be sought for individual staffing groups. The practice has ensured that all staff have the appropriate check.

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*
64	Birchgrove Dental Practice (Moorcastle Ltd)	02/10/2020 Non-compliance 07/10/2020	Awaiting full report		• Mick Allen (DPA) visited practive 07/10/2020, written response to HIW regarding visit findings • Awaiting full report	• DPA visit complete 07/10/2020. • HIW accepted practices non compliance response.
63	Advanced Dental Care (A Nourish)	13/01/2020 Report Published 14/04/20 (found on website)	No improvement recommendations		• DPA satisfied with HIW report, no recommendations.	
62	Mount Pleasant Dental Practice (E Akbas)	05/11/2019 (Report found on website) Published 06/02/2020	A quality patient experience, with friendly and professional staff. Areas of improvement identified including notekeeping, compliance to practice policies and quality assurance including audit. • Sharps bins to be relocated to avoid contamination of clean areas which should be clearly designated • The practice must ensure complaints procedure (Putting things Right) is displayed, mechanism for feedback and display how feedback was acted upon. • Fire safety training and assessment to carried out • Clinical audit including smoking cessation. • Audit of note keeping to identify areas of improvement		• DPA summary report complete. • DPA letter	• DPA continuing to monitor

			• Record of policy awareness updates by staff including whistleblowing			
61	Newport Dental Practice (321 Newport Road S Yeganeh)	02/10/19 Report published 03/01/2020 (Full report found on website)	The practice was found to be committed to a positive patient experience and rated excellent by patients. Areas of improvement were recommended in compliance with current regulations, standards and best practice guidelines. • Immediate improvement plan initiated re emergency drugs and resuscitation equipment • The practice must provide evidence to HIW that the dental nurse has undertaken the required number of hours (five) of verifiable training in disinfection and decontamination. • Feminine hygiene bins must be made available within the appropriate toilets and feminine hygiene waste must be disposed of appropriately. • Patient records must be fully maintained in keeping with current guidance and professional standards for record keeping (including those recommended within this report).		• Immediate improvement action taken and practice confirmed. • DPA summary report Complete • DPA letter	• HIW satisfied with immediate improvement plan.
60	N Dental (Grangetown)	24/10/18 Report published 25/01/19 UHB and practice did not receive report. Final report requested.	Overall a good report confirming safe and effective care. We hope the report highlights areas to further improve the service. • Welsh and English language information to be made available • The practice must ensure that the clinical waste storage remains locked at all times. • The practice must ensure it completes its COSHH protocol and mercury handling policy to be included in its policy file. • The practice must ensure that Infection Control audits comply with WHTM 01-05 • The practice must ensure that the wear and		• DPA summary report completed. • DPA letter	• DPA continuing to monitor

			tear of both treatment chairs is repaired or replaced on moving premises. • The practice must ensure that the floors in both surgeries are properly repaired to an acceptable standard whilst waiting for a move to alternative premises. • The practice must ensure there is a specific policy in place covering medical emergencies and cardiopulmonary resuscitation. • The practice must ensure that all items within the first aid kit are up to date. • Local radiography rules displayed • The practice should undertake a broad range of Audits and MMD to ensure they are meeting with best practice • A secure system for holding records outside of archive • The practice must ensure that when updating the practice policies and procedures they signpost which area of the regulations they are covering			
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 • DPA letter sent 08/11/19 • Response received 08/11/19	• All actions complete
58	Restore dental Group (Whitchurch	30/07/2019 Final report received	Minimal recommendations and an overall positive and complimentary report • Regular fire drills		• DPA summary complete • DPA letter sent	• Improvement plan submitted to HIW 17/09/19 • HIW satisfied with

	Road)	20/09/19	• IPC training for all staff and first floor rear surgery decluttered • patient records are completed in line with professional standards		08/11/19 • Response received 22/11/19	Improvement plan 20/09/19 • DPA continuing to monitor
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 • 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		• 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. • DPA continuing to monitor
56	Penarth Dental Healthcare	01/07/19 Final report	A number of improvements have been recommended, many of which have been		• DPA summary completed.	• DPA continuing to monitor

		received 04/09/19	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 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		• DPA letter sent 08/11/19 • Email response received 15/11/19	
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	23/05/19 Improvement	• Greater selection of info leaflets • Display General Dental Council 9 Principles,		• DPA Letter 16/08/19	• HIW Satisfied with improvement plan submitted 18/07/19

	Practice (RWH Ltd)	plan issued from HIW Final report received 22/07/19	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 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		requesting confirmation of action. • Visit 3/12 (October 19) • Visit booked 27/11/19 @1pm • Practice visit carries out 27/11/19, Satisfied recommendation taken on board.	• Awaiting response
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		• Letter sent to practice 28/6/2019 requesting	• HIW satisfied with improvement plan submitted 29th April 2019 • DPA continuing to monitor

			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 • 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		confirmation / evidence of completed improvement plan • DPA letter resent 10/10/19 requesting evidence. • Response received 21/10/19 unsatisfactory, more evidence requested 25/10/19 • Full response with evidence received 12/11/19	
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		• 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. • DPA continuing to monitor

			• 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			

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*
5	Birchgrove Dental Practice	02/10/2020	07/10/2020	The service must ensure that the arrangements in place at the practice are in line with the 'Standard Operating Procedure for the Dental Management of Non-COVID-19 Patients in Wales' guidance document produced by the Chief Dental Officer	• DPA Mick Allen visited practice 07/10/2020, to write response to HIW. • HIW accepted None compliance response

HIW Concerns Raised (received since last update)

	Practice Name	*Contact from HIW*	*Follow Up*	*Summary of Concerns*	*Summary of UHB Actions*
	N/A	*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

KEY

Issues	Status
Minor issue e .g : Price list not displayed - Translation services not present - Patient Feedback	GREEN
Issue requiring remediation, but not likely to pose patient safety issue. E. g - QA arrangements - Policies updating and signing - Complaints Processes	YELLOW
Serious Issue requiring remediation due to **potential** patient safety concern. e.g: - Safeguarding procedures - IR(Me)R Issues - Record Keeping Issues - Staff Training Records - Access to staff areas - HTM 01-05 issue : Minor	AMBER
Serious Issue requiring immediate remediation due to present patient safety issue:, e. g : - Decontamination processes - Cross Infection control - Emergency Drugs/Equipment - HTM 01-05 : Major	RED

Report Title:	**Independent Blood Inquiry Update**								
Meeting:	**Quality, Safety & Experience Committee**						**Meeting Date:**	**15th December 2020**	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**		**For Information**	**x**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Corporate Governance Legal Advisor**								

Background and current situation:

Following a temporary suspension of Hearings due to Covid-19, the Inquiry recommenced hearings on the 22nd September 2020 and set out an indicative timetable of hearings until the 11th December 2020. Due to the Christmas period, there are no further hearings following the 11th December, however the inquiry anticipates recommencing hearings in early January 2021 with interim hearing dates set for the 12th to 15th and 25th to 26th January 2021. Due to the English lockdown and Covid-19 restrictions, hearings are currently proceeding remotely with witnesses giving evidence via a video link.

Executive Director Opinion /Key Issues to bring to the attention of the Board/Committee:

The hearings have been, and will continue to be, aired online and the Head of Risk and Regulation has put in place arrangements to ensure that hearings are attended virtually by the newly appointed Corporate Governance Legal Advisor, or himself in her absence, so that pertinent information and issues can be reported upon. Requests to physically attend the hearings cannot be made until further notice.

During September Counsel for the Inquiry shared a chronology of the knowledge of risk and following the evidence of Lord David Owen (a former Minister for Health), Counsel presented evidence pertaining to Professor Arthur Bloom and the work of the Cardiff Haemophilia Centre. Following those hearings Haemophilia centre directors from across the UK have given evidence almost daily since. Key Haemophilia reference centre directors and witnesses have given evidence which has provided an intimate insight into the decision making, the development of risk knowledge and the impact of the situation between 1978 and 1995.

During the week commencing 16th November 2020 former Health Board employee Dr Saad Al Ismail gave evidence and spoke in depth about the practices of Professor Arthur Bloom and the work undertaken at the Cardiff Haemophilia Centre. It is anticipated that current Health Board employee, Professor Peter Collins, a Professor of Haematology, will be called to give evidence at the Inquiry in the new year alongside former Health Board employee Dr John Giddings.

Professor Collins, Dr Giddings and other former employees required to give evidence have been given the full support of the Health Board to ensure that they are able to fully co-operate with and assist the Inquiry. Administrative support has been provided internally however, to ensure that

colleagues and former colleagues are able to respond impartially, external independent legal advice has been sourced to assist with the preparation of witness statements and evidence.

Since September 2020 the following key issues have consistently been discussed:

- NHS/UK Self-sufficiency and the production of UK blood products;
- The date of knowledge of the risk of HIV/AIDS transmissions from blood products, particularly from imported commercial Factor VIII blood products;
- Treatment practices and guidelines, specifically the use of cryoprecipitate as opposed to commercial Factor VIII products and the differing approaches taken to children, adults and previously untreated patients;
- Issues of consent to treatment and testing; and
- Generally, the communication of risk and diagnosis with patients.

The Corporate Governance Legal Advisor and the Head of Risk and Regulation have virtually attended each hearing since the 22nd September and are on hand to answer any queries that Committee Members may have.

Should Committee members wish to gain a greater understanding of the work of the Infected Blood Inquiry full details of the scope of the Inquiry and the work undertaken can be found at the following website: https://www.infectedbloodinquiry.org.uk/

An up to date hearing timetable can be found at the following link: https://www.infectedbloodinquiry.org.uk/www.infectedbloodinquiry.org.uk/haemophilia-clinicians-public-hearings/haemophilia-clinicians-public-hearings-timetable

Hearing Transcripts and other evidence shared can be found online at the following link: https://www.infectedbloodinquiry.org.uk/evidence

An online stream of the hearings is also shared on the Infected Blood Inquiry's Youtube Channel. Should Committee Members wish to view historic hearings or daily hearings live (with a three minute delay) they can do so via the following link: https://www.youtube.com/channel/UCmFkDoDeSsnYVZtNgo3150g

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

There is a risk that the evidence shared at upcoming hearings may lead to the publication of adverse press which would affect the reputation of the Health Board.

This risk will be mitigated by the Health Board's open and transparent approach to the Inquiry and through the implementation of a comprehensive communications plan.

Recommendation:

It is recommended that the Quality, Safety and Experience Committee note the contents of this report and links to inquiry resources.

Shaping our Future Wellbeing Strategic Objectives

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	x	Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								